EXPLORING HOLISTIC NURSE MANAGER ROLES WITH NEW PATIENT SATISFACTION DIMENSIONS AND EXPECTATIONS

by

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A Dissertation Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Health Administration

University of Phoenix

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ABSTRACT

The health care environment is transforming with new demands and expectations to improve patient outcomes including patient satisfaction. Health care organizations expect front line nurse managers to improve patient quality and satisfaction without a clear direction or meaningful understanding of the holistic role, functions, and competencies required to achieve organizational goals. The purpose of the qualitative transcendental phenomenological study was to explore the lived experiences and perceptions of the holistic and changing nature of the projected contemporary nurse manager's roles, skills, practices, and dimensions aligned with the expectations for improving patient satisfaction. The exploration of the lived experiences and perceptions among 21 study participants, and data analysis using the modified van Kaam approach, led to the formulation of eight major themes that explained the nature of the experience with the phenomenon. The eight essential themes that encompass the context of the new contemporary and holistic role of the nurse manager to improve patient satisfaction include the following; (a) new expectations, (b) building a patient caring culture, (c) leader rounding, (d) healthy working environment, (e) staff engagement and empowerment, (f) change agent for continuous quality improvement, (g) impact of organization focus and culture, (h) challenges: sustainability of initiatives; lack of interdepartmental and interdisciplinary teamwork. The new proposed nurse manager role in transformation conceptual model aligns nurse manager contemporary and holistic role with transforming cultures for improved patient outcomes. The study findings are significant to health care organization, leaders, policy makers, and educators, in creating new patient caring and healthy working cultures for improved patient satisfaction.

DEDICATION

First and foremost I dedicate my journey to my Lord Jesus who blesses me each day and provides me with the opportunity to learn and experience life. This dissertation is dedicated to all the people in my life who have cared, believed, and supported me in my amazing life journey. I would like to dedicate this dissertation to my primary source of inspiration, my parents Vergis and Daisy Idichandy, who have showered me with their unfailing love, faith, and support. They instilled and inspired in me a love for God, family, learning, social justice, and a drive for excellence.

I dedicate this dissertation to the most important man in my life, my husband Philip who has been my constant source of love, support, patience, and strength, so I could pursue my lifelong goal. I am thankful for his tireless support and sacrifice in attending to our children's and household needs so I could pursue my education. To my dearest children, Michelle, Nicole and Rachelle; my love, my life, and my all, who understood and sacrificed much, so their mother could complete the doctoral journey- I dedicate this work to you. Thank you for being a source of comfort, and support through many struggles and sacrifices, while our all our lives were suspended, to pursue this goal. Hopefully my journey has inspired you to dream and aspire to reach your potential while staying grounded our values, and love for God. I would also like to thank my sister and close family members for their encouragement and assistance with some of my responsibilities while I concentrated on completing my dissertation.

ACKNOWLEDGMENTS

I thank my Lord for providing me a wonderful opportunity to experience learning. My doctoral journey would not have been possible, if it wasn't for special people in my life, who have supported, guided, and mentored me. I would like to extend my deepest and sincere gratitude to Dr. Patricia Traynor, my true and faithful mentor, who in every sense of the word has inspired, believed, and motivated me to reach my goals. Dr. Traynor's unending support, encouragement, and guidance is a source of inspiration and strength in the most difficult of times. Her expertise and knowledge in the research process has given me a sense of direction and clarity for my dissertation. Dr. Traynor, I thank you for believing in me and helping me through a long but wonderful journey. I would like to thank the committee members Dr. Anne Brett and Dr. Dorin Andreescu for lending their research expertise, guidance, motivation, and support through dissertation pathway. I would like to thank Dr. Anne Brett for providing precious insights in nursing, health care, and phenomenology.

I would like to acknowledge and extend my gratitude for the extended family members, close friends, and coworkers who have cheered, supported, prayed, and stood by me, through the last several years. I am ever grateful for the love you bestow on me. I would like to thank my peers, and leadership at my institution for affording me the support and flexibility to attend to my educational goals. I am grateful to the leadership at the various hospitals for providing me the opportunity to conduct the study. In addition I would like to give thanks to the elite group of study participants for giving their time, efforts and sharing their lived experiences and perceptions of the phenomenon. They are a true inspiration and role models for aspiring leaders in health care.

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Chapter 1

Introduction

According to the Institute of Medicine (IOM, 2001a), the United States health care system is highly fragmented, inconsistent, and inefficient resulting in poor quality of health care. Staff members at IOM (2011) emphasized that the changing health care environment, increased competition, federal mandates for improving quality, and consumer-driven health care choices, are drivers for health care organizations to improve patient outcomes such as quality, safety, and patient satisfaction. The health care industry is undergoing transformative changes to provide value, improve quality, and efficiency through stakeholder emphasis on transparency, accountability, and performance (Farquhar, Kurtzman, & Thomas, 2010; Kurtzman, 2010).

Patient satisfaction is a valid measure of quality (Centers for Medicare & Medicaid Services [CMS], 2010a, 2010b; Donabedian, 1980). Patient satisfaction is fundamental to the organization's success in terms of public reporting, pay-for-performance initiative, loyalty, referrals, treatment outcomes, accreditation, fewer malpractice claims, staff satisfaction, competitive advantage, financial health, choice of health providers, and health plans (Press, 2005; Spence Laschinger, Gilbert, Smith, & Leslie, 2010). The Centers for Medicare & Medicaid Services (CMS) required hospitals to report satisfaction measures through the Hospital Consumer Assessment of Health Plans Survey (HCAHPS) or face a 2% reduction in health care reimbursement (U.S. Department of Health and Human Services [USDHHS], 2011a).

As required under the Affordable Care Act of 2010 Section 1886 (0) of the Social Security Act, the Value-Based Purchasing proposal by CMS in 2011 provides incentives

for hospitals based on improvement of quality measures including patient satisfaction under the Inpatient Prospective Payment System (IPPS) (USDHHS, 2011a). Under the pay-for-performance program, CMS, an active purchaser of health care, may withhold 1% of Diagnosis Related Group (DRG) payment reimbursements in 2013 and will rise by 0.25% points each year and capped at 2% in 2017 to promote value and improve quality including patient satisfaction measures (USDHHS, 2011a).

Most hospitals are continually seeking leadership strategies that will improve quality of patient care and health care experience. In a survey of health care executives, 80% claim enhancing the patient care experience was a top priority of health care organization ("Finances Top Concern for CEO's," 2011). Nurse managers leading the largest workforce of health care workers (Bureau of Labor Statistics, 2011) are essential to improving patient safety and quality outcomes (Conrad & Sherrod, 2011; Finkler, Kovner, & Jones, 2007).

Despite health care organizations seeking leadership attributes in nurse managers to improve quality outcomes such as patient satisfaction, nurse managers may lack sufficient knowledge and skills when faced with multiple issues such as lack of adequate preparation for the nurse manager role (Lin, Wu, & White, 2005), lack of defined competencies (Lin, Wu, Huang, Tseng, & Lawler, 2007), high turnover, aging workforce (IOM, 2010), and scarce financial and human resources to meet organizational imperatives (Anthony et al., 2005; Kenmore, 2008; Kerfoot, 2008; McLarty & McCartney, 2009; Zori & Morrison, 2009). Despite the importance of nurse manager roles few if any, empirical studies exist on how the nurse manager will meet new

organizational, stakeholder, and policy demands for improving patient satisfaction in the 21st century contexts.

The aim of the current qualitative transcendental phenomenological study was to explore the lived experiences and perceptions of the holistic and changing nature of the projected contemporary nurse manager's roles, skills, practices, and dimensions that may improve overall patient satisfaction. The intent of extracting exploratory data from participant was to ascertain consistent themes or patterns for consideration in developing new strategies and emerging constructs that may guide the development of a potential model about the relatively unknown phenomenon. The model may assist hospital leaders and other health care organizations in the United States to further define nurse managers' work responsibilities and task-related competencies to address the new organizational, stakeholder, and policy demands for improving patient satisfaction in various hospital settings. Chapter 1 includes a synopsis of the background of the problem, a purpose statement, nature of the study, overview of the research question, hypothesis, theoretical, and conceptual frameworks, definitions of key terms, assumptions, limitations, and delimitations surrounding the topic of the study.

Background of the Problem

The United States (U.S.) health care system is besieged with a high degree of fragmentation at different levels resulting an inability to provide accessible, high quality care at affordable prices (IOM, 2011). In 2001, the Institute of Medicine (IOM) released a groundbreaking report entitled, "Crossing the Quality Chasm: A New Health System for the 21st Century" emphasizing the chasm between stakeholder perception of quality and the actual delivery of quality care (IOM, 2001a; Joint Commission Resources [JCR],

2007). IOM is an independent, nonprofit organization, health arm of the National Academy of Sciences, and an authoritative voice for the public and private sector.

The IOM report entailed recommendations for restructuring the health care system by making use of the best available resources to provide better quality care (JCR, 2007). The focus of the report was on six fundamental dimensions of health care service delivery such as safety, effectiveness, patient centeredness, timeliness, efficiency, and equity (IOM, 2001a). The patient-centered recommendations included provisions that health care organizations are respectful and responsive to the patients' preferences, needs, and values while ensuring the patients' values form the foundational basis to guide clinical decisions (IOM, 2001a).

Health care leaders face issues in balancing multiple priorities of providing safe and excellent quality healthcare amid increasing regulatory and consumer demands, rising costs of healthcare, lower reimbursements, increasing competition, scarcity of human, and financial resources ("Finances Top Concern for CEO's," 2011). Health care organizations face challenges in redesigning current organizational frameworks and with new potential conditions and strategies that improve patient outcomes in dimensions that affect quality, safety, satisfaction, and loyalty (Agency for Healthcare Research and Quality, 2008; IOM, 2001b). The current issues in the United States health care system reinforce the need for leaders who can create and transform health care organizations to new models that continue to improve quality, equity, and efficiency.

In a changing health care landscape, nursing leaders play a vital role in the effective implementation of emerging policies, quality, and performance initiatives (Farquhar et al., 2010). The Advisory Board Company terms nurse managers as

lynchpins that play an important role in the retention, recruitment, and staff satisfaction (Mathena, 2002) as healthcare organization expect that nurse managers enhance staff and patient outcomes (Ten Haaf, 2008). Few empirical studies, if any, focused on how the nurse manager will meet the newer indications and dimensions for improving patient satisfaction.

Nurse Manager Leadership Roles Aligned With Organizational Goals

In a changing health care landscape of increasing transparency, accountability, and value driven health care, nurse leaders will play a significant role to enable hospitals meet quality metrics such as patient satisfaction (Kurtzman, 2010). Three major issues escalated and converged in the 21st century healthcare environment to affect the nurse managers' roles and competencies to meet organizational demands for improving patient satisfaction. First, leaders of healthcare organizations often attempt to solve the management problems by promoting experienced clinical nursing staff based on expert clinical skills without adequate preparation in nursing management skills (Grindel, 2003; McLarty & McCartney, 2009; Zori & Morrison, 2009). Kleinman (2003) emphasized that more than two thirds (69%) of nurse managers in the United States do not hold a graduate degree and little consistency exists in job requirements for a nurse manager within the hospital industry. Nurse managers receive little ongoing professional development, lack of support, mentorship, or training as frontline nurse managers (Harkins, Butz, & Taheri, 2006; McLarty & McCartney, 2009; Swearingen, 2009). This void in management and leadership skill development leads to frustration, poor performance, failure to lead the group practices of other nurses in the unit, and a failure to manage different functions to make the organizations thrive (Anthony et al., 2005).

The second issue is that healthcare organizations face scarce human and financial resources and nurse managers may lack sufficient support from top leaders to manage the business of complex patient care operations, budget management, human resources management, and multi-level communications (McLarty & McCartney, 2009). Managers react to multiple fragmented activities with little time for planning and building effective stakeholder relationships (Yukl, 2010). The United States is currently facing a nursing shortage with a Registered Nurse (RN) vacancy rate of 8.5% that will intensify with demands of the aging Baby Boomer generation, and substantial growth of insured population resulting from the Affordable Care Act of 2010 (American Association of Colleges of Nursing, 2011; American Association of Critical Care Nurses, 2007; Sochalski & Weiner, 2011). Buerhaus, Auerbach, and Staiger (2009) projected a shortfall of 280,000 RNs by 2025 because of a rapidly aging registered nurse workforce. Nurse managers face day-to-day challenges from lack of human resources in addressing operational and system problems with little time available for leadership and staff development (Sullivan, Bretschneider, & McCausland, 2003).

The third issue is that nurse managers face complex challenges in providing adequate staffing and necessary provisions to maintain highly technical, quality, and safe patient care as Baby Boomer nurse managers retire (Kenmore, 2008; Wong & Cummings, 2007). The average age of nursing leaders is more than 50 and by 2020, 75% of the nursing leaders will retire (Bernard Hodes Group, 2006). A failure to develop future nurse leaders with necessary skills and competencies to meet contemporary challenges and requirements will result in a drastic loss of nursing leaders to address quality, efficiency, and equity issues in health care.

Patient Satisfaction

Regulatory agencies, consumer watch groups, accrediting agencies, insurance companies, providers, and consumers increasingly recognize patient satisfaction outcomes as an important indicator of quality care and in many cases reimbursement is dependent on patient satisfaction outcomes (Nash, Manfredi, & Bozarth, 2001; Spence Laschinger, Gilbert, & Smith, 2011; Wagner & Bear, 2009). The construct for considering the level of patient satisfaction is changing toward satisfaction with the *total healthcare experience* including hospital services, delivery, personnel, and the likelihood to recommend (Press, 2005). For every 100 dissatisfied patients, 75 are unlikely to return and potentially influence 485 other potential customers to avoid using a particular health facility; the negative communications and publicity ultimately affects the reputation and revenue of the healthcare facility (Lee, Khong, & Ghista, 2006).

Patient satisfaction surveys provide health care organizations a valid measure of patients' perceptions of the quality of health care for monitoring and improvement of health care delivery (Block, 2006; Glickman et al., 2010). A 2010 federal survey from Hospital Consumer Assessment of Health Provider System (HCAHPS) by CMS reported high levels of patient dissatisfaction with different aspects of patient care such as responsiveness of hospital staff, communications, quietness, and pain management (HCAHPS, 2011). According to the Health Care in America survey by the Kaiser Family Foundation (2006), 54% of Americans are dissatisfied with the quality of health care.

Shelton (2000) reinforced that improving patient satisfaction yields greater patient compliance, decrease in malpractice suites, provides contracting decisions for employer health plans, meets Joint Commission, Centers for Medicare & Medicaid Services

(CMS), and National Committee for Quality Assurance (NCQA) requirements. Patient satisfaction is also a core element in internal and external quality monitoring systems, CMS reporting, Pay-for-Performance (P4P), and Value-Based Purchasing Program (VBP) (Kutney-Lee et al., 2009).

According to the Hospital Value-Based Purchasing (HVBP) Final Rule, CMS reduced the base operating diagnosis related group (DRG) payments to all participating hospital by 1% in 2013 and will progressively increase to 2% by 2017 (CMS, 2011). The money withheld by CMS acts as an incentive to pay hospitals based on their performance on certain domains of quality measures (CMS, 2013). CMS will determine future reimbursements to each hospital depending on performance of each applicable composite of eight domain measures of HCAHPS survey scores. The HCAHPS survey is the basis of the Patient Experience of Care Domain (CMS, 2013). The standardized survey by CMS, published on the Hospital Compare website, facilitates transparency of quality measures, provides incentives to improve care, and increases accountability of the health care organizations (CMS, 2013).

The IPPS Final Rule for FY 2014 that went into effect on October 2013 continues to weight HCAHPS survey at 30% of the Total Performance Score (CMS, 2013). Clinical Care Process accounts for 45% of the Total Performance Score (TPS) and New Outcomes Domains accounts for 25% of the Total TPS. The eight domains include the following quality measures (USDHHS, 2011a): (a) communication with nurses, (b) communication with doctors, (c) responsiveness of hospital staff, (d) pain management, (e) communication about medicines, (f) cleanliness and quietness of the hospital environment, (g) discharge information, and (h) overall rating of the hospital.

Health care organizations, already contending with negative Medicare margins, face potential for even larger financial reductions in reimbursements if they do not meet patient satisfaction and quality requirements. Health care organizations that hardwire continuous quality improvement will survive in a financially challenging health care environment. In response to greater accountability, transparency, and competition, health care organizations use patient satisfaction measures to drive quality improvement initiatives for greater revenue, effectiveness, and efficiency.

Statement of the Problem

A changing global health care environment, fierce competition, and demands by regulatory agencies fuel the need for improving patient satisfaction levels. Decreasing reimbursement by providers, expanding technologies, increasingly diverse consumer population, and rising consumerism (Herzlinger, 2004b) drives the need for internal organizational changes for improving quality of cost-effective care. Patient satisfaction is the primary determinant for sustaining the organization and meeting regulatory demands.

Health care organizations expect nurse managers to be responsible for improving patient satisfaction scores on their units (Kleinman, 2003; Zori & Morrison, 2009). The general problem was that the complex and changing health care environment presents many challenges to a front-line nurse manager to meet organizational goals without adequate leadership and management training, skills, defined roles, and competencies (Kerfoot, 2008; McLarty & McCartney, 2009) while dealing with financial and human resources constraints (Grindel, 2003).

In the 2010 the report entitled "A Summary of the February 2010 Forum on the Future of Nursing Education: Education," IOM issued a call for identifying and

developing nursing leadership roles, skills and competencies to achieve innovation and patient-centered care. The specific problem was that in a changing and turbulent health care environment, the priorities of nurse managers tend to center on day-to-day operational concerns and problems. The nurses' operational focus minimizes the focus on areas such as (a) understanding the projected contemporary and holistic nature of the leadership roles, skills, practices, and dimensions of nurse manager; (b) effectively addressing the broader, relatively unknown dimensions of patient satisfaction improvements; and (c) aligning patient satisfaction and organizational outcomes.

The exploration in the qualitative phenomenological study centered on the lived experiences and perceptions of the comprehensive and holistic nature of projected contemporary nurse manager roles, skills, practices, and dimensions that align with the newer dimensions and expectations for improving patient satisfaction among selected nurse managers at seven acute care hospitals in the northeast segment of the United States. The results of the study provide healthcare leaders, educators, and policy makers with new information or indicators that may lead to the development of new strategic thinking capacities to address the issues associated with the effectiveness of the nurse manager role in increasing patient satisfaction.

Purpose of the Study

The purpose of the qualitative phenomenological study was to explore the lived experiences and perceptions of the comprehensive, holistic, and changing nature of the projected contemporary nurse manager roles, cross-functional practices, and skills that align with the newer dimensions and expectations of increased patient satisfaction. The qualitative transcendental phenomenological approach using a modified van Kaam

method by Moustakas (1994) explored the perceptions and lived experiences of selected nurse managers, Chief Nursing Officers (CNO), and direct supervisors to arrive at the essence or meaning of the relatively unknown phenomenon.

The population for the qualitative data included full time nurse managers directly responsible for the operations of the diverse nursing departments in acute care hospitals in New Jersey. The purposive sample included 13 front line nurse managers, five directors with nurse managerial responsibility, two vice presidents, one performance improvement supervisor, and one chief nursing officer from different nursing units meeting specific selection criteria within seven acute care hospitals in New Jersey. Most health care organizations in the United States use independent vendors such as Press Ganey™, or Health Stream™ to administer random patient satisfaction surveys, including the national HCAHPS surveys, to patients discharged from each hospital.

The patient satisfaction survey scores from the selected hospital and individual in-patient departments provided a mechanism to select the most qualified nurse managers with high patient satisfaction scores among the hospital's inpatient nursing departments. The rich information from the patient satisfaction surveys formulated contextual qualitative questions that addressed areas or categorical dimensions that indicated experiences surrounding roles, tasks, and activities to improve patient satisfaction.

The qualitative method was more appropriate over the quantitative study because the purpose of the study was to gain in-depth insights and perspectives of unknown phenomenon of emerging roles, contexts, dimensions, and indicators of nurse managers who have responsibilities with improving patient satisfaction in real life contexts. Unlike a quantitative method that establishes causal or correlational relationships (Christensen,

Johnson, & Turner, 2010; Willis, 2007), the qualitative phenomenological design was more appropriate because the study was intended to systematically uncover the essence and meaning of relevant lived experiences that provided a foundational basis for projecting an emerging phenomenon in real life contexts (Van Manen, 1990). To meet the objectives of the study, the relatively unknown phenomenon reflecting holistic and changing roles and competencies of the sample of nurse managers emerged from the textural and structural data and provided the thematic basis for considering newer indicators or dimensions of patient satisfaction. The results through themes, indicators, and/or constructs may lead eventually to the development of a model or framework for organizational considerations. The constructs and components of a projected model may eventually lead to the identification of competencies and levels of task attainment by contemporary nurse managers.

Significance of the Problem

Hospitals are experiencing a major shift in their management structures, process, and functions in response to complex demands to provide high quality care in a cost-effective manner. Much of organizational focus is to improve patient outcomes through effective leadership, but little is known about the holistic and changing role, skills, practices, and dimensions of nurse managers with the newer expectations to improve patient satisfaction. Contemporary nurse managers navigating a complex health care environment require innovative skills, effective management, and leadership capabilities to influence and promote the achievement of organizational goals for positive patient outcomes.

Significance of the Study

Increasingly an in-depth understanding of new projected, contemporary nursing management and leadership roles, skills, functions, and dimensions for improved patient satisfaction represents a relatively unknown phenomenon that can be used to facilitate an efficient workforce and work environment. The themes garnered from the experiences of expert nurse managers with the phenomenon are essential to the development of a conceptual framework or model that identifies constructs for nursing managers to begin creating strategies for new competency-based outcomes for patient satisfaction standards. The model may help organizations to define newer contexts for nurse managers' work responsibilities and task-related competencies to address the new demands for improving patient satisfaction in various hospital settings. The study discoveries contribute to healthcare organizations and the field by seeking to optimize skills and competencies among the nurse managers for organizational effectiveness, workforce planning, and redesigning health care delivery systems (IOM, 2010).

The results of the study provided contributions to the healthcare field for developing or modifying structures, processes, strategies, and education or training initiatives that support the leadership, management practices, and behaviors of nurse managers who affect new indicators or dimensions related to improving patient satisfaction (American Association of Critical Care Nurses, 2007). Knowledge regarding evolving, holistic, and contemporary nurse manager roles and experiences for positive patient experiences is important for improving patient satisfaction with the total healthcare experience. The thematic findings may influence potential consumers,

stakeholders, nursing leadership, regulating agencies, and health care organizations to address futuristic nurse manager priorities and needs.

Research in this area may assist healthcare organizations, professional organizations, undergraduate, and graduate nursing leadership programs, continuing education providers, regulatory bodies, and leaders of accrediting agencies to seek and develop newer strategies to foster quality characteristics and practices of nurse managers that result in positive patient outcomes and satisfaction (Cherry & Jacob, 2005). The results of the study contributed to evidence-based management (EBM) of enhancing patient satisfaction that provides linkages with external and internal pay-for-performance metrics, improves overall patient quality care, and enhances financial performance of the organization (Kovner, Fine, & D'Aquila, 2009). In a competitive race to improve patient satisfaction scores, leaders of organizations will need to access information that will seek, validate, improve, modify, and change current skills, roles, and competencies of nurse managers.

Significance of the Study to Leadership

Lack of research or inadequate use of available data on the multi-factorial and multidimensional concept of patient satisfaction could result in the lack of knowledge regarding customer perception (Lageson, 2001). The information in this study is available to help healthcare leaders improve relationships between patients and healthcare providers through mechanisms that center on organizational efficiency, quality of services, patient, and staff interactions and communications, and financial outcomes (Barker, Sullivan, & Emery, 2006). The results of the study contribute to the contextual and conceptual understanding of the newer dimensions and perceptions of patient

satisfaction and the direct alignment with the contemporary and holistic nature of the nurse managers in leadership roles, functions, and required skills and competencies. Understanding leadership attributes that relate to patient satisfaction may also affect new policies, systems, and structures that address alternative approaches and models to recruitment, retention, leadership development, training, and evaluation of healthcare leaders.

Improving patient satisfaction may promote effective outcomes through focused leadership behaviors. The in-depth understanding of nurse manager roles and competencies that improve patient satisfaction with effective leadership behaviors and outcomes provided by this study revealed useful information for educators to revise or modify curricula in traditional undergraduate, graduate programs, online programs, certifications, seminars, continuing education opportunities, and mentoring programs (Kleinman, 2003). The results of this study also provided information for the development of new models on nurse manager leadership, education, and practice to enhance patient-centered outcomes that generate quality outcomes desired by all stakeholders (American Association of Critical Care Nurses, 2007). The results of the study confirmed discoveries from other leadership studies and contributed to the meaningfulness and in-depth understanding of organizational characteristics and evolving management roles and competencies in a changing health care environment.

Nature of the Study

Overview of the Research Method

In a qualitative method, the study entails an exhaustive and in-depth exploration, description, or explanation of a contemporary or little-known phenomenon within its

natural setting (Ellis & Levy, 2009; Leedy & Ormrod, 2005; Noor, 2008). The aim of the qualitative transcendental phenomenological design was to explore the nature of the holistic, changing, and projected contemporary nurse managers' roles, skills, practices, and dimensions that aligned with the newer dimensions and expectations for increased patient satisfaction. Creswell (2007) indicated qualitative research is appropriate when the intent of the study is to understand the holistic research problem from participants' perspectives and lived experiences within the context or natural setting. The qualitative method was more appropriate than a quantitative study because the researcher explored the contemporary nature of the holistic nurse managers' roles, functions, skills, and dimensions that aligned with increased patient satisfaction outcomes rather than study causal relationships existing in the phenomenon (Donalek & Soldwisch, 2004; Morse & Mitcham, 2002).

In a qualitative method, the researcher explores complex or unknown phenomenon from participants' perspectives through inductive reasoning and creative synthesis (Christensen et al., 2010; Leedy & Ormrod, 2005). Researchers in a qualitative study use an inductive approach by reflecting on participants' perspectives of the issue and emerging concepts during data collection and interpreting the meaning of individual actions and behaviors (Creswell, 2007; Neuman, 2003). By contrast, a quantitative method entails conformation or validation of relationships and may eventually extend generalizations from the sample to the broader population through deductive inquiry (Leedy & Ormrod, 2005). A quantitative approach was not feasible due to a newer emerging phenomenon that lacks existing data or established patterns in the knowledge base.

Overview of the Design Appropriateness

In the current phenomenological design study, the researcher explored the perspectives, perceptions, and understanding of the lived experiences of a complex phenomenon that occurs in a natural setting (Leedy & Ormrod, 2005). The qualitative phenomenological design was more appropriate than other qualitative designs because the phenomenological design focused on study participants' experiences and understanding of contemporary phenomena surrounding the roles and practices of a nurse manager who directly aligns with real life contexts, dimensions, and expectations for increasing patient satisfaction (Christensen et al., 2010; Munhall, 2010). Other qualitative designs such as case study, ethnographic, and grounded theory lacked the specific design to address the intent and purpose of the study.

The qualitative case study method was a plausible design to explore perceptions, situations, and experiences of a contemporary phenomenon within real life settings with several sources of evidence (Munhall, 2010; Yin, 2009). The case study research design requires intensive descriptions of a unit or bounded system such as an organization, program, process, an event, group, or community over time (Merriam, 1998). The purposive sample of nurse managers, directors, CNOs, and supervisors from different hospitals and departments was not bounded by any single process, activity, organization, or time, and therefore precluded the use of case study design (Creswell, 2003).

A grounded theory approach involves generating a theory from extensive data to explain an unknown phenomenon (Leedy & Ormrod, 2005), and an ethnographic design enables researchers to interpret shared beliefs, expectations, and behaviors within a cultural group (Gelo, Braakmann, & Benetka, 2008). However, both the ethnographic

and grounded theory approaches lacked the necessary focus for studying the unknown phenomenon by investigating the lived experiences and perceptions of holistic roles and competencies of nurse managers to improve patient satisfaction. The purpose of the phenomenological approach was to seek the essence and meaning of the lived experience and perceptions of the phenomenon among multiple individuals rather than focusing on the rich, intense, and holistic description of bounded cases (Creswell, 2007; Patton, 2002).

According to Moustakas (1994), transcendental phenomenology is a more disciplined and systematic phenomenological research approach to seek the path of knowledge emerging from transcendental or pure ego. Transcendental phenomenology begins with Husserl's concepts of *epoche*, also known as bracketing or setting aside investigator assumptions, biases, and perspectives to revisit freshly the participants' experiences of the phenomenon (Creswell, 2007; Moustakas, 1994). The second step in transcendental phenomenology is phenomenological reduction, which means to perceive freshly the essence and meaning of the lived experience (Moustakas, 1994). The third step is imaginative variation, in which the researchers seek meaning of the phenomenon by exploring varying imaginative perspectives, functions, roles, and positions of participants. According to Moustakas, the final step in phenomenology is synthesis, which employs the integration of textural and structural descriptions by study participants into a common essence or meaning of the experienced phenomenon.

Instrumentation

The Press Ganey™ Likert-type scale questionnaire is a widely accepted validated tool by healthcare organizations in other studies. Press Ganey™ uses the hospital

discharge information from each hospital to send the survey to a random sample of the patient population discharged from hospitals. The instrument is available for use in the public domain. Hospitals use independent vendors like Press Ganey™, or Health Stream™ to administer the national, standardized, and publically reported HCAHPS survey. For the current study, the Press Ganey™, and HCAHPS quantitative archival patient satisfaction survey data for 2012 provided the basis for creating semi-structured, open-ended qualitative interview questions. The intent was to develop meaning and a foundational basis for formulating qualitative research questions to explore the perceptions and experiences of nurse managers on the roles and functions to improve the indicators and dimensions of patient satisfaction.

The archival data on patient satisfaction scores from the current study surveys were assessed according to the newer dimensions and indicators on patient satisfaction and the findings or outcomes of the ratings on patient satisfaction. Supplemental demographic data also indicated the basic characteristics of the nurse managers, patients, and the environment, including years of experience, qualifications, and organizational characteristics.

Sampling

The purposive sample for the current study entailed 13 nurse managers, five directors with nurse managerial responsibility, one performance improvement supervisor, and one Chief Nursing officer (CNO) from seven acute care hospitals in New Jersey, U.S.A. to obtain multiple and diverse perspectives. The effort gained perspectives from multiple participants from various hospitals that increased the representativeness and applicability of knowledge for other related organizations to contribute to building new

understanding of roles, skills, practices, and dimensions of nurse managers for improving patient satisfaction. A purposive sampling technique allowed the researcher to explore the issue from sources with lived knowledge and ability to describe the phenomenon (Patton, 2002).

The patient satisfaction scores from Press Ganey™, Health Stream™, and HCAHPS Survey provided a basis for selecting nurse managers with the highest scores in their respective organization. The selection criteria for the nurse manager prior to the sampling process included at least one year in the nurse manager position and at least three years of clinical experience. The selection criteria for immediate supervisors and Chief Nursing Officers (CNO) of nurse managers included at least one year in the current position and an understanding of the environmental contexts affecting organizational and patient satisfaction outcomes, and nurse manager issues, and indicators for patient satisfaction.

Data Collection and Analysis

Qualitative data collection consisted of face-to-face interviews with open-ended questions using a semi-structured interview guide. Responses to the questions were tape-recorded to capture all responses through electronic transcription methods. Moustakas (1994) suggested the modified van Kaam approach for analyzing and transcribing rich textural and descriptive data from participants' perspectives. The seven steps of the modified van Kaam method included (a) horizontalization, (b) reduction and elimination, (c) clustering and thematizing invariant constituents, (d) validation, (e) constructing textural description, (f) constructing structural description, (g) constructing textural-

structural description. Chapter 3 contains detailed explanation of the modified van Kaam approach by Moustakas.

The NVIVO 10 software provided a mechanism to transcribe and verify themes and categories of data that best represented the indicators or contexts in the participants' text files (Morse, 2006). A cross analysis approach reinforced multiple procedures to determine commonalities and differences among themes (Cooper & Schindler, 2006). The researcher maintained confidentiality throughout the entire process of data collection, analysis, and communication of the results. Triangulation of multiple sources of evidence such as archival HCAHPS quantitative data, observations, and open-ended semi-structured interviews from nurse managers, directors, and CNOs strengthened the phenomenological design (Willis, 2007; Yin, 2009). A selection of highly diverse nurse managers, immediate supervisors of nurse managers, and a CNO from different hospital settings and governance structures provided rich perspectives of the lived experiences of the phenomenon.

Research Questions

A research question narrows a broad research problem and purpose statement into specific questions that the study is proposed to seek by observable evidence (Creswell, 2005; Rubin & Babbie, 2010). The nature of the research question in a qualitative study is exploratory and directly interpretive of the research problem (Ellis & Levy, 2009). The central research question and sub-questions narrowed the boundaries of the primary qualitative study. The research question reflected the purpose of the study and provided a deeper and enriched understanding of the comprehensive nurse manager roles, skills, practices, and dimensions for closer alignment with the patients' perceptions of

satisfaction with the healthcare facility, department, nursing, and total healthcare experience in changing health care environment (Christensen et al., 2010).

The central research question following the qualitative transcendental phenomenological design was as follows: *What is the comprehensive, holistic, and changing nature of the projected contemporary nurse manager's role, skills, cross functional practices, and dimensions, that align with the newer dimensions, and expectations of increased patient satisfaction among selected nurse managers in seven acute care hospitals in New Jersey?*

Further research sub-questions (RQs) narrowed the context of the central question and guided the purpose of the study to develop a comprehensive understanding of the current state along with evolving roles, tasks, practices, and functions of nurse managers and connection to newer organizational constructs with demands to improve patient satisfaction. The exploratory open-ended questions permitted the in-depth exploration of a contemporary phenomenon by investigating the perceptions, perspectives, and lived experience (Van Manen, 1990) of exemplary nurse managers and addressed the issue of increasing patient satisfaction through contemporary and projected nurse manager roles, skills, functions, and dimensions. The sub-questions narrowed the boundaries of the central research question:

Sub RQ1. What are the current practices, dimensions, indicators, and expectations for the nurse managers to monitor, measure, or influence patient satisfaction on their units?

Sub RQ2. What were some of the essential themes from past nurse manager experiences that should be maintained with the new nurse manager role, practices,

attributes, functions, strategies, or performance improvement initiatives that may continue to influence improved patient satisfaction in current and future times?

Sub RQ3. What is the essence of the new complex and transformative changes in the projected nurse manager leadership roles and trends for best practices in the context of new regulatory requirements to improve patient satisfaction in highly competitive health care environments?

Sub RQ4: What is the overall value or benefit of the newer nurse manager position and opportunities in meeting requirements for improving patient satisfaction?

Sub RQ5: What are the influences and or overall obstacles, barriers, or complexities that may challenge the nurse manager within the organizational culture to meet requirements for improving patient satisfaction?

Theoretical Framework

Nurse managers should possess key leadership and management roles, skills, and competencies to navigate the current and future health care challenges by influencing followers to achieve a common goal (Northouse, 2007). Several theoretical and conceptual frameworks related to nurse manager roles, skills, functions, and constructs in patient satisfaction, supported the qualitative phenomenological study design in multiple hospital settings. The following synopsis of the most pertinent theories and brief descriptions of the models that underscore the dimensions of the projected nurse manager roles and responsibilities follow.

Management Theories

Management theories such as great man, trait, bureaucratic, and humanistic theories provide the foundation to many of the current practices in nursing management

and executive leadership. Great man theories assumed that the capacity for leadership was inherent and therefore leaders were born and not made. Bureaucratic management focused on hierarchal communication and relationship between the superiors and the subordinates focusing on rules, regulations, work processes, and technical competence (Weber, 1964). Humanistic theories in the 1960s focused on empowerment, participatory management, and relationships with managers to improve productivity and efficiency. Maslow's (1968) hierarchy of needs, a more popular humanistic theory, provided a basis for understanding motivation among workers.

Motivational theories such as Theory X and Theory Y continued to influence nursing management. According to McGregor (1960), a Theory X individual lacked motivation requiring the manager to control and discipline the employee. Theory Y individuals were self-directed and motivating factors included praise, empowerment, and respect rather than money or benefits (as cited in Forman, 2010). Huber (2006) reinforced that organizations responsive to stakeholder demands will need to restructure and reconfigure the classic hierarchical and bureaucratic management to a more collaborative and participative management structure.

Leadership Theories

Major theories that influenced nursing leadership practice included transactional leadership, transformational leadership, situational or contingency leadership, servant leadership, and authentic leadership. Continuations of the extensive theoretical and conceptual frameworks that support the rationale for the study are found in Chapter 2. The following contains an overview of the major leadership theories that provided the essential framework for the study.

Transactional leadership. A transactional leader identifies follower needs and provides rewards in exchange for expected performance (Bass, 1985; Burns, 1978). In a contract between the leaders and the follower, the leader was seen as a caretaker setting goals for the employees focused on the day-to-day operations (Huber, 2006; Marriner-Tomey, 2004). The transactional leader worked within the organizational culture by actively and passively managing by exception (Burns, 1978).

The expectation for the exchange was the follower effort and performance for contingent rewards (Huber, 2006). A review of literature on transactional leadership styles indicated conflicting results with employee outcomes (Judge & Piccolo, 2004; Windsor, 2009). Bass (1985) suggested a delicate balance of transactional leadership in combination with transformational leadership to meet organizational goals.

Transformational leadership. Leadership styles that promote an open and communicative culture of ownership, respect, and reorientation among stakeholders ensured patient loyalty for repeat business (Kerfoot, 2008; Spinelli, 2006). J. M. Burns (1978), Bass (1985), and Northouse (2007) proposed transformational leadership as an association between the follower and the leader by tapping into the motives and needs of the followers. The relationship between the leader and the follower was based on trust, personal identification, commitment, and fairness (Avolio, Bass, & Jung, 1999).

Transformational leaders did not appeal to the followers' transactional relationship of rewards, but rather to their sense of higher ideals and values. By transcending leaders self -interest to a moral and social and utilitarian level, transformational leadership raised follower self-consciousness by internalizing the values of the leader (Bass, 1985). Wong and Cummings' (2007) meta-analysis on studies

relating to leadership traits and styles with patient outcomes provided positive relationships between transformational leadership with patient satisfaction and reduced adverse events. Limitations of the transformational model included the lack of conceptual clarity with contradictory emphasis on personality, and non-participative traits (Northouse, 2007).

Contingency/situational leadership. Fiedler (1967) contended a single leadership style is perfect for every situation and the manager's ability, power, and nature of the task affects interrelationships between the leader and employee. A multidimensional and situational approach to leadership by Hersey and Blanchard (1977), asserted that the follower maturity level predicted the most appropriate leadership style. As followers matured, the leadership style changed from task-oriented to forming relationships with followers for work effectiveness. Recent theorists contended that organizational culture and values of the leaders and employees, work environments, complexities, and demands of the situation required more contemporary leadership theories (Marquis & Huston, 2009).

Servant leadership. Robert Greenleaf (1977) posited a leadership model with strong ethical basis emphasizing service and spirituality in leadership. Present health care workers tend to seek greater participation, empowerment, and meaning to their work (O'Brien, 2011; Yukl, 2010). Servant leadership supported these needs by displaying the following qualities: (a) valuing and developing people, (b) sharing and providing leadership, (c) building a community, (d) and displaying authenticity (Amadeo, 2008; Yukl, 2010).

Authentic leadership. Authentic leaders hold a keen sense of purpose, know themselves, and remain true to their values and beliefs (Nahavandi, 2008). According to Avolio and Gardner (2005), essential components of authentic leadership included self-awareness, transparency, being true to self, and balanced processing. Researchers suggested that a concept of authentic leadership is at the core of contemporary leadership concepts, yet authentic leaders may also lack the ability to exhibit other leadership traits (Nahavandi, 2008).

Nurse managers and leaders play a pivotal role in shaping an environment that provides quality outcomes for patients and employees. In 2005, the American Association of Critical Care Nurses (AACN) specified authentic leadership as essential to sustaining healthy working environments (Shirey, 2006). Authentic leadership appeared to impact patient outcomes, nursing recruitment, retention, and organizational performance (Kerfoot, 2006).

Kaleba (2006) and Kerfoot (2008) advocated that leaders in healthcare organizations needed to develop leadership styles, competencies, and qualities that promote patient satisfaction and loyalty, yet first line nurse managers had little opportunity or knowledge to develop management skills and leadership attributes. Preparing for the future requires new strategies for re-defining the nurse manager's roles and necessary competencies in a demanding health care environment (Wells & Hejna, 2009).

Conceptual Framework for Nursing Management Models

In the last 25 years, a variety of nursing care models influenced nursing practice with implications for both nursing management and frontline staff. Early models

included versions of team nursing, total patient care, and primary nursing (Marshall, 2010). Organizational structures or professional practice such as Shared Governance, Magnet Hospital Recognition, and concepts of Emotional Intelligence (EI) that support a healthy practice environment can also have positive staff outcomes as well as patient outcomes. The following recent models in hospital setting impact the quality of patient care and nursing outcomes such as staff satisfaction, retention, and recruitment.

Shared Governance

As one recent model, shared governance is a participatory style of nursing management with front line nurses to maintain control over nursing practice, work related conditions, and professional affairs (Stumph, 2001). The model of shared governance is a professional practice framework that fosters creativity, flexibility, and accountability by empowering frontline nurses to make clinical decisions through a formal process thereby improving nursing satisfaction, retention, and recruitment (Nagelkerk, 2005). The major component of shared governance centers on quality, practice, education, and peer governance. More importantly, the shared governance model promotes empowerment and professional autonomy of front line nurses through participatory decision making (Nagelkerk, 2005).

Magnet Recognition Program

Another model, entitled the Magnet Recognition Program by the American Nurses Credentialing Center (ANCC), includes a model for creating a hospital environment that supports nursing professional practice for better patient and nursing outcomes (Barker et al., 2006; Kelly, 2009). The term Magnet describes characteristics identified in hospital environments such as strong participative leadership practices that

enhance professionalism of nurses and high quality patient care (Barker et al., 2006). Several decades of research showed positive patient outcomes such as decrease in mortality, nosocomial infections, pressure ulcers, and greater staff, and patient satisfaction (Aiken, Havens, & Sloane, 2009; Armstrong, Laschinger, & Wong, 2009; Ulrich, Lavandero et al., 2009). Yet, the Magnet Recognition Program reflects a void in aligning nurse manager role and responsibility with improving patient satisfaction.

Healthy Work Environments

The American Association of Critical Care Nurses (AACN, 2005) and Klainberg and Dirschel (2009) recognized leadership practices that support a safe, humane, and respectful environment for nurses, patients, and family members. According to AACN, the six areas of focus that tended to increase a healthy work environment include communication, collaboration, decision-making, staffing, recognition, and leadership. Grossman (2007) also emphasized that nurse managers provide a bridge between frontline nursing staff and executive leadership to align organizational and professional nursing goals.

Emotional Intelligence

Mayer and Salovey (1997) defined emotional intelligence as the ability to use emotions to think, understand, reason, and manage emotions within self and in relationships with others. Goleman (1998) suggested a combination of personal and social competencies to master emotional intelligence. The personal competencies for emotional intelligence included self-awareness, self-regulation, confidence, conscientiousness, and motivation (Goleman, 1998). The social competencies in emotional intelligence focused on empathy, communication, and conflict management.

However, research on emotional intelligence and the nurse manager is limited with external variables and constraints affecting staff outcomes (Lucas, Spence Laschinger, & Wong, 2008).

Theoretical Framework for Patient Satisfaction

While researchers and theorists studied the multidimensional construct of patient satisfaction in past years, the field still lacks a comprehensive and widely acceptable theory. Some of the theories and conceptual frameworks that partially promoted the understanding of patient satisfaction entailed Maslow's hierarchy of needs, Orlando's theory, and Linder-Pelz patient satisfaction theory.

Maslow's Hierarchy of Needs

According to the World Health Organization (WHO, n.d.), health is not just the absence of disease, but entails complete physical, mental, social, and spiritual wellbeing of an individual. Conceptual models such as Maslow's hierarchy of needs postulated that an individual seeks to fulfill basic, and as well as the higher order needs such as self-esteem and self-actualization (Hales, 2009). When applying Maslow's (1968) hierarchy to the contemporary contexts in the health care setting, the foundational base of Maslow's pyramid underscores the premise that physiological needs can be fulfilled through the restoration of health and wellness.

The second layer of Maslow's (1968) pyramid of needs centers on the issues of safety in the health care setting. The third level is the sense of belonging met through close relationships, trust, and bond established with the healthcare provider. Patient satisfaction with the involvement of family decision-making also reflects these needs. The healthcare provider meets self-esteem needs with attributes of respect, attention,

recognition, and responsiveness. When all these goals are met, the patient achieves self-actualization: an ideal patient outcome.

Orlando's Theory

Orlando's theory (1972) asserted that interaction with the patients and nurse is essential to understanding and fulfilling the needs of the patients. Orlando's theory postulated that the nurse's function is to ascertain the needs of the patient through verbal and nonverbal cues and meet the immediate needs of the patients (Schmieding, 1990). Orlando emphasized the need to include the patients in all aspects of care. The theoretical framework provided a basis for the philosophy that encourages patient participation in the decision-making process. Shared decision making is an ideal indicator for patient-centered care in the current context, and improving communication between the provider and the patient draws its concepts from Orlando's theory.

Linder Pelz Patient Satisfaction Theory

Linder-Pelz (1982b) considered patient satisfaction as a positive evaluation of healthcare experience by making evaluations on distinct aspects of care. Experts criticized the theory for vagueness regarding the value and expectation components (Sixma, Kerssens, van Campen, & Peters, 1998). Despite the extensive studies and literature on patient satisfaction spanning several decades, the multidimensional concept of patient satisfaction lacked an acceptable comprehensive theory, framework, construct, or definition (Wasden, 2010).

Conceptual Framework and Models for Patient Satisfaction

Conceptual models provide the framework underpinning the concept of patient satisfaction. Patient satisfaction concepts are operational definitions of implicit abstractions or observable phenomenon (Polit & Beck, 2004).

Patient-Centered Care

The Institute of Medicine (IOM) identified patient-centered care as one of the six domains of quality care and a key competency for all health care professionals (Finkelman & Kenner, 2010). The model centered the structure and delivery of care around the patient with effective and efficient use of resources to improve patient satisfaction, increasing quality of care and reducing expenses (Parsons & Murdaugh, 1994).

In more contemporary environments, patient-centered care require systems and platforms that redesign patient care in the hospital setting by organizing hospital resources and personnel to meet patient health care needs (Falvo, 2010). Patient-centered care includes the following dimensions: (a) respect for patient preferences, values, and needs; (b) coordination of care; (c) communication, information, and education of the patient; (d) meeting physical and emotional needs; (e) involvement of family and friends; and (f) continuity of care (Falvo, 2010). In a restructured patient care environment, nurse managers appear to need new skills and competencies to achieve meaningful patient outcomes through patient-centered care concepts (Forman, 2010; Parsons & Murdaugh, 1994). The current study is intended to explore this anticipated need.

Conceptual or Contextual Framework for Organizational Patient Satisfaction

In the 21st century contexts, the health care industry is experiencing a shift from an emphasis on provider-centered focus of care delivery to a more patient-centered perception of quality care. In a volatile health care environment, health care leaders are experiencing a profound paradigm shift in managing the health care business with patient satisfaction becoming a critical performance indicator (Kovner et al., 2009). In the delivery of health care services, patient satisfaction is a significant dimension of health care quality in addition to measuring other health outcome such as morbidity, mortality, and quality of life (Block, 2006).

The health care leadership environment is responding to demands from external organizations such as Joint Commission on the Accreditation of Health organizations (JOINT), Centers for Medicare & Medicaid Services (CMS), National Quality Forum (NQF), Leapfrog Group, national Pay-for-Performance programs that set outcome performance targets such as patient satisfaction to improve accountability, transparency, and performance (Kovner et al., 2009). Current reporting programs, and incentives for improving patient satisfaction under Value Based Purchasing Program by CMS, Joint Commission, and third party providers translates to millions of dollars for health care organizations (CMS, 2010a).

The American Nurses Association (ANA) recognized patient satisfaction with nursing care as an important nurse sensitive outcome (Spence Laschinger et al., 2011). Research studies indicated that patient satisfaction with nursing care strongly correlates with overall satisfaction and total health care experience (Press, 2005; Spence Laschinger, Hall, Pedersen, & Almost, 2005). Numerous studies linked nursing

indicators such as staffing, satisfaction, burnout, nursing work environments, governance structures, magnet characteristics, and specific nursing interventions to patient satisfaction (Doran, 2011).

Measuring, monitoring, and analyzing patient satisfaction scores assist hospital leaders to seek creative ideas, engage employees in problem solving, empower frontline staff, plan, and allocate resources to enhance patients perception of quality care (Kovner et al., 2009). Identifying nurse manager roles and competencies are necessary for high quality patient outcomes, patient satisfaction, and employee satisfaction (Zori & Morrison, 2009). The blending of evidence-based leadership and management frameworks with new nurse manager roles, skills, and competencies will be necessary to lead a vital, vibrant, and patient-centered organization into the 21st century.

Definition of Terms

The definitions of concepts in the current study provide an understanding and clarification in the study. The definitions provide clarification regarding several concepts in nursing and healthcare. Because similar terms may hold different or varying interpretations in separate healthcare facilities, units, or departmental functions, the definitions provide guidance on terminology used extensively within the study.

Competency: The ability to perform tasks for desirable outcomes through desirable level of skills and knowledge (Kak, Burkhalter, & Cooper, 2001).

HCAHPS: The Hospital Consumer Assessment of Health Providers Systems is a standardized survey instrument and data collection method by the Centers for Medicare & Medicaid (CMS) Services, to measure patients' perceptions of their health care experiences (Centers for Medicare & Medicaid Services, 2010b).

Health Care Quality: "The degree to which health services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge" (IOM, 1990, p. 4).

Leadership: The process of influencing relationship between a leader and employee to accomplish a vision for change through commitment, alignment, focus, and empowerment (Kent, Crotts, & Azziz, 2001).

Management: The process of interconnectedtechnical and social functions within an organization for the purpose of achieving predetermined goals and objectives through the use of human and other resources (Longest, Rakich, & Darr, 2000).

Management Function: The management process includes different functions of planning, organizing, coordinating, directing, and controlling to meet organizational goals (Huber, 2006).

Managers: Individuals formally appointed to a position of authority responsible and accountable for work results by enabling other individuals to perform effectively through proper use of resources within the nursing unit (Longest et al., 2000; Marquis & Huston, 2009).

Nurse Manager: The unit/nurse manager with formal authority who has round the clock administrative as well as clinical responsibilities of the patients on the units. Other common terms include Head Nurse, Unit Coordinator, and front-line Nurse Manager, Nurse Leader, and Patient Care Manager. Frontline nurse managers represent nursing leadership between staff nurses and charge nurses and senior administrative level nursing leadership (Marquis & Huston, 2009).

Nursing Management: The application of management process to coordinate and integrate nursing resources to accomplish nursing care goals for the patient (Huber, 2006). The different functions of management include planning, coordinating, controlling, and directing to meet organizational goals (Huber, 2006).

Patient Care Outcome: A measurable results of patient care such as patient satisfaction (Yoder-Wise, 2003).

Patient satisfaction: A multidimensional construct without a widely acceptable definition. Patient satisfaction is the perception of the level of quality of care received during the hospital stay (Asadi-Lari, Tamburini, & Gray, 2004).

Patient satisfaction with nursing care: The degree to which nursing care of the patient meets the patient's expectation of quality care encompassing the art of care, the technical element, physical setting, convenience, continuity, effectiveness, and outcomes of care (Mrayyan, 2006).

Role: An expected set of activities and behaviors related to the job position (DuBrin, 2009).

Total healthcare experience: A measure of patient perception of the hospital experience that is related to the satisfaction with overall care (JCR, 2003).

Assumptions

Embedded assumptions influence logic, development, and implementation of the research process by assuming that certain conditions and behaviors exist in a research study (Burns & Grove, 2005; Thomas, Nelson, & Silverman, 2010). Four main assumptions provided the underlying foundations for the qualitative research study. The first assumption was that selected study participants provided current and futuristic

information on contemporary and holistic nurse manager roles, practices, skills, and dimensions relevant with the expectations and dimensions of increasing patient satisfaction. The basic assumption was that nurse managers were knowledgeable about recently experienced changes and mandates for increasing patient satisfaction.

The second assumption was that nurse managers were directly responsible and accountable for reviewing patient satisfaction scores of the unit and the nurse managers influenced comprehensive patient satisfaction on their units. The underlying assumption underpinning the current qualitative study was that both the nurse manager and the patient satisfaction phenomenon were interdependent with each other. The possibility existed that nurse managers were not responsible or accountable for increasing or influencing patient satisfaction in the unit of control. If the situation occurred, then the information would lack relevancy or usefulness to the in-depth understanding of holistic roles and practices of nurse managers with patient satisfaction.

The third assumption was that all healthcare organizations in the study considered patient satisfaction as an important indicator in quality improvement process or indicator within the health care organization. The fourth assumption of the study was that research participants provided honest and truthful responses to questions regarding contexts and experiences with contemporary nurse manager roles and competencies with patient satisfaction. In responding honestly and candidly, the assumption was that the participants would not alter the answers to the more perceived answer of choice and thus adversely affect the outcomes of the study. Data containing fabrications, conjectures, or opinions rather than truthful accounts could be harmful to the validity of the study.

Scope and Limitations

The intent of qualitative transcendental phenomenological study using a modified van Kaam approach was to investigate the research phenomenon of the emerging and holistic nurse managers' management and leadership roles, skills, functions, and dimensions with improving patient satisfaction (Christensen et al., 2010; Merriam, 1998). The study reflected several limitations that the researcher could not control and included threats to the trustworthiness or internal validity of the study. The first limitation of the qualitative phenomenological study was the ability to determine eligibility of purposive sample participants to gain rich valuable insights and perspectives on the emerging roles and competencies of nurse managers with increasing patient satisfaction in the unit of control.

The second limitation that could possibly reduce the quality of the study was researcher bias. The transcendental phenomenological research design with a modified van Kaam approach required setting aside biases and assumptions through bracketing (Moustakas, 1994). As a previous front-line nurse manager, the researcher had some experience, knowledge, and perceptions of possible roles and competencies that might influence and improve patient satisfaction in a highly competitive and regulated health care environment.

A possibility of bias also existed in the data collection and analysis due to working knowledge of the researcher in the field. The researcher increased the credibility of the study and controlled researcher bias by bracketing or setting aside assumptions, prejudgments, and presuppositions to reach a state of openness in order to observe the experience with new consciousness (Moustakas, 1994). The researcher also reduced bias

by (a) asking participants to review interview transcripts (Lodico, Spaulding, & Voegtle, 2010) and (b) using a qualitative software program for analysis.

Another limitation of a transcendental phenomenological research design was the possibility that the researcher was not able to fully capture or exhaust the structure or meaning of the participant experience with the phenomenon (Moustakas, 1994). The fourth possible limitation was that the researcher would not be able to interview comprehensively nurse managers, immediate supervisors, and the respective CNOs with varied influences to improve patient satisfaction. Difficulties such as accessibility to study participants, time constraints, individual organization's requirements, and lack of resources limited the generalizability of the phenomenological study because of the contextual nature of the qualitative study sampling.

Delimitations

The study was confined or delimited to the accessibility of the target population of nurse managers and CNOs, or immediate supervisors in seven hospitals in New Jersey. Delimitations of the study included the threats to the external validity or trustworthiness of the study that may reduce the transferability of the study discovery (Blankenship, 2009). By using a small purposive sample of nurse managers in the hospital setting, the generalizability of the findings to the broader population lacked feasibility.

Because the focus of the study was on just nurse managers, immediate supervisors, and CNOs, the study excluded other nursing personnel such as staff nurse, nurse's aides, educators, hospital administrators, and department managers. Other personnel who interact with the patients were also excluded from the study such as respiratory therapists, physicians, dietary personnel, social workers, caseworkers,

radiology technicians, and other personnel. The interaction of other personnel could be controlled or measured that also affected the perception of the patients' overall healthcare experience.

Generalization is not possible with a selective sampling technique in qualitative studies and a small non-random sample. The hospitals in New Jersey are diverse, yet unique, compared to other hospitals in the United States and cannot be generalized to the broader population. A purposive sample with a broader representation of nurse managers from various units may be applicable or transferable to other hospitals of similar size in similar regions facing similar issues with the sample in the current study.

To improve the credibility of the study, acute care hospitals chosen for the study were similar in size to other hospitals in the United States. Specific organizational culture, governance structures, and designations such as Magnet designation, shared governance models, academic versus nonacademic, profit versus not-for-profit, urban versus rural, and hospital size accounted for variation in the exploration of the phenomenon. These differences affected the applicability of the discoveries to other hospitals across the United States, but researchers can replicate or expand this study with similar constructs.

A variety of nurse managers participating in the study from multiple hospitals increased the reliability, trustworthiness, and transferability because the health care environment and challenges facing nursing managers is similar to other states. Transferability is the ability of the reader to transfer the finding of the study from one research site to another by assessing the details and richness of the contextual data (Lodico et al., 2010). Triangulation of multiple forms of data such as semi-structured

interviews, observations, quantitative HCAHPS survey, organization documents that provide detailed information to influence patient satisfaction improved the quality of the transcendental phenomenological design (Lodico et al., 2010).

Summary

According to the Institute of Medicine (IOM, 2001a, 2011), the United States health care system is highly fragmented with disparities in the equitable distribution of quality care in a cost-effective manner. Health care organizations face multiple challenges from increasing regulation, decreasing reimbursements, fierce competition, unproductive service lines, revenue pressures, and greater emphasis on quality (Nahavandi, 2008). The health care environment is shifting toward greater transparency, accountability, and effectiveness to improve quality of care such as patient satisfaction (Huber, 2006). Healthcare redesign, a current theme for health care reform, is used to examine current structures, processes, and outcomes of care including interactions with stakeholders through the application of new contemporary and evidence-based leadership skills and competencies (ACHE, 2011).

Nursing managers lead the largest direct health care workers and are responsible to improve quality measures within the unit of control. Rapid and dramatic changes in healthcare demand nursing managers develop both management and leadership roles and skills to meet stakeholder demands. According to Marquis and Huston (2009), nursing management role should include leadership functions, new skills, and competencies to increase productivity, efficiency, and workforce effectiveness. Much of organizational focus is to improve patient outcomes and quality of care such as patient satisfaction through effective leadership, yet the roles, skills, practices, and dimensions for

performance of nurse managers are ill-defined. The purpose of the qualitative transcendental phenomenological research design was to explore the comprehensive, holistic, and changing nature of the nurse manager roles, skills, practices, and dimensions that align with the newer expectations or dimensions of patient satisfaction.

Conclusion

Chapter 1 included the background of the problem, statement of the problem, purpose of the study, significance of the study to leadership, patient satisfaction, the profession of nursing, and healthcare organizations. The nature of the study provided the explanation of the study design and research question is the basis for the study. The conceptual and theoretical framework on patient satisfaction, nursing management, nursing leadership roles, and constructs established a foundational understanding and existence of the phenomenon of the study. Chapter 1 concluded with addressing the scope, assumptions, limitations, and delimitations for the study and how to mitigate threats to validity. Chapter 2 entails an extensive review of literature on nursing management, historical overview, theoretical, and conceptual frameworks on leadership, practice environments, nursing manager roles, competencies, and patient satisfaction that reinforce the aim and rationale for the current study.

Chapter 2

Review of the Literature

The purpose of the qualitative phenomenological study design was to explore the lived experiences and perceptions of the projected contemporary, comprehensive, and holistic nature of the nurse manager roles and cross functional skills, and dimensions that align with the newer expectations or dimensions of patient satisfaction among selected nurse managers at seven acute care hospitals in the northeast segment of the United States. The aim of the research and central research question centered on the following research question: What is the comprehensive, holistic, and changing nature of the projected contemporary nurse manager's role, skills, cross functional practices, and dimensions, that align with the newer dimensions, and expectations of increased patient satisfaction among selected nurse managers in seven acute care hospitals in New Jersey?

In Chapter 2, the focus of the comparative analysis of the literature review centers on four primary segments related to the research question. The first segment includes the historical overview and theoretical frameworks in nursing management, leadership theories, conceptual, and contextual frameworks framing frontline nursing management, and future implications of nurse manager role. The second segment of the literature review includes an assessment of the nurse manager role and functions and the relationship between nurse managers with staff outcomes. The third segment entails information on patient satisfaction with information on the historical overview, patient satisfaction survey instruments, conceptual, and contextual frameworks unpinning the concept. The latter segment of the literature review contains information on specific

nursing leadership attributes, abilities, roles, and competencies that may contribute to positive patient outcomes.

Title Searches, Articles, Research Documents, and Journals

The documentation section of Chapter 2 includes information from several sources such as peer reviewed journal articles, dissertations, scholarly books, reports, and research documents. The first section provides the content and the organization of the literature review. The second section provides an overview of the gaps in literature related to the study.

Literature Review Content and Organization

The major emphasis of the literature search topics centered on related subjects such as nursing management, nursing leadership, and patient satisfaction in addition to other topics such healthcare leadership, patient outcomes, and quality improvement. An extensive search of scholarly literature for the study entailed a broad database search using electronic databases such as EBSCOhost, ProQuest, ERIC, OVID, Academic Search Premier, and Nursing. Many prominent professional nursing organizations also provided necessary information in the form of research studies, scholarly papers, and statistical reports. Included are scholarly books on the study written by original theorists and specialists in leadership, management, marketing, nursing, and patient satisfaction. The use of World Wide Web, and Google search engines for individual nursing professional organization websites, healthcare organizations, governmental, regulatory, and health care industry websites provided rich and current information on issues related to the current study topics. Other diverse information from books, and dissertations provided comprehensive information.

The literature search included terms such as nurse manager, nurse manager roles, nurse manager competency, leadership, nursing management, patient satisfaction, patient outcomes, staff nurses, quality improvement, and cross references of search terms to provide new perspectives, ideas and approaches regarding the phenomenon. Search terms for patient satisfaction revealed 31,368 peer-reviewed articles of which 27, 365 articles were published within the last 10 years. Dissertations on patient satisfaction provided published sources from 10,357 in the last four years, which indicated an immense need to understand and provide meaning to the concept of patient satisfaction.

Search terms for nurse manager role revealed 913 peer-reviewed articles within the last 10 years, and 515 within the last 5 years. Search for nurse manager competencies revealed 66 articles within the last 10 years, and two related to the relationship between patient satisfaction and nurse manager competency. A tally of the reference sources by source and period (see Table 1) depicts the extensive review of literature on patient satisfaction has yielded pertinent information from 249 peer reviewed journal articles, 126 books, 32 dissertations, 14 papers through professional organizations, and 37 reports.

Table 1

References by Date Range

Date Range	Patient Satisfaction		Nurse Manager	
	N	%	N	%
2006 to present	73	53%	129	50%
2000-2005	36	26%	76	30%
1990-1999	18	13%	30	12%
1980-1989	9	7%	5	2%

Of the 467 references, 53% are current and 47% are from original theorists, books, and studies five years and older. Table 2 contains a tally of the literature sources in each category of research topic

Table 2

Search Terms

Search Term	Peer-Reviewed Journals	Articles	Dissertations	Books
Nurse Manager Role	60	10	10	16
Nurse Manager Competency	9	5	2	3
Patient Satisfaction	77	9	8	4
Patient Centered Care	21	0	3	1
Shared Governance	5	0	0	0
Magnet Designation	18	14	2	0

Literature Review: Gaps in the Literature

Much of organizational focus is to improve patient satisfaction through effective leadership to meet contemporary organizational goals. Patient satisfaction is a valid indicator for quality of patient care (IOM, 2001a). In a highly competitive health care environment, with patient volume still driving reimbursements, front line nurse managers are responsible to monitor, and maintain an environment of high patient satisfaction or risk losing patients to hospitals with exemplary customer service. The benefits of monitoring patient satisfaction include lower costs of new customer acquisition, referrals patterns, increasing patient volume improving performance, and quality of care (Kovner et al., 2009; Messina, 2005). The driving force in many hospitals is to enhance the patient care experience and in turn improve patient satisfaction scores. With research conducted over the past decade on various aspects related to patient healthcare and satisfaction, health care leaders are only starting to realize the critical role of the front-

line nurse manager in assuring organizational success. Insufficient evidence exists about the holistic and changing role, skills, practices, dimensions, and required competencies of nurse managers to understand newer dimensions and achieve increased levels of patient satisfaction.

The comparative analysis of the literature showed strong correlation between nursing leader and staff job satisfaction (Sellgren, Ekvall, & Tomson, 2008; Utriainen & Kyngas, 2009), intent to stay (Mrayyan, 2008), burnout, turnover (Bruyneel, den Heede, Diya, Aiken, & Sermeus, 2009), retention (Tourangeau, Cummings, Cranley, Ferron, & Harvey, 2010), and organizational commitment (Wieck, Dols, & Landrum, 2010). Research studies also indicate strong relationships between staff nurse behaviors and patient satisfaction (Chang, Ma, Chiu, Lin, & Lee, 2009; Davis, 2005; McGilton, Robinson, Boscart, & Spanjevic, 2006; Wysong & Driver, 2009), staffing ratios, and patient outcomes (Flynn & McKeown, 2009).

Wong and Cummings (2007) found significant relationships between positive leadership behaviors and patient outcomes such as mortality, adverse events, and increasing patient satisfaction to some extent. Very few quantitative or qualitative studies established direct relationships with nurse manager leadership skills and competencies with patient outcomes such as patient satisfaction. Lack of methodological rigor such as convenience sampling, lack of quasi-experimental study design, and limited qualitative studies in nursing leadership role and competencies with patient satisfaction indicated the need for the current study. Research studies on nurse manager role, skills, and practices revealed a lack of emphasis on dimensions that influence patient satisfaction.

A leader's role includes expectations to influence employees to carry out organizational strategies for improving quality of patient care such as patient satisfaction and safety (Kenmore, 2008). A recent surge in nursing leadership studies concentrated on executive level nursing leadership role, but and not specific to the front-line nurse manager (Torres, 2009). Because the healthcare environment is changing for greater accountability for providing safe, quality care so also is the role and accountability of the nurse managers in meeting those expectations.

The research literature revealed that many nurse managers are not prepared for the responsibilities and rigor of the nurse manager position (Kerfoot, 2007; Swearingen, 2009). During organizational changes, nurse managers accept additional roles and responsibilities without sufficient education, training, mentoring, resources, and support (Mathena, 2002; Shirey & Fisher, 2008). As Baby Boomers nurse managers retire, new nurse managers need the necessary skills to manage complex environments. Kerfoot (2008) emphasized that the present day nurse manager performs his or her role without formal leadership training, on the job training, or experience. In a changing health care environment with looming nursing shortage, decreasing reimbursement, increasing competition, and regulation, an understanding of skills, practices, dimensions, functions, and competencies of nurse managers to improve patient outcomes, can help organizations to create strategies to develop skilled and competent nurse managers (Cummings et al., 2008).

Health care organizations often promote frontline nurse managers from the ranks of clinical staff positions because of expert clinical skills without adequate preparation in nursing management. According to McLarty and McCartney (2009), nurse managers

receive very little ongoing professional development and training to manage different functions and make the organizations thrive. A review of literature on nursing leadership development programs provided some limited evidence on the effectiveness of the leadership on perceived staff outcomes (Cummings et al., 2008). The findings from current research indicated the need for leadership training for front line managers to optimize their effectiveness in their role.

These issues and gaps in the literature in the health field formed the rationale for the current study, which was to explore new and holistic front-line nurse managers' role, skills, practices, and dimensions to improve patient satisfaction on his or her unit of control. The current study findings were intended to address the gap in literature regarding new expectations and the holistic role, functions, responsibilities, and the related dimensions necessary of the contemporary nurse manager to improve patient satisfaction.

Historical Overview of Nursing and Nursing Management

The following segment includes the historical overview and progression of nursing and nursing management from the early 1900s through the 1990s in the context of dramatic changes in the health care environment. Nursing care of the sick has been in existence as long as the beginning of time. Health practice has evolved over time incorporating religious, cultural, and superstitious beliefs to ensure survivability of the groups. Although the specialized role and function of a nurse did not develop until recent times, cultures have recognized the need for nursing care of the sick and injured (Masters, 2005).

Florence Nightingale (1820-1910) was a nursing leader who reformed hospitals, military, advocated for health prevention, sanitary conditions, extensive nursing training, and education (Andrist, Nicholas, & Wolf, 2006). From 1900 to 1940s, the first training schools in the United States were modeled after Florence Nightingale School of Nursing in St Thomas. The first nursing university started in 1909 followed by an associate's degree in 1952. Nursing schools legitimized nursing as an occupation (Andrist et al., 2006). State licensure of nursing started in 1903 with requirements for educational standards, thus providing public recognition for the profession of nursing (Masters, 2005).

Industrial growth in the early 1900s spurred the unprecedented rise of hospitals and the public health sector (Andrist et al., 2006). In the 1930s, hospitals started to gain more influence as employers and hospital leadership employed graduate nurses over private fully trained nurses to cut human resources costs (Andrist et al., 2006; Masters, 2005; Moiden, 2002). Nurses abandoned independent practice and were absorbed into the hospital governance system (Andrist et al., 2006). Head nurses and superintendents were former nurses from the ranks of educated nurses to perform administrative duties (Helmstadter, 2008; Moiden, 2002). Within hospitals nursing leadership embraced the model of bureaucratic management for greater efficiency and productivity. Review of historical evidence indicated that nursing administration started to use a top down centralized approach of management style (Moiden, 2002). Division of labor, task orientation, functional nursing, and use of procedural manuals encouraged efficiency (Andrist et al., 2006) and demands coupled with the economic and poor hospital working conditions led to unionization of nursing services.

Many dramatic changes in health care in the post-depression era included the introduction of the Social Security Act in 1935 that provided benefits to the elderly as well as the disabled. Title VI of the Social Security Act authorized the use of public funds to train public health personnel such as nurses (Masters, 2005). In the 1940s and 1950s, the concept of team nursing became an inspired model for shared responsibility of patients (Moiden, 2002). In the team-nursing model, a group of nurses were assigned to take care of a group of patients. Team nursing also resulted in alienation between nursing managers and staff (Moiden, 2002).

During 1945 to 1960, dramatic technological advances in medicine created an impetus for increase in training and expansion of nursing role and responsibilities. The Hill Burton Act of 1946 marked increased government commitment of federal funds for construction of new hospitals that increased the demand of nurses. As number of hospital beds increased with postwar economic resurgence, the nursing shortage became evident, creating stress to existing nurses (Masters, 2005).

In 1965 under Title XIX and Title XVIII of the Social Security Act, the Centers for Medicare and Medicaid (CMS) services, provided health care of older, poor, and disabled (Cherry & Jacob, 2005; Masters, 2005). Medicare reimbursement led to increased hospital occupancy and demand for nurses. In same era nursing education moved from hospital training schools to colleges and universities (Andrist et al., 2006). In this decade new educational programs in nursing administration supported the need for increasing the skill and competencies of nursing leaders. The societal reform also helped navigate nursing profession for expectation for professionalism and control over work (Andrist et al., 2006). The nursing profession grew into more specialized realms such as

the intensive care unit, nurse anesthetist, and clinical specialists (Masters, 2005). Primary nursing introduced in 1966, was an important step in the professional nursing practice that advocated for the total care of the patient by the primary nurse (Moiden, 2002). However, existing rigid hierarchal governance structures in hospitals restricted the opportunities that primary nursing could provide (Moiden, 2002). Primary nursing aligned nursing practice with professional nursing values (Moiden, 2002), a model supported by nursing managers.

In the 1970s, health care costs soared due to significant reimbursements for patient care but nursing salaries did not reflect reimbursement increases causing discontentment and alienation between management and front line staff (Cherry & Jacob, 2005). Dramatic changes during 1980s changed the dynamic relationship between the government and the healthcare industry. In the early 1980s, Managed Care influenced the healthcare organizations to reduce costs under the concept of selective contracting (Konetzka, Zhu, Sochalski, & Volpp, 2008). Medicare from 1965 till 1982 paid hospitals on the principle of "reasonable and necessary costs" (p. 11) through a system of retrospective payment system (Marquis & Huston, 2009). In 1980, despite private and public healthcare policies to stem to rise of health care costs, the United States spent 9.1% of its gross domestic product (GDP) on healthcare (Anderson & Erickson, 1986). From 1980 to 1983, inpatient expenditures for Medicare patients increased to 16.5% whereas cost of inflation increased only 6.5% (Anderson & Erickson, 1986). Concerns regarding rising healthcare costs shifted focus of policy makers from quality and access issues to cost containment. The federal government began to encourage competitive market strategy to contain health care costs (Patel & Rushefsky, 2006). The federal

government through market-oriented policies and federal mandates of the Deficit Reduction Act (DRA) of 1982, sought to reduce rising costs (Patel & Rushefsky, 2006).

The Social Security Act of 1983 enacted a payment method for Medicare Part A recipients receiving inpatient hospital services (CMS, 2010a). This system of payment was called the Prospective Payment System (PPS) (Bodenheimer & Grumach, 2009). The Prospective Payment System reimbursed hospitals for services provided to the patient prospectively rather than retrospectively. The intent of the PPS was to reduce Medicare costs and to make hospitals more efficient. Departing from the cost-based payment system, Medicare offered per case pricing system inducing hospital incentives such as reducing costs per admission, increasing the number of admissions and developing new sources of profit not subject to payment restrictions (Marquis & Huston, 2009). The system used Diagnostic Related Groups (DRG) to classify reimbursement by determining the payments prospectively (CMS, 2010a). Each DRG had a payment weight allocated to it, based on average resources to treat the Medicare patient in that DRG (Bodenheimer & Grumach, 2009). The new system of payment expanded the role of nurse manager to improve quality of patient care and ensure coordination of care across the health care continuum.

In the 1980 and 1990 healthcare organizations moved toward more flatter management structures. In response to high administrative costs, decentralization expanded the roles and responsibilities of nurse managers (Moiden, 2002). The decentralized work design removed vertical layers of management and greater responsibility and authority to the frontline nursing staff (Moiden, 2002).

In the 1990s, health care costs continued to consume a large portion of the Gross Domestic Product (GDP) triggering political action for health care reform. The focus started shifting to managed care and preventive medicine limiting excessive hospitalizations that resulted in massive downsizing of hospital nurses (Cherry & Jacob, 2005). Managed care led to the control of health care costs in the 1980s and through late 1990s but lost the competitive advantage in the post Managed care era when the hospitals due to the market competition were also responsible to hold down costs (Konetzka et al., 2008). Increased competition in health care started the trend for hospital consolidating through mergers and acquisitions into multi-hospital systems. In 1979, only 32% were part of the health systems and by 2001 the number increased to 54% (Dranove & Lindrooth, 2003).

The healthcare environment has changed in the last few decades with increasing numbers of hospital closures. In the past two decades, health care organizations, especially acute care hospitals are undergoing pressure to remain financially solvent due to greater accountability, economic downturn, and cost containment measures by providers. Between 1980 and 2000, the number of hospitals in the United States decreased by 17%, others experiencing an average of 10% reduction in admissions, 28% reduction in bed utilizations, and decrease in average length of stay from 7.8 to 5.8 days (AHA Commission on Workforce for Hospitals and Health Systems, 2002). In the past 2 decades, there were 25 hospital closures and six bankruptcies in the state of New Jersey (New Jersey Hospital Association, 2009), adding to challenges in leading a lean and decentralized organization.

In summary, nursing, nursing management, and nursing leadership evolved in the last century in response to changes in the health care environment to address health care issues of quality, access, and cost. The next section includes the theoretical framework and conceptual framework for nurse manager management and leadership roles.

Theoretical Frameworks on Nursing Management

The origin of the word management means to both direct and lead through the effective use of resources (Marquis & Huston, 2009). Management in nursing is the art and science of planning, organizing, coordinating, directing, and controlling unit resources to accomplish organizational goals (Huber, 2006). Management in nursing adopts several theories from different disciplines such as business, sociology, psychology, and anthropology (Marquis & Huston, 2009). Organizational theory studies in healthcare and nursing management addresses contextual needs of the organization's adaptation to changes, innovation (external and internal), strategies, quality, efficiency, profit, sustainability, and motivation of employees. Nurse managers with an understanding of effective management and leadership theories are able to influence staff with strategies and initiatives to improve patient satisfaction.

Great man and trait theories conceptualized between 1900 and 1940 include management theories of the Frederick Taylor and Max Weber that had a major influence on nursing management practices during the depression era (Andrist et al., 2006; Taylor, 1911; Weber, 1997). Fredrick Taylor, the father of Scientific Management proposed organizational goals and rewards as motivations for workers, defined the role of employee selection and training, setting wages and work standards for organizational performance and productivity (Longest et al., 2000; Taylor, 1911, 2008). Scientific

management theory also delineated the role of the manager to plan, prepare, and supervise employees in a cooperative and interdependent relationship. Max Weber's conceptualized ideal bureaucracy controlling and defining worker responsibilities and behavior through rules, policies, and procedures (Weber, 1997; Wren, 2004).

Evidence from journal articles and nursing records indicate that application of scientific management theories led to the reorganization of hospital nursing and division of labor in nursing in the 1930s to its present form (Lewis, 1990). A majority of health care organizations still operate under similar professional and administrative hierarchies as suggested by Weber's and Marx's bureaucratic theories and design (Daly, Speedy, & Jackson, 2004). Current research cites controlling, intimidating, and lack of participative management among nurse managers affecting staff outcomes (Azaare & Gross, 2011). Current health care environment is facing increasing competition, stakeholder, and regulatory demands for better quality, efficiency, and effectiveness that require new flexible management and leadership roles. Leaner, entrepreneurial, and less bureaucratic organizations will need to redefine new roles and competencies for nurse managers to improve quality of patient care.

Behavioral theories popular in the mid-1940s saw changes to organizational theory shifting from productivity, psychology of the organization to motivational studies of individuals and teams in organizations. Proponents of such more humanistic approach in management were Henri Fayol, Mary Parker Follet, Elton Mayo, Douglas McGregor, and Abraham Maslow. Henry Fayol identified strategic planning, employee motivation, employee guidance as important factors in retention and performance (Wren, 2004). The management process proposed by Fayol includes the following phases of planning,

organizing, directing, and staffing functions, process, and delivery (Marquis & Huston, 2009). Mary Parker Follet sought to include teamwork in the study of scientific management (Wren, 2004). Follet believed that managers should exercise authority with the employees than over the employee, thus laying the foundation for participative management (Marquis & Huston, 2009). The Hawthorne experiments by Elton Mayo highlighted the flaws in the bureaucratic management theory proposing informal work environment reinforcing employee productivity.

Maslow's Hierarchy of Needs

Maslow (1954) addressed the hierarchy of human needs. Maslow categorized basic needs into five categories of a hierarchy. These levels, ranging from lowest to highest include physiological needs, safety needs, social needs, esteem needs, and the need for self-actualization (Maslow, 1954, 1970). Maslow proposed that people have different needs hence are motivated by diverse incentives to attain organizational goals and objectives (Longest et al., 2000). As basic needs are met higher needs need to be fulfilled and monetary rewards are no longer primary motivators to job performance and productivity (Benson & Dundis, 2003). Humanistic and behavioral theories have an influence on how the current nurse manager perceives their behaviors, roles, and relationships with the staff and the consumers they serve.

Theory X and Theory Y

Douglas McGregor in 1960 proposed Theory X and Theory Y to explain the differences between the directed employee with rewards as motivation (Theory X) and creative, self-directed, and self-actualized workers as motivation factors to improved productivity (Theory Y) (McGregor, 1960; McGregor & Cutcher-Gershenfeld, 2006;

Wren, 2004). In Theory X, managers assume that employees have little ambition, direction, and avoid responsibility and hence the management style is to direct, control, threaten employees to perform (Marriner-Tomey, 2004; McGregor, 1960). McGregor proposed the management philosophy of Theory Y to use positive incentives such as praise and recognition, providing opportunities for individual growth, delegation of responsibilities, encouraging participation in planning and decision-making to motivate employees to perform (Marriner-Tomey, 2004; McGregor, 1960).

Many of the humanistic management theories barely influenced nursing management until the 1970s with little influence over an entrenched bureaucratic environment (Marquis & Huston, 2009). Traditional bureaucratic structures and management practices conflicts with a participatory style of management resulting in unmet organizational goals (Marquis & Huston, 2009). Current and emerging issues in health care may require redefining nurse manager roles and responsibilities to meet organizational goals for improving patient satisfaction. Human relations theories that operate under static and closed system and may not be applicable to complex health care organizational structures that require developing interdisciplinary collaboration for positive patient and staff outcomes (Daly et al., 2004). Current literature does not provide information of nursing management practices of Theory X and Theory Y to influence patient and staff outcomes.

Systems Theory

Bureaucratic management in nursing shifted to a different approach in organizational theory with the adoption of Systems theory. Systems theory emerged in the early part of the century explaining how systems worked, and it was applied to many

universal concepts such as that of the study of cells to the study of the universe (Boje & Gephart, 1996). Systems theory was applied to organizational studies in the 1960s in other industries except nursing management resulting in a more humanistic and holistic approach to management. Systems theory is still considered a desired mindset and way to approach organizational management, change, or innovation. Design of systems organization is different with interrelated circles and horizontal networks rather than the traditional hierarchal vertical departmentalized management (Boje & Gephart, 1996; Pfeffer, 1997). Systems theory becomes difficult to apply in a bureaucratic hospital system with strong departmental silos (Huber, 2006).

Attaining a steady state of equilibrium in a chaotic and turbulent health care environment may be difficult to achieve. Nurse managers require a systems thinking approach to analyze and understand interrelationships with different disciplines to acquire an in-depth understanding of his or her role to influence and improve patient satisfaction. Planning patient satisfaction initiative will have to take into consideration a holistic and systems perspective identifying inputs, outputs, throughputs, and necessary feedback loops (Huber, 2006). The concepts of interrelatedness and interdependence fit well in health care organizations that value shared governance and multidisciplinary teamwork approach to patient care (Huber, 2006). Lack of current evidence of systems approach among nursing managers to influence patient or nursing outcomes provided the rationale for the current study.

Theoretical Frameworks for Nursing Leadership

The definition of leadership is changing from the concepts of managing, organizing, and ordering to accomplish organizational goals, to a highly evolved

relationship between leader and follower (Kent et al., 2001; Kotter, 1990). Leadership is seen as influencing and marshaling others to accomplish a vision for change through commitment, alignment, focus, and empowerment (Kent et al., 2001). Both management and leadership skills are necessary to meet current and future health care challenges. Nurse leaders create structures and implement nursing care process to affect positive patient and staff outcomes (Cummings et al., 2008). Nurse managers will need to integrate management skills and leadership competencies to effectively lead group practices for positive patient outcomes (Marquis & Huston, 2009). The following leadership theories influencing nursing management include transactional, transformational, contingency/situational, servant, structural empowerment, and authentic leadership theories.

Transactional Leadership

Transactional leadership as proposed by J. M. Burns (1978), is an economic exchange for follower expected work performance. A transactional leader maintains stability within the work environment between leaders and follower by exchanging goals and objectives for material and social rewards (Sarros & Santora, 2001). Although there is at present a widespread use of this leadership style (Bass, 1985) transactional leadership is self-limiting. Once the exchange of rewards for worker participation has run its course, the follower, and leaders renegotiate, or terminate relationships. Followers are not motivated to perform beyond the expectations for set rewards (Lussier & Achua, 2009). The three basic dimensions to transactional leadership are the following:

1. Contingent reward-Concepts of contingent reward bases its premise that measurable and tangible rewards guide worker actions (Judge & Piccolo, 2004).

Transactional leadership is a reciprocal relationship between leader and follower to exchange of skill and ideas for material reward (Sarros & Santora, 2001). The leader appeals to the basic wants and needs of the follower such as promotions, pay raises, positive job performance, or evaluations.

2. Management by exception –active, is an active process between leader and follower by actively monitoring follower's performance, and taking proactive steps to prevent problems.
3. Management by exception –passive is also called laissez faire leadership as leaders lead by non-action or react only when any situation warrants action.

Transactional leaders trust their followers to meet the goals and objectives on their own, without input, or inspiration (Sarros & Santora, 2001). This leadership style prohibits creativity, communication, and constructive feedback resulting in a stagnant work environment providing little room to strive beyond expected outcomes. Transactional leadership styles have shown to have influence on staff dissatisfaction, reduction in organizational commitment, and nursing staff turnover (McCutcheon, 2004; Smith, Hood, Waldman, & Smith, 2005; Windsor, 2009). Recent empirical nursing research supports contingent reward aspect of transactional leadership to motivate employees for positive outcomes (Adadevoh, 2003; Judge & Piccolo, 2004). The nurse manager leadership style is crucial in maintaining relationships with staff and patients to meet organizational goals.

Transformational Leadership Model

Compared to transactional leadership, transformational leadership tends to be associated with a more enduring leader-follower relationship based on trust and

commitment than contractual agreements (Avolio et al., 1999). J. M. Burns (1978) introduced the concept of transformational leadership and postulates transformational leaders do not appeal to the follower's transactional relationship of rewards but rather to their sense of higher ideals and values. By transcending leaders self interest, to a moral and social and utilitarian level, transformational leadership raises follower self-consciousness by internalizing the values of the leader (Bass, 1985). Bass (1985, 1999), extending the work of J. M. Burns, provides a comprehensive view of transformational theory with four major components.

1. Idealized Influence is the behavior often synonymously described as charisma. Certain qualities exhibited by the leader appeal to the followers to follow the convictions and visions of the leader. In idealized influence leaders appeal to the follower's innate need to fulfill their purpose in life, of values thereby giving meaning to their existence (Sarros & Santora, 2001). The charismatic leader portrays a dynamic personality, self-determination, self-confidence, has excellent communication skills, is emotionally, and socially confident to influence followers to accomplish a vision.
2. Inspirational motivation is the manner in which the leader inspires and motivates the followers with vision, meaning, importance, and relevance to the followers. The leaders articulate these visions clearly, compelling, and motivating followers to align themselves to the vision for the organization (Judge & Piccolo, 2004; Sarros & Santora, 2001). These leaders are seen encouraging and challenging employees to implement creative ideas for the organizational growth.

3. Intellectual stimulation involves the leader actively seeking employee participation for creative ideas and change from the standard operational methods. They challenge and stimulate the intellectual capabilities of the employees to think beyond the box. Leaders are inclusive, supportive, and coaching involving followers to participate in this process (Sarros & Santora, 2001).
4. Individualized consideration is the degree to which the leader takes an active role in listening, accepting, and guiding the follower through the planning, implementation, and evaluation of the vision (Sarros & Santora, 2001). The leader acts like a mentor to develop the full potential of the follower (Judge & Piccolo, 2004). Leaders approach their followers with consideration and genuine sense of caring, listening to their needs and concerns, creating an amicable workplace.

Transformational leadership theorists emphasized that empowerment is essential to build commitment to meet organization's objectives (Avolio, 1999; Bass, 1999; Yukl, 1999). Lowe, Kroeck, and Sivasubramaniam (1996) argued that transformational leaders help employees reach full potential by transforming follower's preferences, needs and values. Followers of transformational leaders identify with their leader through psychological empowerment (Laschinger, Finegan, & Shamian, 2001). Bass (1985) advocated the delicate combination and balance of both transformational and transactional leadership model to be an effective leader. Judge and Piccolo (2004) suggested that transformational theory augments, supplements, and even compliments transactional leadership. The Institute of Medicine (IOM) called for transformational

nursing leadership to implement management practices that provide for safe patient cultures (Wong & Cummings, 2007).

Nurse managers adopting evidence-based practice and data driven approach have management success instead of consumed with fighting fires especially in times of transformational changes within the health care industry (McLarty & McCartney, 2009). According to Zori and Morrison (2009), a contemporary nurse manager needs to adopt a transformational leadership style that will help translate organizational mission, vision, and goals into unit strategies aligning staff to organizational goals.

A review of nursing literature from the 1990s until present provides empirical support of nursing leader's transformational leadership style relationship with multiple variables. Transformational leadership is higher among nurse executives (Dunham-Taylor, 2000; McDaniel & Wolf, 1992) and critical care nurse managers (Ohman, 2000) than mid-level and other front-line nurse managers. Literature review on nurse leaders with transformational leadership styles show positive impact on staff nurse's organizational commitment (McGuire, 2003; Upenicks, 2002; Windsor, 2009; Wong & Cummings, 2007), staff satisfaction (Brown, 2010; Doran et al., 2004; Failla & Stichler, 2008), staff retention (Drenkard, 2005; Kleinman, 2004); reducing staff burnout (Kanste, Kyngas, & Nikkila, 2007; Stordeur, D'Hoore, & Vandenberghe, 2001), work satisfaction, patient satisfaction (Casida & Pinto-Zipp, 2008), and organizational outcomes (Robbins & Davidhizar, 2007). Transformational leadership style has greater organizational effectiveness as well as greater employee satisfaction than transactional and passive avoidant leadership style as measured by MLQ (Raup, 2007). Prior to the current study, little was known about the direct relationship between transformational leadership among

nurse managers and improving patient satisfaction in current contextual challenges in the health care environment.

Contingency or Situational Leadership Model

The contingency/situational leadership model evolved as result of the changing landscape of leadership. The information age brought in changes and a shift in traditional leadership roles and management structure. Contingency theory as proposed by Fiedler and Garcia (1987), maintained a conditional approach to leadership. In this theory the situation is the determining factor for implementing leadership styles rather than the behaviors, values, beliefs, and attributes of the leader. External factors such as nature of the task, leader's physical and personality, task level, competence, or a dire situation has an impact on leadership effectiveness (McFadden, Eakin, Beck-Frazier, & McGlone, 2005). Fiedler and Garcia proposed leadership styles should differ and be adapted based on the follower (a) competency of skill, tasks, and experience; and (b) follower psychological maturity and self-confidence. Fiedler and Garcia differentiated situational variables according to leaders member relation, task structure, and position power. Leader-member relation is the personal relationship of the leader with followers. Task structure refers to the structure of the group work or tasks. Position power is the formal or informal power conferred to the leader by the organization. The most favorable situation for positive organizational outcomes occurs with great leader-member relations, high task structure, and high position power (Fiedler & Garcia, 1987; Huber, 2006). There is insufficient research to make further suggestions or practical applications of the model in nursing management.

Hersey and Blanchard (1993) proposed the situational theory of leadership, most popular among current situational theories. The authors of the model proposed each situation demands a leadership style that is unique to the situation with synthesis of task behavior, readiness of followers, and relationship between follower and leaders as optimal condition for effective organizational outcomes (Hersey, Blanchard, & Johnson, 1996). The four types of leadership levels that match developmental needs and maturity level of followers include (a) high task, low relationship focus; (b) high task, high relationship focus is appropriate in low follower maturity level; (c) Low task, high relationship focus; (d) low task, low relationship focus represents a laissez-faire leadership style with little concern for productivity or relationship (Hersey et al., 1996; Marriner-Tomey, 2004). Latter developments to the model identified four major effective leaderships styles depending on the maturity level of followers addressing both relationships and task behaviors as the following: (a) telling or giving direction; (b) selling or participative coaching; (c) participating or sharing decision making; and (d) delegating or assigning responsibility for the task or goal achievement (Hersey et al., 2008).

Studies on situational leadership in nursing management show differences in perception of nurse manager effectives between the nurse manager and staff nurses (Johnson & D'Argenio, 1991). Most studies on situational leadership in nursing management and leadership posit the effectiveness of this style as related to internal and external environmental changes in health care (Cardin, 1995). Variables such as educational preparation may account for variances in the effectiveness of situational

leadership suggesting the holistic and comprehensive role of a nurse manager to effect quality outcomes (Mathena, 2002).

Forces such as rising consumerism, competition, globalization, and diversity pressure health care organizations to be more responsive to consumer expectations and demands for greater satisfaction. In a dynamic health care environment, skilled and competent nurse managers need to flex, change, and cope with changes (Geedey, 2004) but little was known about the effectiveness of situational leadership in improving patient quality outcomes. The current study was an attempt to shed light on how nurse managers in this study were able to modify their leadership style depending upon the maturity levels of the followers from setting clear expectations, to monitoring and evaluation of patient caring behaviors, using shared governance models for greater participation, and finally for highly motivated employees, engaging and empowering *staff champions* to create a patient caring culture.

Servant Leadership

Servant leadership is a leadership style proposed by Robert Greenleaf in 1977 suggesting that the leader is first a servant to his followers. This type of leadership places the interests of the followers before that of the leader (Greenleaf, 1977; Greenleaf & Spears, 1998). A servant leader assumes, "a non-focal position in the group, providing resources and support without an expectation of acknowledgement" (Smith, Montagno, & Kuzmenko, 2004, p. 81). To be selfless and to serve as a servant leadership assumes that the person is humble in nature. Effective managers put the needs of the employees, customers, and community as their priority over organizational goals.

Nurse managers are responsible to direct operational process for a supportive, efficient, and a patient-centered environment in the delivery of patient care (Otten & Chen, 2011). Studies also show significant positive impact on servant leadership orientation of the first line manager and employee job satisfaction (Jenkins & Stewart, 2008, 2010; Ramer, 2008). Nurse managers with servant leadership behaviors may improve quality patient outcomes by demonstrating characteristics of caring, commitment, persuasion, and awareness to patients and staff (Kerfoot, 2006; Ramer, 2008). Lack of empirical support of servant leadership characteristics among nurse managers provided the rationale of the study to improve patient quality of care.

Structural Empowerment Theory

In the late 1970s, many theorists argued that organizational culture, values of both leaders and follower, work complexities all contribute to developing a more empowering leadership style. The nursing profession experienced issues with staff retention and satisfaction due to lack of empowerment and decision-making (Stevens, 2002). Kanter's structural empowerment theory perceived power as the employee's ability to achieve goals, increased autonomy, access to resources, learning, growth, and positive relationship with organizational members and mastery of skill (Kanter, 1977). An empowering workplace provided employees access to information, support, resources, and opportunities to perform effectively (Kanter, 1977). Employees perceived a feeling of empowerment in a working environment that provided opportunities for growth and power through systemic sources of formal and informal power (Kanter, 1977).

A leader with an empowering leadership style develops relationships within the organization that provide opportunity, power, and proportion to the role of a leader

(Kanter, 1993, 1997). In a contextual domain, empowerment is an effective tool for managers to engage staff for organizational effectiveness (Kanter, 1993). Several studies link structural empowerment with respect, trust, organizational justice, and work engagement (Gilbert, Laschinger, & Leiter, 2010; Patrick & Laschinger, 2006; Spence Laschinger & Finegan, 2004). Empowerment studies in nursing have shown positive relationship on job satisfaction and work performance (Casey, Saunders, & O'Hara, 2010; Laschinger, Finegan, Shamian, & Wilk, 2002; Sarmiento, Laschinger, & Iwasiw, 2004), improving the safety, and quality of patient care (Armstrong & Laschinger, 2006; Laschinger, Almost, & Tuer-Hodes, 2003). The study findings are important in light of current issues with nurse's job dissatisfaction, and organizational commitment to quality patient care. Nurse managers can create organizational structures that empower staff nurses have control over work in a positive work environment leading to greater work engagement (Albrecht, 2010).

Authentic Leadership

According to Avolio and Gardner (2005), the Greek meaning for the word authenticity is "To thine own self be true" (p. 319). Authentic leaders have high moral character and are aware of thoughts, behaviors, values, morals, and strengths of self and others (Avolio, Sosik, Jung, & Berson, 2003). According to Shamir and Eilam (2005), characteristics of authentic leaders include the following: (a) authentic leaders are true to themselves instead of conforming to external influences and expectations; (b) personal values guide an authentic leader rather than an expectation to please others; (c) authentic leaders share information about self and openly relate to other people building close relationships; (d) an authentic leader is able to consider multiple perspectives, inputs,

assess information from self and others. The current study findings indicate authentic leadership among nurse managers influence followers to build new patient caring cultures for positive patient outcomes.

In summary, management and leadership theories have evolved over the last century to address the issues of meeting organizational goals across different disciplines. The first generation leadership studies focused on theory building, analysis, research design, and measurement (Avolio et al., 2003). The next generation of leadership studies focused on the analysis of the relationship between leader and follower within concepts and constructs of different settings, workgroups, and networks, increasing an understanding the phenomenon of change and culture (Avolio et al., 2003). Current literature on leadership concentrates on the collective leadership phenomenon, cross-cultural leadership, and integration of several levels of leadership theories. Leadership is the relationship between leaders and follower within a context (Northouse, 2007). Very little was known about the relationship between the leader, follower, stakeholder, and organization and leadership effectiveness within different contexts (Avolio et al., 2003).

Both nursing management and leadership theories are equally important in the development of an effective nurse manager. A review of literature on nursing leadership indicates perceived positive staff outcomes with leadership development programs emphasizing leadership skills and competencies (Cummings et al., 2008). A majority of quantitative nursing leadership studies contained a theoretical framework but lacked random sampling or quasi-experimental study designs to strengthen proposed relationships. Avolio et al. (2003) suggested the use of triangulation of quantitative and

qualitative research designs to test the effectiveness of leadership and management within contexts and constructs.

Current leadership studies emphasize the ripple effect of positive leadership behaviors through positive staff behaviors that finally impact client outcomes (Turner, 2010). A review of nursing leadership studies indicated nurse managers lacked strong relationships with direct patient outcomes (Olinger, 2010). This and other gaps in literature emphasized the need to understand and explore the holistic, comprehensive, and projected contemporary role, dimensions, skills and practices of the nurse manager to improve stakeholder outcomes such as patient satisfaction in the current context of a changing health care environment. The following sections contain the conceptual models and frameworks for nursing management and leadership. The important conceptual models influencing nursing management and leadership include shared governance, magnet hospitals, healthy working environment, emotional intelligence, professional practice, and interactional leadership model.

Conceptual Models in Nursing Management and Leadership

Shared Governance

In the 1980s, shared governance models were introduced in nursing practice with clinical ladders to reward engaged nurses. Shared governance was a management strategy to empower frontline staff to greater accountability, improved safety, and quality of care (Hook & Winchel, 2006; Styer, 2007), increased job satisfaction, commitment to the organization (Edwards, 2008; Robertson-Malt & Chapman, 2008), and organizational effectiveness (Bednarski, 2009). The shared governance model exemplified decentralized decision making with implications for nursing management, patients, and

health organization. Shared decision-making model is still embodied among in nursing leadership that discards an autocratic form of management for a supportive and shared decision-making leadership strategy that transforms the workplace to provide high quality patient care (Huber, 2006). Research on shared decision-making model continues to show the relationships with increased staff nurse involvement, investment, participation, shared power, cooperation, accountability, and interdependence in professional nursing practice (Huber, 2006; Kramer et al., 2009). In the current study, nurse managers used shared governance models to create a healthy working environment for staff participation, engagement, and empowerment in improving patient satisfaction outcomes. The current research was designed to bridge the knowledge gap between perceptions of the nurse managers' role, skills, and practices to improve patient satisfaction.

Magnet Recognition Program®

In the 1980s, the American Academy of Nursing introduced the Magnet Recognition Program® to retain and attract nursing staff (Upenicks, 2003). Magnet hospitals offered autonomy, self-governance for staff nurses with flexible staffing, adequate staffing rations, and clinical career opportunities (Marquis & Huston, 2009). Hospitals that apply for Magnet status to the American Nurses Credentialing Center (ANCC) must provide comprehensive documentation of compliance with American Nurses Association (ANA) standards and onsite evaluation. ANCC awards Magnet status for a four-year period after which the organizations must reapply (Munroe & Lash, 2005).

Forces of Magnetism composed of 14 specific characteristics or attribute for the designation of Magnet status by the American Nurses Credentialing Center (ANCC) a

subsidiary of the American Nurses Association (ANA). These characteristics exemplify excellence in nursing practice. Magnet qualities include the following (www.nursecredentialing.org/ForcesofMagnetism.aspx):

1. Quality of Nursing Leadership: Nursing leaders are asked to embody qualities of a visionary, strategic, strong, risk taking, articulate, and strong advocates for nurses and patient care.
2. Organizational structure: Flat, decentralized, shared decision-making models, with strong nursing representation at the reporting structure of the organization.
3. Management style: Nursing leaders should be visible, approachable, communicate effectively, encourage staff participation, and feedback.
4. Personnel policies and programs should support a healthy working environment, professional growth, work/life balance, and delivery of quality care.
5. Professional Models of Care will encourage accountability and provide continuity of care across the continuum.
6. Quality of Care: Nursing leadership is responsible to provide work environment influences quality patient outcomes.
7. Quality Improvement: Hospital has structures and process to measure quality of care and services.
8. Consultation and Resources: The healthcare organization that promotes utilization of Advanced Practice Nurses (APN), and encourages participation in professional organizations and community.
9. Autonomy: Staff nurses practice with autonomy consistent with professional standards.

10. Community and Healthcare organizations: the healthcare organization develops partnerships with the community to promote client outcomes and health of the community
11. Nurses as Teachers: Nurses serves as teachers and mentors for all levels of students from different academic programs and promote patient education.
12. Image of nursing: Nursing is an integral discipline influencing system wide process.
13. Interdisciplinary Relationships: Various disciplines work collaboratively, with mutual respect for positive clinical outcomes.
14. Professional Development: Health organization promotes professional development of staff through competencies of clinical and leadership management development program.

Early articles on Magnet hospitals highlight organizational characteristics such as participatory structures, autonomy of nurses, and empowering leadership (Havens & Aiken, 1999; Kerfoot & Talbot, 1992; Kramer & Schmalenberg, 1988a, 1988b, 1991a, 1991b, 1993, 2003). Current literature on Magnet hospitals continues to show positive staff outcomes such as work satisfaction (Laschinger, Shamian, & Thomson, 2001); control over practice, better relationship with physicians, healthy work environments (Aiken, Buchan, Ball, & Rafferty, 2008; Choi, Bakken, Larson, Yunling, & Stone, 2004; Schmalenberg & Kramer, 2009); and limited evidence with positive patient outcomes (Aiken et al., 2009; Armstrong & Laschinger, 2006). Research on Magnet hospitals continues to show improvement in staff satisfaction, recruitment, and retention of staff nurses specifically related to nurse manager leadership (Aiken, Clarke, Sloane, Lake, &

Cheney, 2008; Friese, 2005; Stone et al., 2009; Stone & Gershan, 2009). Some studies on Magnet characteristics with patient outcomes do not show significant differences between Magnet and non-Magnet hospitals (Carlton, 2009; Solomita, 2009).

Healthy Work Environment

Nurse managers are also called to build and sustain healthy work environments and manage change (AACN, 2005) by redesigning work environments through leadership skills and competencies, influencing staff performance, attitude, satisfaction, and morale to provide high quality patient care (Mathena, 2002; Sullivan et al., 2003). According to the American Association of Critical Care Nurses (AACN), standards to maintain a healthy work environment involves maintaining relationships to improve quality and safety of patient care as well improve financial health of the organization (Ulrich, Lavandero et al., 2009). A coalition of nursing organizations called the Nursing Organization Alliance has identified nine elements of healthy work environments to have the following (www.aone.org/…/PrinciplesandElementsHealthyfulWorkPractice.pdf; Sherman & Pross, 2010, para. 2):

1. Collaborative practice culture;
2. Rich combination culture;
3. Accountability;
4. Adequate qualified nursing staff;
5. Presence of expert, competent, credible, and visible leadership;
6. Shared decision making at all levels;
7. Encouragement of professional practice, continued growth, and development;
8. Recognition of the value of nursing contribution;

9. Recognition by nurses of their valuable contribution to practice.

Authors of recent studies have focused their attention to healthy work environments that impact staff satisfaction, retention, improved patient performance, and organizational performance (Aiken, Clarke et al., 2008; Ulrich, Lavandero et al., 2009). Research of Magnet hospital finds healthy aspects of healthy work environments (Choi et al., 2004; Ulrich et al., 2007). Nurse managers are asked to contribute to healthy work environments for better staff and patient outcomes (Kramer et al., 2009; Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2009).

In a survey of critical care nurses healthy work environments, staff nurses rated communication and respect among staff registered nurses as high compared to communication with nursing administrators (Ulrich, Lavandero et al., 2009). In the same study, 40% of registered critical care staff nurses rated the competencies of the frontline manager as good, while 25% rated the frontline manager competency to be fair, and 20% as excellent (Ulrich, Lavandero et al., 2009). The competencies include elements of communication, collaboration, effective decision making, recognition of contribution, leadership, providing staff, and non-human resources (Schmalenberg & Kramer, 2009; Ulrich, Lavandero et al., 2009). A review of literature revealed a lack of evidence how front line nurse managers will remodel their role and attain the desired competencies in a healthy working environment to improve patient satisfaction.

Increase in Emotional Intelligence by Nursing Managers

Emotional intelligence (EI), proposed by Mayer and Salovey in 1997 and later by Goleman in 1998, is defined as the ability of the manager to use emotions effectively for high performance. Emotional intelligence is the ability of an individual to manage

emotions and relationships effectively (Lucas et al., 2008). Emotional intelligence attributes include self-awareness, self-management, social awareness, and relationship management (Brown & Moshavi, 2005; George, 2000; Goleman, 2006; Salovey & Sluyter, 1997). A manager with high EI is self-aware, self regulates, motivates, is empathetic, and has proficiency in social skills. Leaders who are self-regulated choose appropriate emotional responses to different situations and have the capacity to be tolerant and are self-disciplined individuals. Leaders aware of their strengths and weaknesses, are self-confident, honest with followers, and open to change and growth. Leaders with empathy understand their followers and establish relationships with their followers for team building. Self-motivated leaders motivate employees to perform beyond expectations for the sake of achievement for the organization. Leaders with excellent interpersonal relationship based on purposeful friendliness, build rapport with their followers.

Goleman (2006) found intellect a strong predictor of outstanding leadership performance and emotional intelligence more important than technical and cognitive skills for leadership excellence. Studies revealed strong relationships between emotional intelligence (EI) of nurse manager with staff empowerment (Akerjordet & Severinsson, 2008) and performance (Codier, Kamikawa, & Kooker, 2011). EI studies with nursing leadership limited to quantitative correlation studies with small sample sizes (Smith, Profetto-McGrath, & Cummings, 2009). Although EI has demonstrated effective staff and client outcomes in nursing staff as well as other professions (Ball, 2010; Budnik, 2003; Diaz, 2008; Freel, 2009; Landa & Lopez-Zafra, 2010) few research studies demonstrate qualities of emotional intelligence among front-line nurse managers

(Akerjordet & Severinsson, 2007; Ohlson, 2010). As the health care industry is grappling with problems with poor quality of patient care amid nursing shortages, the current study on nurse manager emotional intelligence may provide clues to support innovation and initiatives to improve outcomes (Budnik, 2003).

Nursing Professional Practice Model

The Nursing Professional Practice Model is a relatively new nursing model gaining acceptance through Magnet characteristics and new nursing practices within hospitals. Hoffart and Woods (1996) defined professional practice environments as a system that supports the control over practice and delivery of nursing care. The five basic characteristics of nursing professional nursing practice are; (a) professional values, (b) professional relationships, (c) care delivery models, (d) governance or management, (e) professional recognition, and (f) rewards (Hoffart & Woods, 1996). The focus of the professional practice model is to increase nursing autonomy and empowerment through organizational support of professional practice such as the shared leadership or decision-making model (Marshall, 2010). The role of the nurse manager is to facilitate support the professional practice model within the unit to achieve high patient outcomes. A review of literature lacked sufficient data to strengthen the use of the model in the current contexts. The current study findings did not provide enough evidence of the professional practice model and its significance to the nurse manager role in improving patient satisfaction.

Interactive Leadership Model for Nursing Managers

A transforming health care environment requires new skills and competencies for nursing managers to address multiple challenges. Emergent interactive theories promote

evidence-based management practices within current contextual realities and constraints (Marquis & Huston, 2009). The contemporary 21st century leadership theories build and reengineer many 20th century interactive leadership theories within current contextual frames.

Brandt's Interactive leadership model (1994) suggests that leaders should create a work environment encouraging follower autonomy, creativity by providing value and empowerment (Brandt, 1994; Marquis & Huston, 2009). Leadership and management in nursing is a synergistic and symbiotic relationship, as nurse manager requires both leadership and management skills, roles, function, and competencies. As healthcare landscape is changing, the nurse manager needs to integrate both managerial and leadership roles to meet organizational objectives. J. W. Gardner (1990) proposed that managers with integrated leadership qualities possess six specific traits. An integrated manager-leader is a visionary, looks at the bigger picture, influences others, emphasizes vision, values, motivates, is politically astute, and is a change agent for the organization (Gardner, 1990).

Leadership and management in nursing are overlapping yet distinctly important and interactive processes to meet organizational goals (Huber, 2006). Few studies, if any, exist on the effectiveness of an integrated nurse manager and leader. The principles of effective leadership and management theories related to the work of a nurse manager with improving patient satisfaction may help in improving personal effectiveness and organizational productivity (Huber, 2006). The results of the current study supported the interactive model of nurse managerial and leadership role to improve patient satisfaction. The complex nurse manager holistic role is comprehensive including both managerial

function for daily operations and a leadership role for improving outcomes and leading followers in building new cultures. The following section contains current contexts and issues in the 21st century that provide the rationale and the significance for the current study.

Current Contexts for the 21st Century

The prevailing challenge of the health care system in the 21st century is to balance stakeholder demands and address the issues of cost, quality, and access. Health care organizations in the 21st century face multiple challenges with healthcare reform, demands for better quality, and financial accountability in the face of constraints in human and financial resources. According to a 2010 annual survey by the American College of Healthcare Executives (ACHE) regarding top issues confronting hospital leaders, financial challenges in the form of reimbursements ranked number one, followed by health care reform implications, government mandates, patient quality, safety, and satisfaction (ACHE, 2011). During the 21st century, hospital prices and healthcare premiums have continued to rise at a much higher rate since 2001 due to increasing costs. The loss of effective price controls in the past decade will affect measures that will mitigate hospital cost inflation in a post managed care era (Konetzka et al., 2008).

Organizations in recent years are facing challenges with interval restructuring, downsizing, reduction in management layers, increasing responsibilities, competition for market share, and meeting regulatory standards (Mathena, 2002). Decentralized or flat organizations have a top administrative layer, frontline managers, and nursing staff with frontline managers reporting directly to Chief Nursing Officers (Roussel, Swansburg, & Swansburg, 2006). Decentralization in health care organization eliminates middle

management with front-line nurse managers having greater responsibility of management, coordination among units, departments, and service (Swansburg & Swansburg, 2002).

As governance structures collapse, an increasing number of nurse managers are responsible for administrative decisions previously delegated to directors (Kleinman, 2003). In a flat governance structure, the role of a nurse manager is expanding in scope with increasing development of new knowledge and skills (Swansburg & Swansburg, 2002). Decentralization enhances the role of the front-line nurse manager with greater decision making authority and response to client and environmental changes in health care. Decentralized governance structures require knowledgeable, and capable front line nurse managers with greater managerial responsibility and accountability for staff and patient outcomes such as patient satisfaction (Finkler et al., 2007). Decentralization also allows for greater involvement and empowerment of staff nurses in decision-making (Finkler et al., 2007). The results of the current study supported the current contexts, as study participants recounted lived experiences with greater span of control, decentralized governance structures, and increasing expectations and responsibilities to improve both patient and staff outcomes.

Rapid technological growth, health care reimbursement changes, stricter regulatory requirements mandate that healthcare organization provide high quality, safe, and cost effective care (Frey, Leighton, & Cecala, 2005). The Affordable Healthcare Reform Act and Medicare reform will result in large-scale changes in operating and financial strategies of health care organizations to assure financial viability in a constrained economic reality. Medicare, the single largest payer of health care, is now

shifting its role from a passive payer of health to a more active payer to improve effectiveness and efficiency in the system (U.S. Department of Health and Human Services [USDHHS], 2011a). Health care reform strategies will result in lower margins for Medicare and Medicaid reimbursements accompanied by high costs of providing care (Centers for Medicare & Medicaid (CMS) Services, 2010a, 2010b; Institute of Medicine, 2009). Hospitals also face decreasing annual commercial payment rates by consolidated commercial insurers. Other financial constraints will test the existing health care leadership strategies to increase revenue and lower costs to achieve efficiency and value. The economic recession creates further volatilities in patient volume resulting several cost cutting measures to compensate for lower revenues (Goldstein, Martin, & Nelson, 2010). The current challenges provided the rationale for the study to understand the holistic and comprehensive role of nurse managers to meet organizational objectives such as improving patient satisfaction.

Demographics of Registered Nurses

Another prevailing challenge in nursing leadership and management is the demographic profile of the nursing in United States that offers a glimpse of nursing followership. According to the RN survey of 2008, 3,063,162 licensed registered nurses live in the United States; an increase of 5% from March 2004 (USDHHS, 2010). In 2008, 2,598,399 or 84.8% are currently employed in nursing, the highest in the last several years (USDHHS, 2010). This is an increase of 5.3% from 2004 with a net growth of 153,806 RNs (USDHHS, 2010). While 444,668 RN received their first United States license, 291,000 have let their licenses lapse, indicating the first wave of retirements from

the nursing field (USDHHS, 2010). Thus, even as new graduates enter the field, the overall workforce growth is affected by RNs leaving the profession.

Hospitals still employ a large percentage of nurses; with 62.2% of employed RN with the 90% of RN less than 25 working in hospitals compared to less than 53% of RNs older than 55 working in hospitals (USDHHS, 2010). RN in a management and administrative position accounts to 12.5% of the RN employees while 66.3% are employed as staff nurses (USDHHS, 2010). The demographics represent the following: 45.4% have an Associates degree, 34.2% have a bachelors or higher and 20.4% have a hospital diploma-based program (USDHHS, 2010). Men comprise of 6.2% of RN employed, while the population of RNs from ethnic minority groups have seen an increase from 333,368 (12.2%) in 2004 to 513,860 (16.8%) in 2008 (USDHHS, 2010). The nursing demographic data indicates a changing trend in the nursing workforce and may result in reengineering nurse manager role for effective workforce utilization.

Attrition Rates and Shortages of Nurses

The nursing profession is besieged with shortage of nurses, high attrition, and turnover rates. According to American Hospital Association (AHA) current RN vacancy rate stands at 8.1%, with a total of 135,000 open position needs to be filled (as cited in American Association of Colleges of Nursing, 2011). Buerhaus et al. (2009) projected the growth of nursing shortage to reach 260,000 by 2025. Data supplied by the staff members of U.S. Bureau of Labor Statistics (2012) indicated that the projected need for new and replacement RN positions would grow from 2.74 million to 3.45 million by 2020, an increase of 26%. Poor nursing school enrollment is one of the reasons for the shortage. For the data year 2008, staff at AACN (2011) reported that nursing programs

turned away 49,948 applicants due faculty shortage, budget constraints, lack of classroom space, and clinical sites.

As fewer nurses enter the profession, more mature nurses are employed in the workforce. According to the Nursing Management Nursing Workforce Survey conducted by the Bernard Hodes Group, the average age of RNs in the year 2012 will be 44.5 years and 55% of the current nurse manager workforce is expected to retire by 2011-2020 (American Association of Colleges of Nursing, 2011). Nursing as a second career is growing. More than 21% have had a degree prior to a nursing degree and 2/3rd reported working in a health profession prior to initial nursing profession (USDHHS, 2010). Older RNs over the age of 50 comprise 44.7% of the total RN workforce compared to 33% in 2000 (USDHHS, 2010). The percentage of older RNs in the workforce has declined recently because new graduates enter the workforce. Only a smaller proportion of older RNs work in hospitals while a larger percentage work in nursing homes/academic/and home health settings (USDHHS, 2010).

The scarcity of human resources in nursing is mainly due to an increasing demand, increased turnover due to stress, burnout issues, and fewer nurses entering the workforce (Medland, Howard-Ruben, & Whitaker, 2004). Many nurses are leaving the highly stressful environment of hospital nursing for more lucrative compensation, flexible work schedules, and diverse career options (Medland et al., 2004). The nurses left behind are faced to work in highly stressful situations with short staffing. Buerhaus, Donelan, DesRoches, Lampkin, and Mallory (2001) reported hospital inpatient RNs' perceptions of stress and burnout are greater than nurses from outpatient and other healthcare settings. The reasons for burnout include poor staffing, high and complex

acuity of patients, mandated overtime, and working double shifts (Medland et al., 2004) despite evidence of registered nurse staffing and patient quality outcomes (Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002).

In 2008, 29.3% of registered nurses reported that they were extremely satisfied and 51.8% reported being moderately satisfied with the principal nursing position (USDHHS, 2010). RNs working in academic education reported the highest satisfaction rates (86.6%). Among the RNs surveyed who were working in 2007 and not working in 2008, 27.3% reported retirement as reasons for leaving, while 73% reported lack of good management, and inadequate staffing (USDHHS, 2010). Lack of recognition and respect were major reasons for staff leaving (Spence Laschinger & Finegan, 2004). Others reported personal, career reasons, pay or benefit increase were other factors for job change. Among RNs who were 55 years and older, 8.9% intended to leave their current jobs within 3 years (USDHHS, 2010). According to Andrews and Dziegielewski (2005), the nurse manager is the key to staff nurse job satisfaction.

Due to several economic, political, and cultural influences, the decrease of nurses in the healthcare field has implications for patient, delivery, services, and nursing outcome (Biron, Richer, & Ezer, 2007). The organization incurs high costs associated with high Registered Nurses (RN) turnover from recruitment, training, orientation, and supervision. Jones and Gates (2007) estimated the replacement costs of Registered Nurse (RN) turnover, and replacement between $82,000 and $88,000. Increased stress and poor health can further contribute to poor productivity, job satisfaction and a host of other work related issues. Literature review on nursing outcomes suggested a relationship between nursing turnover and job stress, dissatisfaction, and burnout (Biron et al., 2007;

Gardner, Thomas-Hawkins, Fogg, & Lantham, 2007; Newman & Maylor, 2002; Tai & Robinson, 1998).

Studies relate the issues and variables of nursing staffing with patient safety (Biron et al., 2007; Park, 2011; Rogers, Hwang, Scott, Aiken, & Dinges, 2004). In addition to high organizational costs nurse turnover results in poor continuity of care that can result in poor patient outcomes such as patient safety (Gardner et al., 2007; O'Brien-Pallas, Murphy, Shamian, Xiaoqiang, & Hayes, 2010) wound ulcer, patient complaints (Blegen, Goode, & Reed, 1998) increasing length of stay, poor collaboration between professionals, late detection of complication, and failure to rescue (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Curtin, 2003; Pronovost et al., 2001). Aiken et al. (2002) concurred that the morbidity and mortality rates of patient are affected by poor nurse-patient ratio. The nurse manager influences adequate staffing that match patient acuity with a patient focused work allocation model over task focused work (O'Brien-Pallas, Catling-Paull, Duffield, & Roche, 2009). Nurse managers are in a position to perceive the challenges in the health care environment, and adequately lead nurses to achieve high quality care of patients (Sellgren et al., 2008). The lack of sufficient information on how nurse managers can influence positive patient outcomes signified the need for the study. The following section contains multiple challenges for the nurse manager in a changing health care environment to affect quality outcomes and highlight the need for the study.

Current Stressors of Nurse Manager Role

The health care environment presents many challenges to a frontline nurse manager. Changing market conditions in recent years such as diminishing reimbursements, stricter regulations, fierce competitions have led to merges,

reorganizations, restructuring, downsizing, and reductions in management layers (Mathena, 2002). The health care crises compound problems by increasing demands on a strained workforce. Despite the push to improve quality and safety, the prevailing issues in healthcare impact the quality and safety of patient care. Other issues involve gaps and deficiencies involving healthcare efficiency, patient outcomes, quality, safety, communication, and employee satisfaction creating healthcare crises in alternative ways.

A review of literature on nursing leadership development indicates a positive influence of leadership training and mentoring with observed leadership skills (Cummings et al., 2008). Despite empirical evidence, McLarty and McCartney (2009) reported nurse managers receive very little ongoing professional development and training to manage different accountable functions and make the organizations thrive. Nurse managers are less equipped and trained to manage the business functions than clinical activities of the unit (Mathena, 2002). Lack of support, mentorship, or training for the front-line nurse manager will lead to frustration, poor performance, and a failure to maximize potential (Grindel, 2003). Most nurse managers are promoted from the ranks of clinical nursing staff without ensuring adequate management training (Grindel, 2003; Kleinman, 2003; McLarty & McCartney, 2009; Wilson, 2005).

American Association of Colleges of Nursing (AACN, n.d.) recommended nurse managers achieve a Masters degree in Nursing Administration and obtain a nurse manager certification in addition to obtaining a certification in appropriate clinical specialty area yet only a small percentage of the current nurse manager meet these requirements. The certification as a nurse manager requires a Baccalaureate degree in

nursing and at least two years experience in a nurse manager's role to be eligible for the certification exam.

The failure to meet financial and organizational variables may affect nurse manager satisfaction. The variables include budget variances, especially concerning overtime, patient satisfaction, staff turnover, staff morale, and lack of reaching management objectives (McLarty & McCartney, 2009). A survey of nurse managers and leadership roles reveal job satisfaction from intervening and seeing success with patient, families, and staff (Sullivan et al., 2003). Other satisfying factors of their roles as leaders consist of flexibility, autonomy, managerial influence, ability to influence practice decisions, and positive outcomes (Sullivan et al., 2003). A systematic review of literature by H. Lee and Cummings (2008) on nurse manager satisfaction provides evidence that reducing span of control, improving empowerment, and organizational support of front-line managers provide positive patient and staff outcomes.

In a study to understand nurse managers' stress and work complexity, the researchers in a study identified three major categories of stress for nurse managers such as people and resources, task and work, and performance outcomes (Shirey, McDaniel, Ebright, Fisher, & Doebbeling, 2010). Within the category of people and resources, conflict resolution, performance evaluation, for sub-performing employees, organizational politics, patient and family complaints, maintaining physician relationship, retention, and recruitment issues as major sources of stress (Shirey et al., 2010). Under the task and work category, a majority of nurse managers surveyed identify staffing, understanding financial side of the role, and workload contributing to stress (Shirey et al., 2010). Regarding performance outcomes scores, nurse managers voiced concerns

regarding patient satisfaction scores, patient safety, and operational effectiveness as major source of stress (Shirey et al., 2010).

Other causal factors increasing stress among nurse managers are concerns regarding high level of diverse and multiple responsibilities, unable to complete tasks, regulatory mandates, organizational quality improvement initiatives, and system inefficiencies (Shirey et al., 2010). In this study the researchers also alluded to the unrealistic expectation, and configuration of a nurse manager role and responsibilities (Shirey et al., 2010). The unrealistic expectations may increase stress perceptions causing harm to both the manager and the work environment. The nursing shortage, high patient acuity, and high nurse-patient ratio contribute to staff nurse turnover and burnout (Grindel, 2003) and add to nurse manager stress.

The current issues cause problems with retention and high turnover among of nurse managers compared to other industries with organizational costs between $62,000 and $67, 000 per nurse (Swearingen, 2009). Wong and Cummings (2007) predicted a shortage of nursing leadership due to aging workforce affecting nursing leadership as well as staff nurses. The average age of nursing leaders is more than 50 and by 2020, 75% of the nursing leaders will retire (Bernard Hodes Group, 2006).

A failure to develop future nurse leaders with necessary skills and competencies to meet healthcare challenges and requirement will results in a significant loss of nursing leaders. The suggestions include a co-manager model or Clinical Leader model to assist in the various responsibilities, to enhance employee retention, patient satisfaction, personal empowerment, and enhance succession planning. Other suggestions include supportive organizational structures to enhance the role and peak performance of the

nurse manager to produce effective outcomes (Shirey et al., 2010). Many of the above-mentioned issues including employee stress, inadequate communication, lack of education, and preparation, affect the delivery of quality care (Mathena, 2002). The nurse managers need to address his or her ambiguity, lack of skill, and knowledge regarding roles before leading effective employees in the change process (Mathena, 2002).

Contemporary Nurse Manager and Leader Practices (2011 and Beyond)

Research and evidence-based medicine is shifting the focus from disease management to outcomes research. The changing healthcare environment calls for greater accountability for healthcare leaders to operate more efficiently, decreasing costs while continuing to provide excellent quality and patient outcomes (Sherman & Pross, 2010). Standardization of care and centralization results in faster patient throughput, high turnover with emphasis on increasing patient volume (McWhirter & Scholes, 2009). According to Wells and Hejna (2009), health care organizations in a highly competitive marketplace should identify and incorporate leadership competencies including customer service management. Nurse managers need to prepare for the challenges that lie ahead with key competencies and skills for effective management (Kirby, 2010).

Affordable Care Act of 2010 introduced by President Obama seeks to address the issue of equity of healthcare by expanding healthcare insurance to the uninsured. The legislation also aims to reduce healthcare costs by expanding the number of uninsured and providing options for affordable coverage to the insured (Kirby, 2010). The new health care reform will extend coverage to 32 million people, increasing demand for health care providers and registered nurses in primary and other health care settings

(Sochalski & Weiner, 2011). The Affordable Care Act provides funds for education and training to increase the supply of registered nurses and Advanced Practice Nurses (APN) (USDHHS, 2011b).

In October 2010, IOM released "A Summary of the February 2010 Forum on the Future of Nursing Education: Education" report, highlighting the role of nurses in meeting the objectives of the 2010 Affordable Care Act. The intent of IOM call to action report was to transform the future of nursing profession by asking nurses to practice according to their scope of education and training: attain higher education and training: create equal partnership with other health care professionals to redesign health care: create better data collection and information infrastructure for effective workforce planning and policy (Fairman & Okoye, 2011; IOM, 2010). As education level increases so does quality and safety of patient care. Promotion of advanced education opportunities for employees is seen as an essential imperative for high performing organizations. A study conducted by Nogueras (2006), has shown positive relationship between level of higher education in nurses and commitment to their jobs. The changing healthcare landscape calls for nurse managers to evaluate and identify roles, competencies, and skills for quality improvement and better patient outcomes.

Aging demographics of the United States population or the baby boomer generation will add additional strain to the demand of nurses. Nursing managers will be facing high demand for health services with low supply of human capital with serious implications for improving quality of care. Leadership behaviors are the essential to productive organizations with satisfied employees (Bass, 1985). According to Jones and Gates (2007), a strong nursing leadership helps transform the workplace to improve

nursing retention and improve patient outcomes. The health care industry is starting to recognize the importance and holistic role of the nurse manager in a changing health care environment to affect positive patient outcomes.

In summary, the literature search signified many approaches to theories, conceptual, and contextual framework that explains the healthcare management and leadership concept. Together they provide a comprehensive framework toward better understanding of nursing management roles, skills, and dimensions in the present health care environment. Current literature lacked strong evidence on specific factors that increase the effectiveness of nurse manager leadership and managerial role (Cummings et al., 2008).

Despite extensive literature on nursing management and patient satisfaction, literature search revealed a lack of sufficient information regarding direct influence of nurse manager in improving patient satisfaction and provided the rationale for the current study. The next segment contains a review of current and future expectations and constructs of nurse manager role, functions, and competencies to improve quality of nursing care and patient outcomes. The first part contains the nurse manager role and functions in quality improvement trends to lead an effective workforce and meet organizational objectives.

Quality Improvement Trends for Nurse Manager Role in the 21st Century

Management role is a set of particular behaviors evident in the position. Henry Mintzberg conceptualized managerial roles into distinct but interrelated interpersonal, informational, and decisional roles (Longest et al., 2000). In a position of formal authority, managers act in the role of a liaison, leader, and a figurehead. In a liaison role,

the manager establishes relationships with different stakeholders to meet organizational objectives. Managers act as leader to motivate, influence, inspire, and lead employee by his or her actions (Longest et al., 2000).

The figurehead role is a symbolic representation of authority. The informational role of the manager includes that of a monitor, disseminator, and a spokesperson. In a monitor role, the manager gathers information, filters, evaluates, and makes appropriate decision regarding the information. As a disseminator, the manager decides on who and what information to disseminate. As a spokesperson, the manager becomes a spokesperson to stakeholders regarding specific area of responsibility (Longest et al., 2000).

Decisional roles of a manager include that of a negotiator, entrepreneur, conflict manager, and resource allocator. As entrepreneurs or change agents, managers help design that improves performance in their area. Managers also handle many disturbances that may arise in their daily work. As resource allocators, managers help allocate human, financial, physical, and technological resources to manage their units. In the role of a negotiator, a manager acts to interact and bargain with difference stakeholders (Longest et al., 2000).

Researchers from the Council on Graduate Education for Administration in Nursing (CGEAN) defined Nursing Administration as a subspecialty of healthcare administration, accountable for the nursing care delivery across all settings (Scoble & Russell, 2003). Nurse managers consist of the largest number of middle managers in health care organizations and interact with both nursing as well as other disciplines providing direct patient care (Mathena, 2002). Nurse managers are critical to the success

of the healthcare organization by leading the largest group of health care employees (Finkler et al., 2007; Mathena, 2002). Frontline nurse or unit managers provide a direct link between senior leadership and nursing staff on an ongoing basis.

Nurse managers are accountable and responsible for round the clock quality of nursing care delivered in their practice setting (Fry, 2010). Leaders of organizations expect the nurse manager of the nursing units to be directly responsible for unit performance such as implementation of quality improvement activities that will improve patient outcomes. More recently the focus has shifted from the delivery to the patient care outcomes such as mortality, morbidity, patient satisfaction, discomfort, and disability to measurements for healthcare system efficiency and effectiveness on many quality indicators. Indicators are necessary to compare benchmarking data, and improve system, process, and outcomes in the delivery of care. Nurse managers are responsible to monitor, track, plan, implement, and evaluate quality improvement programs based on quality indicators in individual units.

Nurse managers are responsible for several daily operations including (McLarty & McCartney, 2009);

1. Making complex decisions that impact daily patient care operations;
2. Communicate with staff, patients, families, physicians, various departments;
3. Implement change process and culture for better quality, and safe patient care;
4. Institute evidence-based practice or best practice standards of patient care;
5. Ensure retention, performance, job satisfaction, and professional development of staff nurses;

6. Optimal use of medical technology for development of timely and safe patient care practices.

The role of the nurse manager is shifting from the nursing responsibility for budget, staffing, and unit compliance to a broader accountability toward patient service across a continuum (Shirey & Fisher, 2008). Prior thoughts on nursing leadership contend the relationship between the nurse manager and patients as being indirect and less influential than frontline staff nurses. The changing healthcare environment calls for greater accountability for healthcare leaders to operate more efficiently, decreasing costs while continuing to provide excellent quality and patient outcomes (Sherman & Pross, 2010). Recent literature search provided information on expectant nurse manager role in a changing health care environment without providing specifics on how the nurse manager will actually fulfill organizational goals. The following is a literature review of the nurse manager and leadership role to affect multiple performance variables within the health care organization.

Maximizing Nurse Manager Leadership Roles with Performance

According to Zori and Morrison (2009), the role of a nurse manager is to achieve organizational goals of providing high quality, safe, and affordable patient care by improving satisfaction, reducing mortality, morbidity, length of stay with the diligent use of human, financial, and technological resources (Kirby, 2010; Lee & Cummings, 2008; Sherman, Bishop, Eggenberger, & Karden, 2007). Substantial research revolves around nursing manager leadership style and behaviors with nursing staff job satisfaction, productivity, and organizational commitment (Bruyneel et al., 2009; McNeese-Smith, 1995, 1997; Mrayyan, 2008; Sellgren et al., 2008; Utriainen & Kyngas, 2009) through

building high trust leader-follower relationship (Andrews & Dziegielewski, 2005) and promoting nursing autonomy (Erenstein & McCaffrey, 2007; Wilson, 2005). Improving nurse manager visibility, being approachable, consistent, coaching, mentoring, working side-by-side, practicing organizational values, engaging in supportive communication to improve staff satisfaction builds high trust relationships (Andrews & Dziegielewski, 2005; Brown, 2010; Kouzes & Posner, 2005).

For nurses job satisfaction several other factors such as salary, staffing, benefits, working conditions, career advancements, in addition to empowerment, managerial support, and decision-making ability create a positive effect (Jenkins & Stewart, 2010). According to Armstrong and Laschinger (2006), nurses perceiving the organization to be empowering are more satisfied, committed to their jobs, and provide high quality care. Manager exerting positional power and intimidation without staff participation lack staff nurse's trust, satisfaction, and confidence to plan and implement policies for quality improvement (Azaare & Gross, 2011). Nursing job satisfaction is affected by organizational characteristics that promote leadership, autonomy, empowerment, and involvement with staff (Wieck et al., 2010).

Leaders of health care organizations expect nurse managers to provide leadership and guidance, create structures, process, and manage staff for positive patient care outcomes (Anthony et al., 2005; Lee & Cummings, 2008). Studies indicate that senior leadership core behaviors such as employee recognition, communication, and mission have a significant relationship to patient loyalty attributes (Worman, 2008); yet frontline managers tend to overlook these attributes. In a study by D. K. McNeese-Smith (1999), nurse managers' motivation for power positively correlates to patient satisfaction. Nurse

managers with motivation for power were more likely to round on patients leading to higher patient satisfaction scores and better quality of nursing care.

However, the same leadership behavior negatively correlates to staff nurse perception of leadership qualities of the nurse managers and staff satisfaction (McNeese-Smith, 1999). Nurse managers will need to redesign work environments through leadership skills and influence on staff to provide high quality care. High quality and safe nursing care provided by qualified, competent, and satisfied employees lead to improved patient satisfaction (Ten Haaf, 2008).

Health industry research is limited with nurse manager role in improving patient quality outcomes. A study by Hay Group (2006), a management-consulting firm, looked at nurse manager leadership qualities with indicators of performance such as patient satisfaction, patient complaints, nurse staff turnovers, absenteeism, and medical errors. High performing nurse managers have 36% lower staff turnover, and 57% lower absenteeism rates compared to lower performing managers (Hay Group, 2006). The Hay Group (2006) study indicated several recommendations for organizations interested in maximizing performance for nurse leaders.

The recommendation include developing a well defined role for nurse managers, establish accountability for performance, provide support for leadership styles, ensure authority to make decisions, create development opportunities for leadership styles, train nurse managers to understand the impact of leadership style on patient outcomes and organizational performance (Hay Group, 2006). Industry research lacked sufficient empirical evidence of direct relationships between nurse manager abilities, roles, and competencies with patient satisfaction outcomes and provided the rationale for the

current study. The results of the current study supported and expanded the current understanding regarding understanding, developing, and supporting the new nurse manager role to meet organizational goals for improving patient satisfaction. The following section contains evidence from literature on key nurse manager functions to perform effectively in a healthcare organization.

Key Nurse Management Functions to Improve Quality

Management functions in nursing are a set of social and technical functions such as planning, organizing, staffing, directing, and controlling (Longest et al., 2000; Marquis & Huston, 2009). Planning includes a decision-making process to meet organizational goals. Organizing involves establishing patterns of relationships among people and resources to fulfill goals and objectives. Staffing functions includes hiring, maintaining, and retaining human resources. Directing is socio-behavioral function of leading, motivating, and communicating with staff members. The controlling function of a manager involves regulating activities and performance management. Decision making is integral in all functions of the nurse manager's role.

Managerial functions of a nurse manager include knowledge and skills regarding human resources, financial management, quality, risk management, collective bargaining, interdepartmental communication, and relationships with staff as well as other managers, and executives (Zori & Morrison, 2009). Nurse managers are also responsible for coordination of patient care, hiring, retention, termination of staff, managing staff schedules, payroll, and performance reviews (Lee & Cummings, 2008).

An effective nurse manager needs to understand the required holistic and comprehensive roles and functions to attain desired outcomes. A review of related

literature on nurse manager roles and functions emphasized the human resources, financial resource, and daily operational management without providing sufficient information on the new, holistic, and comprehensive role of the nurse manager in light of the contextual phenomenon of improving patient satisfaction and the need to conduct the current study. The following section contains a literature review of current nurse manager and health care executive leadership competencies that provided a conceptual framework for understanding comprehensive nurse managers' competencies.

Nurse Manager Leadership Competencies

A nurse manager role is to perform their functions effectively with underlying skills and competencies. Roles are broad areas of responsibilities that require a combination of expertise and competencies. Relevant competencies define the roles of nurse manager (DeOnna, 2006) to navigate the current and future health care challenges by influencing followers to achieve a common goal to improve patient outcomes (Northouse, 2007). Competencies form the basis of training, evaluation, and assessing developmental needs for current and future nursing leaders (Mulholland, 1994; Sherman et al., 2007). Nursing leadership at different levels require different set of competencies with front-line nurse managers requiring skills in human resources, material, and environmental management (Lin et al., 2007).

According to Longest et al. (2000), the competencies for effective manager are conceptual, clinical or technical, collaborative, political, business, and governance. Conceptual competence enables managers to comprehend the organization's culture, values, beliefs, norms, and relationship with stakeholders. Managers need to be competent in both clinical and managerial skills of their domain. Interpersonal

competence is an important ingredient to motivate communicates, handle negotiations, and manage conflicts.

Political competence allows for managers to influence policies and protocols within the organization within their domains (Longest et al., 2000). Commercial competence requires managers to create value of quality and price in negotiations with other stakeholders. Governance competence applies to senior level managers in creating vision, promotes a culture, allocating resources, and accountability to stakeholders. The nurse manager through leadership skills influences the group practices of the staff to achieve organizational success.

Perra (2000) suggested nurse managers should possess strong skills regarding critical thinking, decision-making, problem solving, clinical, and patient advocacy. To function as an effective leader, nurse managers will need critical thinking skills that incorporate the value of inquisitiveness, reasoning, systematcity, open mindedness, confidence, and truth seeking (Zori & Morrison, 2009). Research shows nurse managers with critical thinking skills function as transformational leaders (Zori & Morrison, 2009) and provide a positive practice environment for staff resulting in job satisfaction and better patient outcomes (Zori, Nosek, & Musil, 2010). The nurse manager role and competencies to improve patient satisfaction in the current context was ill-defined by both health care industry and nursing education. The following section contains conceptual models and frameworks evident in management literature and health care industry that provide a foundation to understand multiple competencies for the nurse manager.

Current Concepts and Findings for Nurse Manager Competency

Healthcare organizations demand knowledgeable and skilled nursing leaders at all levels of management and administration. The nurse manager requires a large variety of skills and competencies to achieve the outcomes such as human resource management, financial management, quality improvement, negotiation, change management, strategic planning, and high emotional intelligence (Lucas et al., 2008). Nurse managers and nursing leaders need to evaluate nurse manager roles, skills, competencies, and identify areas for improvement. The following contains the conceptual framework for development of managers' competencies in other industries and relevant to nursing management.

David McClelland in the 1970s, through behavioral event interviews, popularized the process-driven methodology for identification of key competencies (DeOnna, 2006; McClelland, 1973). Employees provided detailed descriptions of critical elements and situations of their jobs focusing on important behaviors, thoughts, and actions to address the situation. Exemplary performers provided traits and characteristics forming the basis for competency modeling. Boyatzis's (1982) model of Effective Job Performance provided a conceptual and contextual framework for competencies assessing roles, job demands, and work environment of the employee. Society of Industrial and Organizational Psychology recommends inclusion of technical and functional competencies through job analysis with personality, behaviors, and value orientation (Shippmann et al., 2000). The next generation of competency modeling blended best practices of process and outcome driven methodologies to identify and describe work related competencies.

Dubois and Rothwell (2004) explained two different schools of competency modeling as outputs driven methodology and the process driven methodology. Outputs driven methodology comprises of job responsibilities and tasks driven by knowledge and skills based on job analysis. The Developing a Curriculum (DACUM), and Mastery Path are examples of outputs driven methodology. Process driven methodology focuses on the underlying characteristics of the individual to support performance and can include knowledge and skills (Rothwell, Lindholm, & Wallick, 2003). The DACUM methods seek perspectives of experts on work activities, tasks, knowledge, skills, and behaviors of workers. The information is organized into charts and becomes basis of formulating underlying competencies essential to work outputs (Dubois & Rothwell, 2004).

Russell and Scoble (2004), proposed a competency model called the Mastery path focusing on management practices, competencies, and skills of first, middle, and executive level managers. The Mastery path defines skills-based activities of human, conceptual, and technical skills under five major areas of management practice such as

1. Managing human capital,
2. Managing health care finances,
3. Managing professional nursing practice,
4. Managing health care operations,
5. Managing organization growth and development (Russell & Scoble, 2004).

Identifying nurse manager leadership styles and competencies are necessary for quality patient outcomes, patient satisfaction, and staff satisfaction (Zori & Morrison, 2009). In a study by Mathena (2002), nurse managers rated interpersonal skills and employee development skills most important to his or her success as managers. Financial

skills, technical skills, and general skills were most important to professional development while clinical skills were least important for success and development (Mathena, 2002). Nurse managers in this study cite practical experience and mentorship as key to factors for development as a nurse manager (Mathena, 2002).

The American Organization of Nurse Executives (AONE), the American Association of Critical Care Nurses and the Association of Perioperative Registered Nurses collaboratively developed a *Nurse Manager Leadership Partnership (NMLP) Learning Domain Framework* to identify key nurse manager skills and competencies (Sherman & Pross, 2010). The three domains include (a) The Leader within: Creating a leader in yourself, (b) The art of leadership: leading people, and (c) The science of leadership such as managing the business. The skills under the first domain include personal and professional accountability, career planning, personal journey disciplines, and optimizing the leader within (AONE, 2006b). The second domain suggests the art of human resource leadership, relationship management, diversity, and shared decision-making (AONE, 2006a). The third domain of managing the business include competencies in financial management, staff performance improvement, critical thinking skills, technology, human resource management, strategic management, and clinical knowledge (AONE, 2006a). A review of current literature provided scant evidence to support the effectiveness of the NMLP model among nurse managers to improve staff and patient outcomes.

The American Organization of Nurse Executives (AONE) promotes the use of the Nurse Manager Inventory Assessment. The Nurse Manager Inventory available in the public domain addresses the need of development of the nurse manager at the unit level.

AONE provides a framework and tools to assess nurse managers perceived level of competency and functioning along three domains from a scale of minimal to expert. The domains include managing the business, creating a leader in yourself, and leading the people (AONE, 2006b).

The nurse manager's immediate supervisor also completes the same inventory tool and compares to identify areas for improvement. The *Relationship with Staff* subcategory assesses the nursing manager's interaction and behaviors with staff. The Personal Mastery domain describes the nursing manager's professional development such as visioning, decision-making, professional development, and systems thinking. The administrative category includes the manager role, human resources management, fiscal management, and outcomes (AONE, 2006b).

The manager role category contains competencies pertaining to day-to-day operations, staffing, safety, and regulatory body compliance. The human resources category deals with nurse manager's competencies relating to cultural competency, recruiting, hiring, evaluating, and retaining staff. The administrative function is outcomes measuring the effectiveness of patient focused measurement, quality management, evidence-based practice measurement, and risk management. A review of current literature provided scant evidence to support the effectiveness of the model and inventory assessment among nurse managers and patient outcomes (AONE, 2006b).

The National Center for Health Care Leadership (NCHL, 2005) a non-profit health care leadership organization, created a NCHL Health Leadership Competency Model establishing core competencies for health leaders at very level. The Leadership Competency Model 2.1 version contains 26 competencies under three domains of

Transformation, Execution, and People (NCHL, 2005). Transformation consists of visioning a change process for all stakeholders around new models of healthcare (Calhoun et al., 2008). Execution consists of translating the vision into strategies for optimal performance. People domain requires healthcare leaders to create a healthcare environment that values all employees, improves capability of self and employees (Calhoun et al., 2008). The model requires more rigorous research in industrial application for health care leadership assessment, development, and credentialing (Calhoun et al., 2008). Of the 26 competencies mentioned, none specifically address how health care leaders will impact or influence patient satisfaction.

Some health care organizations choose to use competency models as they provide a foundation for expected leadership behaviors for consistency, clarity, and connections to developmental plan (Conger & Ready, 2004). Other organizations shy from using competency models as they conceptual, complicated, and idealized, failing to recognize variances in leadership level, culture, and situation. Review of current nurse manager competency models indicated broad and comprehensive categories to improve quality but failed to provide specifics in how nurse managers may improve patient outcomes.

Role and Competency Development of Nurse Managers

Kouzes and Posner (2003) advocated for leadership development and succession planning for future leaders. Nurse managers need adequate preparation for challenges that lie ahead with key competencies and skills for effective management (Kirby, 2010). However, very few nurse managers receive the required training or education to impact positive staff and patient outcomes. The following section contains suggestions from

related literature on the how health care organizations can develop competencies of novice nurse managers.

The nurse manager needs to address his or her own ambiguity, lack of skill, and knowledge regarding roles before leading effective employees in the change process (Mathena, 2002). In a survey of nurse managers expressed the need for a formal structured orientation and mentoring process for new managers to succeed in the roles (Sullivan et al., 2003). Very few nurse manager orientation programs contain the didactic, with hands on program to help new nurse manager transition into a leadership role. A survey on nurse manager orientation program by nurse managers suggests a need for a more structured program (Conely, Branowicki, & Hanley, 2007). Developmental needs identified for nurse managers involve basics managerial skills involving communication, conflict resolution, role transitioning, scheduling, budgetary, payroll management, performance evaluation, and staff counseling (Sullivan et al., 2003).

Nurse managers can benefits organization support through formal and informal training and education, coaching, mentoring, empowerment, clerical, and leadership support (Kirby, 2010). Organizations investing in the training and education to develop skilled nurse managers will promote nursing retention, improve productivity, and decrease turnover (Duffield, Roche, O'Brien-Pallas, Catling-Paull, & King, 2009). In one institution, the leadership development program led to a 4%-24% increase in nurse retention rates (Swearingen, 2009). A mentorship program for front-line nurse managers will help facilitate ongoing learning, knowledge acquisition, application, and critical reflection for both professional and personal growth (Grindel, 2003). The benefits of

mentorship in studies show increase in job satisfaction, self-esteem confidence, promotion, advancement, and higher earnings.

Swearingen (2009) recommended a formal leadership education and training program for different leadership levels by expert members and leaders of the organization. "Vision 2020: Future Nurse Managers Project" is the multi-phased projection regarding the type of nurse managers needed in the near future. Phase I includes a critique of existing curriculum and Phase Two involves identifying education, skills, knowledge important to the development of nursing leaders in management and administrative positions (Scoble & Russell, 2003). The role of the nurse managers is ill defined therefore improving patient satisfaction becomes an obscured competency in relation to other responsibilities. Research on existing nurse manager competencies was lacking especially relating to improving patient outcomes. The purpose of the study was to explore the comprehensive, holistic, and changing nature of the nurse manager roles and practices that align with the newer dimensions of patient satisfaction. The next segment of the literature review contains a historical overview of the patient satisfaction theoretical, conceptual and contextual frameworks to understand the multidimensional construct underlying patient satisfaction.

Historical Overview on Patient Satisfaction

Initial efforts to evaluate patient satisfaction in the 1950s and focused on the relationship between nursing care and the unmet needs of the patient (Abdellah & Levine, 1957). In the survey of 8,660 patients in 60 hospitals the researchers Abdellah and Levine (1957) sought a better understanding patients needs by assessing needs unmet by staff nurses. Patient satisfaction concept began with the consumer movement in the

1960s with demands and expectations for high quality care (Turris, 2005). The goal of Total Quality Management (TQM) movement of the 1980s was to improve the organization's efficiency and effectiveness by improving patient care process (Donabedian, 1988). According to Avedis Donabedian (1980, 1988), the father of quality management patient satisfaction is the valid indicator for quality of care. In the past two decades there has been extensive research and editorials regarding the concepts of patient satisfaction of hospital services and interventions. Up until the 1990s, patient satisfaction played a minor role in health care organizations superseded by other priorities such as application of medical technology and emphasis of provider credentials for revenue growth, and reputation (Nash et al., 2001).

With the advent of intranet in the 1980s and 1990s the healthcare industry witnessed a rise in consumerism with corresponding attention to consumer's needs and wants. The shift of consumer demand for better quality services was aided by technology. Consumers became more active in searching the web for personal health information, health care products, services, and providers.

Theoretical Frameworks for Patient Satisfaction

Because patient satisfaction is such a multidimensional construct and very hard to define, there are few theoretical or conceptual models found in literature that adequately describe the concept (Cole, 2008; Davino, 2007; Milutinovic, Brestovacki, & Cvejin, 2010; Wasden, 2010). Patient satisfaction is a multifactor concept and despite it variability and subjectivity, the data plays an important role for organization success (Lageson, 2001).

Maslow's (1968) hierarchy of needs aptly applies to the healthcare setting for the purpose of the health care organization is to restore patient's health. The base of Maslow's pyramid is the physiological needs are met through the restoration of patient's health. The second layer of needs addresses the issues of safety in the health care setting. The third level is the sense of belonging met through close relationships, trust, and bond established with the healthcare provider. Patient satisfaction with the involvement of family decision-making also reflects these needs. Need for self-esteem met with attributes of respect, attention, recognition, and responsiveness by healthcare provider. When all these goals are met, the patient achieves self-actualization an ideal patient outcome (Maslow, 1968).

When an individual approaches a healthcare system or provider, the communication should elicit the values, beliefs, perceptions, life stories, logic of decision making, physical, social, mental, and financial constraints affecting health of the individual (Young & Flower, 2002). The patient feels dissatisfied with the total healthcare experience even if the physical needs are met such a treatment of the disease. The healthcare system should acknowledge patient values, beliefs, culture, and expectations to satisfy the mental, social, financial, and spiritual needs of the patient. The nurse manager can influence practices, process, and culture of the unit that address both basic and higher level needs of the patient.

Orlando's theory (1972) explains the interaction with the patients and nurse is essential to understanding and fulfilling the needs of the patients. Orlando's theory asserts that the nurse's function is to ascertain the needs of the patient through verbal and nonverbal cues and meet the immediate needs of the patients (Schmieding, 1990).

Orlando emphasized the need to include the patients in all aspects of care. Shared patient's decision making draws its concepts from Orlando's theory. The theoretical framework provides a basis for the philosophy that encourages patient participation in the treatment decision-making process. Literature focuses on the staff nurses role in ensuring or improving patient satisfaction providing very little information on the role of nurse leader to improve patient outcomes. The review of literature was lacking on specific competencies and role of nurse managers to implement shared decision making in the practice setting and provided the rationale to conduct the study.

According to patient satisfaction theory developed by Linder-Pelz (1982a), patient satisfaction is a subjective evaluation of all aspects of patient care. Linder-Pelz (1982b) considered patient satisfaction as a positive evaluation of healthcare experience by making evaluations on distinct aspects of care. Linder-Pelz (1982b) studied social psychological variables of patient expectations, values, entitlements, and perceived outcomes. Expectancy variable compared to values and entitlements explains greater variance in patient satisfaction scores. Linder-Pelz (1982b) indicated that greater the discrepancy between perceived occurrence and prior expectations, less the patient satisfaction. Expectancy value model has been criticized for its vagueness regarding its value and expectation components (Sixma et al., 1998). Despite extensive research in patient satisfaction, researchers cannot provide a comprehensive conceptual framework for understanding patient expectations and perception of service for service improvement.

Conceptual Framework for Patient Satisfaction

Patient Centered Care Models

Patients' active participation in their care contributes to improved patient health outcomes, compliance to medication regimen, beater treatment results, and greater levels of patient satisfaction (Sainio, Lauri, & Eriksson, 2001). In recent years a new approach to improving quality of care from a one-size-fits-all standard and a provider centric model to a patient centered model. Patient centered care introduced in 1990s was a system perspective for improving quality of patient care. Patient Centered Care (PCC) is a personalized approach to meet patients' needs, preferences, and expectation by encouraging patients to participate in decision-making regarding his or her care (Sidani, 2008). Patient centered care is multifaceted involves several disciplines and every individual within the organization to improve patient care quality and satisfaction (Moiden, 2002).

In patient centered or consumer centered care, the provider ascertains and addresses the consumer's expectation, goals, values, fears, concerns, needs, preferences, beliefs, and attitudes providing optimal benefits in this exchange experience (Alvarez, 1997; Berntsen, 2006; McCormak, 2003; Radwin, 2004; Young & Flower, 2002). Healthcare providers then discuss the condition and plan of care with the patient, encourages participation in decision making related to treatment, and implement the treatment in consistent with patient needs (Attree, 2001; Larrabee & Bolden, 2001; Schoot, Proot, Meulen, & deWitte, 2005).

In 2001, the Institute of Medicine recognized patient centered care as one of the core competencies for health care professionals (IOM, 2001a). IOM (2001a) defined

patient centered care competency to identify, respect, listen, and care about the patient's values, preferences, differences, needs, pain through shared decision-making, and management. The health care dilemma of improving cost, quality, and access that started in the late 20th century continues to impact the health care industry in the 21st century. The concept of patient-centered care is being applied in different hospitals across the nation to improve patient satisfaction, address the quality, cost, and access dilemma. The concept of patient or consumer centered care is still evolving in the 21st century with emphasis on effective communication between the consumer and provider.

Extensive studies indicating proposed benefits of patient centered care include patient satisfaction (Poochikian-Sarkissian, Wennberg, & Sidani, 2008; Stone, 2007; Wanzer, Booth-Butterfield, & Gruber, 2004; Wensing & Grol, 2000; Wolf, Lehman, Quinlin, Zullo, & Hoffman, 2008b), improved patient functioning (Kaplan, Greenfield, & Ware, 1989; Meterko, Wright, Lin, Lowy, & Cleary, 2010; Sidani, 2008), better health outcomes (Fremont et al., 2001; Safran et al., 1998), and quality of patient care (Poochikian-Sarkissian, Sidani, Ferguson-Pare, & Doran, 2010; Sidani, 2008). Other benefits of patient centered care include an increased sense of patient optimism, authentic self-representation, and wellbeing (Radwin, Cabral, & Wilkes, 2009).

Studies also indicate an evidence of patient centered care with participation in self-care post discharge (Chaaya, Rahal, Morou, & Kaiss, 2003; Poochikian-Sarkissian et al., 2010). Improvement in patient participation for self-care is significant for hospitals to avoid future reimbursement penalties for hospital readmissions resulting from patient non-compliance to care. Hospitals implementing the patient centered model have seen a decrease in patient length of stay (+5%), increase in staff satisfaction, and decrease in

staff overtime through reengineering nurse manager role as a Patient Care Team Coordinator, cross training and multidisciplinary collaboration (Miller, 1999). However, a 26-month longitudinal study on Patient Centered Medical Homes, part of the National Demonstration Project by CMS shows little improvements in improving patient experience (Jaen et al., 2010).

Studies provided evidence on patient centered care with an increase in nurse job satisfaction, retention, and safe working environment (Rathert, 2005). In a study on patient centered model, the four indicators for satisfaction with nursing care included nursing competency, efficiency, and communication (Chaaya et al., 2003). In many organizations, patient satisfaction with nursing care is a strong predictor of quality of patient care (Greeneich, 1993). Miller (1999) indicated the importance of the nurse manager role in the implementation of Patient Centered Models to integrate and coordinate the efforts of the interdisciplinary team. However some studies indicate that other factors such as work environment, work culture, management leadership qualities, and quality improvement initiatives, influence positive patient and staff outcomes than just a patient centered approach (Bicknell, 2008; Kelleher, 2006; Peterson, 2009; Wolf et al., 2008a). Very few nursing literature existed on how to translate the concept of patient centeredness to the nurse manager role and competency, influencing patient satisfaction within the unit of control. Despite widespread research, few articles provided satisfactory explanation of patient satisfaction or a comprehensive conceptual model to explain its measurement (Speight, 2005).

Current Contextual Frameworks for Patient Satisfaction

Patient satisfaction is a subject debated by economists, policy makes, psychologists, and organizational researchers (Wasden, 2010). Aharony and Strasser (1993) emphasized that patient satisfaction process is individualistic, multidimensional, relativistic, dynamic, and patient-centered. While Zeithaml, Parasuraman, and Berry (1990) defined service quality is the discrepancy between customers' expectations and perceptions.

Patient satisfaction can be also defined as "the extent of an individual's experience compared to his or her expectations" (Asadi-Lari et al., 2004, p. 2). Therefore, the operational definition of patient satisfaction can be the extent of to which patient satisfaction of services are met or exceeded during the healthcare experience (Wagner & Bear, 2009; Wasden, 2010). The process becomes complicated as each patient brings in his or her own set of expectations to the healthcare experience. According to S. N. Bleich, Ozaltin, and Murray (2009), patient experience accounts for only 10% variation while patient expectations, age, health status, and societal factors account for a major portion of patient satisfaction component. The definitions imply that satisfaction is unique to each individual as the patient attaches attributes of satisfaction to personal values, past, and present experience (Speight, 2005).

Pascoe (1983) described patient dissatisfaction as a comparative process of the cognitive evaluation and affective response to the structure, process, and outcomes of healthcare services. Strasser and Davis (1991) considered patient satisfaction as the value judgment before and after the healthcare experience. Strasser, Aharony, and Greenberger (1993) expanded the definition of patient satisfaction as a cognitive,

multidimensional, dynamic, iterative, and individualistic process based on personal values, beliefs, previous health experience, current health status, and expectations. At a unit level, patient satisfaction with nursing care is the degree to which nursing care meets patients expectation of care including the components of the art, technical quality, availability, continuity, and efficacy of nursing care (Mrayyan, 2006; Wagner & Bear, 2009). Evidence suggested that nursing staff cohesion and interpersonal management with other healthcare workers significantly relates to patient satisfaction (Bae, Mark, & Fried, 2010).

Patient Satisfaction Contexts for the 21st Century

The trend for consumerism is ever increasing with patients as consumers make decisions based on quality and price through evaluating publically reported measures. Websites such as Healthgrades provide specific information to consumers regarding hospitals. Healthcare organizations also publish the results of patient satisfaction scores on individual websites. Major health care regulation agencies are demanding that hospitals improve quality of care by increasing patient satisfaction scores. Joint Commission Standard P1.1.10 require hospitals to collect data on patients' perceptions of care, treatments, care, services meeting patients' needs, expectations, safety, and pain management (JCR, 2005). Joint Commission also publishes quality measures on the website for consumers to make informed decisions choice of provider.

Transformative polices of CMS is changing health care system and the role of CMS from a passive purchaser based on patient volume to an active purchaser of safe, high quality, and affordable care (CMS, 2011). A combination of quality metrics, and resource utilization tools will provide a framework for establishing efficiency and

implementation of payment incentives that reward high quality care and encourage competition among hospitals. The hospital pay-for-reporting initiative known as the National Voluntary Hospital Reporting Initiative that started in 2003 allowed Medicare beneficiaries the information on the quality of care to make informed decisions while encouraging hospitals to improve quality of care. In Fiscal Year (FY) 2007 hospitals that did not submit data received a 2% reduction in Medicare payments. Hospitals currently report patient satisfaction measures to CMS and survey data are available to the public on the Hospital Compare website.

Starting FY 2013, Value Based Purchasing program for hospitals under Section 3001 of the Affordable Care Act of 2010, Deficit Reduction Act of 2005, and Medicare Modernization Act has started to provide value-based incentive payments on eight HCAHPS patient satisfaction measures (CMS, 2011) among other quality indicators. The funding of financial incentives to improve quality of care is to reduce the base operating DRG payments for each discharge by 1% in Fiscal Year 2013, 1.25% in FY 2014; 1.5% in FY 2015; 1.75% in FY 2016; and 2.0% in FY 2017 and subsequent years. To avoid large financial losses from Medicare payments hospital leadership is looking to new methods to improve patient satisfaction measures. Patient satisfaction is emerging as an important indicator for health care quality and tied for financial growth of the organization.

Constructs for Patient Satisfaction-Expectations

The new age of consumerism leads to higher expectation of quality than ever before. Consumer-driven healthcare is a system under which consumers drive the demand for healthcare products and services and providers respond to such needs by

offering innovative products and services in a cost-effective manner (Herzlinger, 2004a). As in any market-based system, the consumer-driven healthcare matches demand with supply. With any consumer-driven market system, choice, and affordability are major concerns that drive innovation, competition, and efficiency in supply of services and products (Berkowitz, 2006). A marketing mix addresses the essential five components of marketing such as product and service, place of distribution, price, promotion, and positioning (Berkowitz, 2006). The following contains the different constructs of patient satisfaction such as consumer expectations, loyalty attributes, and retention.

Consumer Expectations and Patient Health Care Services

American consumers are knowledgeable because in addition to competitive pricing, quality places an important part in decision or selection of service, products, or provider (Shi & Singh, 2011). According to Yavas and Shemwell (1996), price, acceptability of insurance, quality of services, safe care, location, and accessibility are important to consumers when choosing a hospital. Swan, Sawyer, Van Matre, and McGee (1985), found a strong relationship between patient's expectation and patient satisfaction. According to B. Stone and Jacobs (2007), satisfaction reflects how well an organization meets customers' expectations in all aspects of the consumer experience or marketing mix. Logic, emotion, and brand proposition play a big part in consumer satisfaction.

Health care organizations are seeking to improve quality and safety of care to improve patient satisfaction. Patient satisfaction HCHAPS survey correlates highly with technical performance of all medical and surgical care supporting the validity of using patient satisfaction as a measure of quality of care (Issac, Zaslavsky, Cleary, & Landon,

2010). Advantages of high patient satisfaction include high rates of patient compliance to treatment (Homer, Nightingale, & Jobanputra, 2009; Kumar et al., 2007), lower rate of malpractice claims (Hall, 2008; Prakash, 2010), quality improvement (Barr et al., 2006; Hsieh, 2010; Lee et al., 2006; Milutinovic et al., 2010; Scotti, Harmon, & Behson, 2007; Shelton, 2000), and greater profitability by attracting more patients (*Healthcare Financial Management*, 2010). For every 100 dissatisfied patients, about 70 customers will not patronize the organization, and 75 of the customers will inform an average of nine family member and friends (Lee et al., 2006). Eventually through word of mouth 465 potential customers will be not patronize the health care organization (Lee et al., 2006).

Retaining a customer is more desirable and profitable than losing another customers or even trying to obtain one (Clark, 2002; Gemme, 1997). Recent impetus has shifted to identifying and retaining those customers loyal to the organization. Patient retention is the process by which health care organizations influence loyalty, thus maintaining existing patients (Mather, 2007).

Satisfaction and loyalty are similar yet different aspects of measuring healthcare service attributes. When customers receive value and quality service, they are more likely to be loyal to the organization (Mather, 2007). Loyalty is behavioral repetition that builds consumer value over time (Stone & Jacobs, 2007). It starts with being transactional and advances to being a habit. According to B. Stone and Jacobs (2007), contractual, emotional, and functional loyalty is at times less dependent of consumer satisfaction. The level of satisfaction determines if the customer will return to the organization for repeat experience (Mather, 2007). Additionally experiences can set

future expectations for the consumer's next healthcare experience (Press, 2005; Wasden, 2010).

Patient satisfaction leads to greater competitive advantage for the health care organization through patient loyalty and referrals guaranteeing continued revenue (*Healthcare Financial Management*, 2010; Spence Laschinger et al., 2005). According to Reichheld and Sasser (1990), a 5% increase in customer loyalty can produce a corresponding 25%-85% increase in profit. Satisfied patients are more likely to be loyal to the provider by intentions to use service in the future and likelihood to recommend (Otani & Kurz, 2004; Spence Laschinger et al., 2005). Patients become customers when they return to the same facility for continued services (Davino, 2007). As repeat business determines organizational success, patient satisfaction of present experience effects future decisions (Press, 2005; Wasden, 2010).

Otani, Faulkner, Boslaugh, Burroughs, and Dunagan (2009) found staff care and nursing care as most influential to patients to rate hospital experience as excellent. Excellent rating by a patient is a stronger predictor of organizational loyalty than merely satisfied (Otani et al., 2009). Good communication and attention to customer needs, wants, desires, expectations, and perceptions will impact how customer evaluates satisfaction with the experience (Mather, 2007). The implication for hospital leaders is to focus on improving attributes for excellent satisfaction ratings by patients. Few studies provided evidence of the competencies of nurse managers in a leadership role to influence high ratings of patient satisfaction.

Assessments of Patient Satisfaction as a Multidimensional Construct

Researchers have considered patient satisfaction as a multidimensional construct with a variety of influencing factors affecting the assessment of patient satisfaction with healthcare experience (Cole, 2008). Some describe patient satisfaction as rating healthcare services based on personal expectations and experiences, while other definitions lean toward gaps in the perception of patient's expectation and experiences in the healthcare setting (Sixma et al., 1998). Research on customer satisfaction and expectations can provide information on customer perceptions. The following is an overview of an extensive body of literature on patient satisfaction with supporting evidence of patient satisfaction as a valid measure of quality.

First generation patient satisfaction studies concentrate on the examining the demographic characteristics such as age, education levels, gender, ethnicity, and social support, with levels of patient satisfaction. Several studies have shown how demographic variables relate to patient satisfaction. In a review of literature on variables that relate to patient satisfaction, elderly, married men, with lower education levels and previous hospitalizations have indicated higher satisfaction ratings than women, people with higher education levels, and no hospitalization experience (Chang et al., 2003; Dayasiri & Lekamge, 2010). In contrast other studies support older patients, women, and highly educated patients rate higher satisfaction levels (Alhusban & Abualrub, 2009; Cleary, Carlson, Shaul, & Eisen, 2002). Patients with prior hospitalizations and shorter length of stay are more satisfied that patients who have not been hospitalized before (Quintana et al., 2006). The discoveries are meaningful but demographic factors cannot be modified hence provide little significance to performance improvement within an organization.

The next generation of patient satisfaction studies focuses on the multidimensional constructs of patient satisfaction (Otani et al., 2009). The studies sought to clarify the concept of patient satisfaction (Wagner & Bear, 2009; Williams, 1994), explanatory factors, establish patient satisfaction as a valid measure of quality of care in different groups, settings, and contexts (van Campen, Sixma, Friele, Kerssens, & Peters, 1995). These studies concentrate on attributes of patient satisfaction such as access and delivery of care focus on waiting times, perceived quality of care, information received, nurse-patient, nurse-physician relationship, privacy, noise levels, and language (Otani et al., 2009). Patient satisfaction in medical clinical trials measures relation to compliance to treatment (Speight, 2005). Patient satisfaction is an outcome indicator in many clinical trials for new medications, and treatment options that may be similar in biomedical effects but vary in terms of patient experiences such as convenience, administration, ease of use, and future adherence to treatment (Speight, 2005).

Many studies illustrate the need for patient education to achieve compliance in treatment and for patient satisfaction (Clever, Jin, Levinson, & Meltzer, 2008; Homer et al., 2009; Kumar et al., 2007). Communication with the patient and the nursing staff through patient education is integral part of treatment modality. Information regarding patient status, hospital procedures, treatments, medications, potential side effects, course of recovery, post-discharge care, and follow up is essential component of nursing function (Bail, 2008). In recent studies, researchers assessed patient satisfaction on information provided via web technologies (Koop et al., 2010). A recent approach to patient satisfaction relates to the technical and operational aspects within the current context and settings (Mrayyan, 2006).

A study by S. N. Bleich et al. (2009), showed that patient care experience only accounts for 10% of the variation in the concept of patient satisfaction, and 17.5% accounts for patient expectation, health status, plan coverage, and type of care. Researchers contended that larger socioeconomic factors may explain for the differences in patient satisfaction indicators (Bleich et al., 2009). Other studies found contradictory evidence that information given to the patient does not significantly improve patient satisfaction supporting the theory that patient satisfaction is a multidimensional concept with subjective evaluation (Cole, 2008; McGilton et al., 2006; Walker, 2007). Many studies evaluated the perceptions of patient satisfaction, values, and attitudes that may contribute to weakness of the study because of subjectivity bias. The variables may provide an important contribution to the comprehensive understanding in evaluation of quality of care. Ongoing research in patient satisfaction seeks to address gaps in current literature on conceptual foundation with a contextual focus. Lack of research or inadequate use of available data can result in the lack of knowledge regarding customer perception. Gaps existed in the how health care leaders use information on patient satisfaction in current context and leadership role to influence or improve patient satisfaction scores.

Patient satisfaction and nursing care. Patients' expectations with respect to care not only involves knowledge and skills of the nursing staff but also the qualities of empathy, good communication skills, level of attention, emotional, and physical support (Milutinovic et al., 2010). The aim of Milutinovic et al.'s (2010) study on patients' perspectives of nursing care was to explore the meaning of quality of nursing care. Insight into consideration is a dynamic nurse patient interaction process on four

interrelated categories of concordance, helpful atmosphere, emotional response, and patient rights. The subcategories include important characteristics of nursing care important to the patients are the following; treating patient as equal partner in care, freedom to discuss matters with nurse, trust, sensitivity, thoughtfulness, interest in patient, active dialogue, support, right to information, decision making, choice, and responsibility (Larsson, Sahlsten, Sjostrom, Lindencrona, & Plos, 2007).

Several researchers have studied the consequences of patient satisfaction with nursing care. The inpatient survey of Press Ganey™ (see Appendix J) assesses the structure, process, delivery, and outcomes components of the healthcare experience. The survey asks the patients specific questions on the admission process and discharge process, tests, and treatments, nursing care, physician service, social service, room, cleanliness, noise level, meals, visitors, personal issues, discipline, and departmental specific issues. According to the Press Ganey 2009 survey, from 3,047,705 patients at 2162 facilities nationwide, nursing questions correlate highly with likelihood to recommend and overall rating of the hospital. Nursing questions include questions regarding (a) friendliness /courtesy of the nurses, (b) promptness in responding to call button, (c) nurses attitude toward requests, (d) amount of attention paid to your special or personal needs, and (e) how well the nurses kept you informed and skill of the nurses. These results highlight the importance of patient satisfaction with nursing care.

Numerous researchers have examined patient's' satisfaction with nursing care as well as the perceptions of the quality of nursing care. A review of literature indicates that patients' perceptions of nursing skill and competence are mostly influenced by the interpersonal nursing skills such as kindness, caring, compassion, empathy,

communication, gentle touch, attentiveness (Cescutti-Butler & Galvin, 2003; Davis, 2005; Fosbmder, 1994; Johansson, Oleni, & Fridlund, 2002; Kralik, Koch, & Wotton, 1997; Radwin, Farquhar, Knowles, & Virchick, 2005; Wysong & Driver, 2009) and other interpersonal attributes such as courtesy and ability to comfort (Chilgren, 2008).

Other variables that affect patient satisfaction is the active participation in the decision making regarding treatments, health, goals, behavior, and to achieve goals (Baars, Markus, Kuipers, & van der Woude, 2010; Brotherton & Abbott, 2009; Florin, Ehrenberg, & Ehnfors, 2008; Lantz et al., 2005). Other researchers provide inconclusive evidence of patients' shared decision making on overall patient satisfaction (Jacobowski, Girard, Mulder, & Ely, 2010; Renzi et al., 2006; Watanabe, Takahashi, & Kai, 2008).

Studies indicate that differences exist in the staff nurses perception of patients' satisfaction and patients' perceptions of satisfaction (Ekman, Schaufelberger, Kjellgren, Swedberg, & Granger, 2007; Young, Minnick, & Marcantonio, 1996). Staff nurses, managers, and patients value their care differently (Young et al., 1996). Researchers found gaps between patients, nurse managers, and staff nurses regarding perceptions on patient satisfaction and quality of care (Price, Fitzgerald, & Kinsman, 2007), and the value of patient-centered care (Young et al., 1996). Differences in perceptions of quality of care occur when patient needs or expectations are not being met. Assessing values of the unit team and the patients may help address the perceptions and closely align with the patient's actual perception of care.

Identifying patients' expectations, needs, and perceptions of quality care can help improve patient satisfaction through performance initiatives (Cappabianca, Julliard, Raso, & Ruggiero, 2009). Staff nurses perceptions of interdisciplinary collaboration,

teamwork, and quality of patient care contributes to greater job satisfaction (Chang et al., 2009). Research shows strong relationships with patient satisfaction and staff nursing variables such as high group cohesion, coordination, and low staff turnover (Bae et al., 2010) and satisfaction (Harris, Dearth, & Paul, 2007).

Shared governance, healthy work environments, and Magnet characteristics are three concepts in the health care industry that provide evidence of staff nursing behaviors and patient satisfaction. Shared governance is a participatory management of nurses at the front line to maintain control over practice decisions, working conditions, and professional matters (Stumph, 2001). Study results indicated positive patient outcomes associated with nursing staff in a constructive work environment, higher job satisfaction, productivity, and retention (Bae et al., 2010; Stumph, 2001). Increasing evidence in nursing literature points to positive outcomes of healthy work environment that contribute to improved staff (Schmalenberg & Kramer, 2009; Shirey, 2006; Shirey & Fisher, 2008) and patient outcomes (Aiken, Clarke et al., 2008). Patient's reports better symptom management in units with better work conditions such as participation in the decision-making process, teamwork with other disciplines, and autonomy rather than increased staffing levels (Bacon, Hughes, & Mark, 2009). Hospitals with Magnet designations have a positive correlation with high patient outcomes and satisfaction levels due to favorable work conditions (Aiken, Clarke et al., 2008; Aiken, Sloane, Lake, Sochalski, & Weber, 1999; Armstrong et al., 2009; Ulrich et al., 2007).

A study by Vahey, Aiken, Sloane, Clarke, and Vargas (2004), showed a positive correlation of patient satisfaction with low staff nurse burnout. A study conducted by Nogueras (2006), has shown positive relationship between level of higher education in

nurses and commitment to their jobs. According to Armstrong and Laschinger (2006), nurses who perceive the organization to be empowering have greater job satisfaction, job commitment, and provide high quality care. Unit managers fostering staff nurse engagement and effective symptom management of patients positively influences patient satisfaction (Bacon & Mark, 2009). Work engagement is personal involvement and commitment to work through proactively responding to patient needs (Bacon & Mark, 2009).

Implication for nursing leadership is to monitor patient satisfaction surveys on a constant basis, assess gaps, and variations for improving patient satisfaction through quality improvement initiatives (Erwin, 2006; Milutinovic et al., 2010). Strategies to improve customer satisfactions will entail the following (Zeithaml et al., 1990):

1. Commitment to quality.
2. Leadership commitment to service, quality, and training.
3. Standardizing and automating tasks, scheduling, service, and delivery with use of technology.
4. Improving work process.
5. Provide and measure specific employee goals with appropriate feedback.
6. Improve employee training, competence, interpersonal skills, and empowering employees in front-line decision-making.
7. Open communication lines for data sharing and integration of strategic organizational plan between operations, marketing, finance, and human resources.

Patient satisfaction with comprehensive patient care. Satisfaction with staff care and nursing care is a strong predictor for overall satisfaction of patient care

experience (see Appendix D; Otani, Waterman, Faulkner, Boslaugh, & Dunagan, 2010), outcome of nursing care (Milutinovic et al., 2010), and indicator of customer repeat business. Recent studies in patient satisfaction combine theoretical models with quantitative models to find that patients do not average out attributes to form overall impression of patient satisfaction (Otani, Kurz, Burroughs, & Waterman, 2003). These studies helped nurse managers to increase patient satisfaction by focusing on those attributes that make a difference in overall rating of patient satisfaction. The findings of the studies on patient satisfaction provided information to health care leaders to focus on those attributes that provide greater meaning through performance improvement initiatives.

Patient Satisfaction Measurement

The concept and application of measurement of patient satisfaction varies. Satisfaction measured post service is the confirmation or disconfirmation the consumers' expectations regarding the performance of the chosen product. In a post purchase evaluation of service organization the satisfaction survey measures the importance of particular service to the satisfaction and if expectation are confirmed or disconfirmed (Berkowitz, 2006). Patient satisfaction measures determine effectiveness of health care services. Review of data can help organizations improve quality standard in patient care (Rider & Perrin, 2002).

Several patient satisfaction measurements exist unique to each setting, discipline, category, and mode of delivery. Several patient satisfaction scales focus specifically on measurement of satisfaction with healthcare delivery, treatment, medication with separate subscales in each category. SERVQUAL developed in market research concentrates on

customer expectations and experiences and is applied in continuous quality improvement programs (Parasuraman, Zeithaml, & Berry, 1988). The SERVQUAL instrument widely applied in many patient satisfaction surveys within the healthcare setting. The size and direction of gaps occurred at different continuum of the continuous quality improvement process. The gaps occurred between (a) customer and management perceptions, (b) management perceptions, and service quality specifications, (c) quality specifications and delivery of care depends upon the management perceptions of expectations (Sixma et al., 1998). Researchers also focus on developing instruments to measure patient satisfaction and establish validity and reliability. Currently, there are several nursing instruments that measure nurse sensitive outcomes and measures to patient satisfaction. Risser in 1975 created the Patient Satisfaction Scale along dimensions of technical/professional behaviors, communication/interpersonal skills, and educational relationship of the staff nurse with the patient. In 1993, Larson, Ferketich, Wleczorek, and Molzahn developed a 29-item measurement CARE/SAT derived from CARE-Q to measure caring behaviors of a staff nurse.

In 2002, Centers for Medicare and Medicaid services partnered with the agency for Healthcare research and Quality (AHRQ) branch of the Department of Health and Human Services and developed a HCAHPS survey. The National Quality Forum an alliance of healthcare organizations, providers, consumer groups, accreditation, and federal agencies endorses HCAHPS. The Deficit Reduction Act of 2005 mandated hospitals that participate in Inpatient Prospective Payment System (IPPS) must collect and submit HCAHPS data to receive full payment. Hospitals that fail to participate receive a 2% reduction in IPPS payment. The Patient Protection and Affordable Act of

2010 uses the HCAHPS performance measures from July 2011 to calculate base data for Value Base-Purchasing program that started in 2012.

The HCAHPS survey with 27 questions contains four screener questions, five demographic questions, and 18 core questions about the critical aspects of the patient's hospital experience. The HCAHPS contains patient rating items on topics concerning communication with physicians, nurses, regarding discharge medications, discharge information, responsiveness of nursing staff, pain management, cleanliness, and noise (HCAHPS, 2011). A copy of the HCAHPS survey is contained in Appendix G. The HCAHPS survey may be implemented by the hospital vendor via mail, telephone, and mail with follow up telephone, or active interactive voice recognition (HCAHPS, 2011). CMS and HCAHPS project team periodically conduct inspections to ensure the quality of administration and analysis of survey data.

CMS publishes participating hospitals results on the Hospital Compare Website four times a year. The goals for public reporting HCAHPS survey are to have a national objective, valid, and meaningful comparison of patient perspective on care. Public reporting will help improve quality, accountability, and transparency of care (HCAHPS, 2011). Survey vendors and hospital self administering the HCAHPS survey must meet compliance with the Quality Assurance Guidelines and must seek approval prior to administration of the survey (HCAHPS, 2011). Press Ganey™ is an industry leader for improving health care performance partnering with 10,000 health care organizations and about 50% of hospitals nationwide to administer patient satisfaction surveys including HCAHPS survey questions.

Merging Nurse Manager Role and Patient Satisfaction

Since the 1990s, patient satisfaction is an important indicator for delivery of quality care (Kovner et al., 2009). Changes in the health care industry will require health care leaders to discard the status quo, seeking innovative strategies, leadership roles, and competencies to meet new challenges. Measuring, monitoring, and analyzing patient satisfaction scores assist hospital leaders to seek creative ideas, engage employees in problem solving, empower front line staff, plan and allocate needed resources to enhance patients perception of quality care (Kovner et al., 2009).

Researchers have identified roles, competencies, qualities, concepts, and attributes of nursing managers for practice environment without defining an effective approach, roles, and competencies with increasing patient satisfaction. The preceding review of literature revealed established relationships between nurse manager and staff outcomes, nursing care and patient outcomes but lacked sufficient evidence regarding how nurse managers will impact patient satisfaction outcomes.

Some studies support effective nursing leadership and practice environments with staffing levels contributing to reduction in adverse patient events. The nurse manager influences adequate staffing that match patient acuity with a patient focused work allocation model over task focused work (Duffield et al., 2009). Tumulty (1992) used a cross sectional correlation study to study the relationship between nurse manager role and patient outcomes such as patient fall, nosocomial infections, and patient skin integrity. Tumulty reported low nurse manager satisfaction negatively impacts patient outcomes.

Management support, transformational leadership style, participatory management, accessibility, and visibility in nursing contribute to positive staff outcomes

such as satisfaction, retention, and recruitment (Manojlovich & Laschinger, 2007; Wong & Cummings, 2007). Previous studies in industries have shown an association with how a leader leads, with impact on staff performance for quality care, and organizational financial performance (Lee & Cummings, 2008). A systematic review of literature on nurse manager leadership and satisfaction provides evidence that reducing span of control, improving empowerment, and organizational support of frontline managers reduces adverse patient events, mortality, improves patient satisfaction and staff outcomes (Lee & Cummings, 2008; Wong & Cummings, 2007).

A study by Hay Group (2006) studied nurse manager leadership qualities with indicators of performance such as patient satisfaction, patient complaints, nurse staff turnovers, absenteeism, and medical errors. According to Kenmore (2008), managers who demonstrate a more flexible style of leadership appropriate to the situation are high performing managers with high patient outcome scores. High performer managers create structures, provide clear, objective, achievable goals, ongoing feedback, minimize bureaucracy, foster staff cooperation, and instill pride in the nursing profession for positive patient outcomes (Anthony et al., 2005; Kenmore, 2008). According to Darby and Daniel (1999), managers of frontline staff can signal their commitment and dedication to service quality through work involvement, service culture, educational programs, and service provision. Purposeful rounding occurs when nursing staff rounds on patients to address specific important needs such as the needs for pain management, personal needs, toileting needs, assess position and need for turning, moving, or emotional needs. Such methods have shown to improve patient satisfaction, decrease falls, and needs for call bell (Meade, Bursell, & Ketelsen, 2006; Torres, 2007).

The RN4CAST study funded by the European Commission with representatives of Europe, USA, Africa, and Asia is the largest ongoing nursing workforce forecasting study on nursing work environment, productivity, and patient outcomes. The RN4CAST study aims to improve forecasting models on effective nursing management of resources (Bruyneel et al., 2009). Preliminary results of the international study shows significant relationship between qualities of leadership, staffing, time constraints and stressful work environment contributing to poor quality nursing care (Milisen, Abraham, Siebens, Darras, & de Casterlé, 2006). The study and several others encouraged a shift to use patient-centered or patient-focused criteria to measure quality indicators.

A deep commitment of the healthcare organization to customer service orientation supports greater patient satisfaction (Darby & Daniel, 1999). An organizational culture, culture of the staff nurses, and the manager influences quality of patient care. W. B. Young et al. (1996) claimed the unit manager's role is important in influencing the culture of unit by facilitating employee understanding regarding aligning with customer perception. These studies provided insufficient information to develop a comprehensive understanding of the projected contemporary, comprehensive, and holistic nurse manager roles and competencies to improve patient satisfaction and resulted in exploring the unknown phenomenon.

Controversial Findings on Nurse Manager Roles and Patient Satisfaction

As leadership experts expound on the importance of nurse manager role and patient outcomes, literature review reveals contradictory evidence in the relationship between nurse manager and patient satisfaction. A systematic review of research between patient outcomes and nursing leadership by Wong and Cummings (2007)

provided insignificant relationships between patient outcomes and nursing leadership. A study by Eriksen (1995), did not report statistical significant relationship between quality of nursing care and patient satisfaction. A study by Lageson (2001) did not indicate a relationship between patient satisfaction and qualities of the nurse manager such as quality mindedness, leadership quality, and communication.

Nurse managers with high EI but a large span of control are not able to empower staff to practice a full scope of the professional role (Lucas et al., 2008). Current organizational structures with flattening governing structures do not allow for the mentoring and close working relationships with staff (Lucas et al., 2008). According to Hay Group (2006) study 30% of the variability in patient outcomes can be attributed to organizational climate. Therefore, it may be important to determine the type of organizational climate that leads to high-performance, and role of nurse managers.

Trends in Health Care: Nurse Manager Roles and Patient Satisfaction

Changes in healthcare involve changes in healthcare economics, mergers, acquisitions, integrated health care delivery system, advances in technology, alteration in governance structure, rapid growth of managed care, and outcomes management expands the role and responsibilities of the nurse executives and managers (Kleinman, 2003). Recent advance technology and medicine is dramatic. The future looks at changing landscape of healthcare through increasing government regulations, reimbursement structure, pay-for-performance initiatives, e-health, acquisition, and integration of new business lines (Kleinman, 2003). The Affordable Care Act of 2010 introduced by President Obama was designed to address the issue of equity of healthcare by expanding healthcare insurance to the uninsured. The legislation also aims to reduce healthcare

costs by expanding the number of uninsured and providing options for affordable coverage to the insured (Kirby, 2010).

As consumerism, health care reform, personal responsibility for health takes precedence, consumers will be more aware of health choices in terms of service, quality, and cost effectiveness. Trends in nursing include the following (Tomey, 2009):

1. Moving from hospital nursing to community nursing with close patient follow-up post hospital discharge,
2. From centralized to decentralized structures,
3. Nursing models of care to multidisciplinary models of care,
4. Bedside to coordination of care,
5. Transactional and autocratic to transformational, participative management.

The preceding review of literature on the patient satisfaction provided the basis for understanding theories, concepts, context, constructs, and future trends in health care to addresses gaps significance and gaps to justify the need for the study.

Conclusions

The United States health care system is in a stage of crises with issues of poor quality, limited access, and high cost of health care (Kronenfeld, 2007; Sultz & Young, 2010). The health care system is undergoing complex restructuring and redesigning in the delivery of patient care to meet stakeholder demands for quality care amid issues of scarce resources, regulation, competition, decreasing reimbursements, and consumerism. Consumer-driven health care needs to deliver positive outcomes and addresses consumer need and wants in the context of unique social, political, economic, and cultural circumstances with highly trained, committed professionals for the delivery of quality,

safe, and efficient patient care (Biron et al., 2007). Leaders in hospitals and other healthcare organizations seek strategies to improve patient's healthcare experience and measure success through positive patient outcomes such as patient satisfaction. Healthcare leaders are responsible to assess, create opportunities, and strategies to improve staff and patient outcomes, especially patient satisfaction.

The current context of transforming health care environment demands front line nurse managers to redesign work environment through leadership and management skills, influencing staff to provide high quality care to achieve organizational goals. The nurse manager will need to incorporate evidence-based management, leadership theories, concepts, and constructs in the current context (Zori & Morrison, 2009). Many nurse managers in a constrained and stressful environment lack the skills and competencies necessary to improve quality of care and patient satisfaction as perceived by the patient. The review of the recent literature signified gaps in developing a comprehensive understanding of the projected contemporary, comprehensive and holistic role and competencies of front line nurse manager to improve patient satisfaction in the current context.

The purpose of the study was to explore the lived experiences and perceptions of the comprehensive, holistic, and changing nature of the projected contemporary nurse manager roles and cross functional skills, practices, and dimensions that align with the newer expectations or dimensions of patient satisfaction among selected nurse managers at seven acute care hospitals in the northeast segment of the United States. A transcendental phenomenological research design is the methodology of choice when the objective of the study is to explore the little known phenomenon the new holistic and

contemporary role of the nurse manager aligned with improving patient satisfaction. A primary qualitative approach is well suited for this study as study participants can recount their lived experiences and perceptions, that may lead to understanding the meaning of the essence of the phenomenon of interest. Preparing for the future requires redefining the nurse managers' roles with necessary competencies to improve patient satisfaction in a transforming health care environment. Nurse managers will need to exploit and effectively manage the current changing environment for numerous opportunities it presents for organizational growth and mitigate threats with effective leadership roles and competencies.

Summary

Since the 1990s, patient satisfaction is considered an important indicator of delivery of quality care (Kovner et al., 2009). Changes in the health care industry will require health care leaders to discard the status quo, seeking innovative strategies, leadership roles, and competencies to meet new challenges. Measuring, monitoring, analyzing, and improving patient satisfaction scores assist hospital leaders to seek creative ideas, engage employees in problem solving, empower front line staff, plan and allocate needed resources to enhance patients perception of quality care (Kovner et al., 2009). The benefits of monitoring patient satisfaction include lower costs of new customer acquisition, referrals patterns, increasing patient volume improving performance, and quality of care (Kovner et al., 2009; Messina, 2005). The driving force in many hospitals is to enhance the patient care experience and in turn improve patient satisfaction scores.

In a highly competitive health care environment, with patient volume still driving reimbursement, front line managers are responsible to monitor, and maintain an environment of high patient satisfaction or risk losing patients to hospitals with exemplary customer service. Nursing leadership is the most significant factor impacting nursing workforce satisfaction and retention (Bleich et al., 2003; George, 2000). Leaders of health organizations expect frontline managers to make decisions that impact patient outcomes, staff morale, medical practice, and the hospitals' financial picture by effectively managing the day-to-day operations, empowering staff nurses to improve quality, and building high performing teams (Kleinman, 2003). Chilgren (2008) suggested strategies for managers such as providing staff autonomy, empowerment, leading high quality interdisciplinary teams, and aligning staff to organizational mission for improving patient satisfaction.

The literature review in Chapter 2 consisted of peer-reviewed literature on existing varied roles, functions, and competencies of nurse managers, construct of patient satisfaction, dimensions, and contexts within the health environment for improving health care quality. The review contained relevant and pertinent information regarding historical context of nursing, nursing management, leadership, and patient satisfaction studies. A summary of theories, concepts, and constructs relating to patient satisfaction, nurse manager management and leadership role provide the foundations that underscore the current study contexts.

The intent of the chapter was to provide information on nursing management, nursing leadership, attributes, and patient satisfaction from general to specific detailed information. Current and past research focused on studying the effects and variables of

multiple nursing management and leadership theories, concepts, constructs but failed to provide an adequate and comprehensive framework to improve patient outcomes. Overall, the review of peer-reviewed scholarly research on patient satisfaction, relationship to variable attributes, constructs, and staff nurses is also extensive.

In the current context, improving patient satisfaction is critical to the success of the health care organization. Research in the health care industry and leadership addressed the multifaceted roles and competencies of nurse manager and health care leaders but failed to indicate specifics on improving patient satisfaction. The comprehensive analysis of literature reflects a critical need toward understanding the efficacy of changing holistic and contemporary roles and practices of nurse managers in relation to new considerations in the dimensions for improving patient satisfaction outcomes. Despite extensive literature in patient satisfaction and nurse manager roles, very few studies provided information to understand the required contemporary holistic role and competencies of nurse manager to influence patient satisfaction.

The objective of Chapter 3 is to provide an explanation of the qualitative phenomenological study research design, and a description of the purposeful sample and geographic location of the study. The next chapter contains specifics on the research question, informed consent, confidentiality, and instrumentation. Chapter 3 also contains an overview of the data analysis with discussion of data validity and reliability.

Chapter 3

Method

The purpose of the qualitative transcendental phenomenological study was to explore the lived experiences and perceptions of the comprehensive, holistic, and changing nature of the projected contemporary nurse manager roles, skills, practices, and dimensions that align with the expectations of patient satisfaction among selected nurse managers in seven acute care hospitals in the northeast segment of the United States. Leaders in health care organizations realize the significance of patient satisfaction with loyalty and the likelihood to recommend that translates to future revenue and reputation. Patient satisfaction is an important dimension of quality that determines health care reimbursement in a Value Based Purchasing Program (Wagner & Bear, 2009).

Reforms resulting from the Affordable Care Act of 2010 focus on rewarding health care organizations through Value-Based Purchasing or Pay-for-Performance programs based on quality indicators such as patient satisfaction (CMS, 2011). In 2012, CMS started to incorporate eight measures from the HCAHPS survey to generate 2013 Diagnostic Related Group (DRG) payments (CMS, 2013). Understanding front line nurse managers' new roles and dimensions to improve patient satisfaction may provide health care organizations, regulatory agencies, and teaching institutions with necessary information to recruit, train, and develop nursing leaders to improve organizational outcomes.

Chapter 3 includes a description of the study design, rationale for research design and approach, population, and selection criteria. The chapter also includes information on the sampling procedure, consent, confidentiality issues, and geographic location of the

study. Included in Chapter 3 is a discussion on the data collection plan and detailed step-by-step procedure for qualitative data analysis. The concluding sections of Chapter 3 provide information on validity, reliability and feasibility of the study.

Research Method

In a qualitative study, the researcher employs an in-depth, subjective, and holistic exploration with a naturalistic, interpretive, and humanistic philosophy of inquiry (Burns & Grove, 2005; Christensen et al., 2010; Leedy & Ormrod, 2005; Merriam, 1998). According to Bianco and Carr-Chellman (2002), "the perception, perspectives, and experiences of participants are important epistemological notions in understanding situation or context" (p. 254). In a qualitative study, the researcher becomes the key instrument by seeking the description and interpretation of the essence or meaning that multiple participants ascribe to a problem in natural settings through inductive data analysis (Creswell, 2007). The qualitative method for the current study entailed the use of an in-depth exploration of a complex, contemporary, holistic, multifaceted, or little-known phenomenon in a real life context (Ellis & Levy, 2009). Insights from selected expert research participants provided intensive value and insightful manifestations about a phenomenon (Connelly & Yoder, 2000; Merriam, 1998; Sandelowski, 2000) to reveal the explicit and organized meaning or essence of collective experience (Willis, 2007).

The qualitative method was best suited for this study because nurse managers have an opportunity to express valid and naturalistic perceptions and recollections of their experiences with the contemporary role to improve patient satisfaction within the context of a highly dynamic, competitive, regulated, and accountable health care environment (Corbin & Strauss, 2008; Leedy & Ormrod, 2005). Relevant insights, themes, and

perceptions of roles, and functions for patient satisfaction formed the basis to drive meaningful conclusions and drive practice improvements (Christensen et al., 2010).

A quantitative research design was not appropriate for the current research study because of lack of established knowledge of specific variables of nurse manager roles, tasks, skills, and dimensions related to improving patient satisfaction. Researchers in qualitative studies gain new insights, discovery, and interpretation about the participants' lived experience of the relatively unknown phenomenon compared to quantitative studies that restrict information with a narrow focus from objective sources (Creswell, 2009; Leedy & Ormrod, 2005; Merriam, 1998; Neuman, 2010). Unlike quantitative research, which is structured to establish any causal relationships between specified variables, the purpose of this qualitative research was not to establish any causal relationships between nurse manager roles and patient satisfaction, test hypotheses, or examine the frequency of nurse manager behaviors.

The current study was different from a traditional mixed research design as the qualitative method satisfied the objective of the study by describing the essence of the lived experiences of nurse managers' roles, skills, and practices to improve patient satisfaction. In a mixed methods study, both qualitative and quantitative methods are complimentary and effective to address the research question (Christensen et al., 2010). The value of a quantitative component appropriate in a mixed methods study could not be derived from the purpose and objective of current study.

Design Appropriateness

Phenomenology is the study of structures and phenomena as they appear in our consciousness or experience, ascribing true meaning to the subjective experience (Cohen,

Kahn, & Steeves, 2000; Creswell, 2009). According to Van Manen (1990), phenomenology is the systematic attempt to uncover the meaning through discovering the recollective and pre-reflective perceptions of immediate lived experience of the phenomenon. Phenomenology is the most appropriate qualitative design when the objective of study is to gain a deeper understanding of the nature or meaning of experiences (Van Manen, 1990) of nurse managers' roles with improving patient satisfaction.

Other qualitative research designs such as narrative, grounded theory, ethnography, and case study were insufficient to fully describe the depth and richness of the unknown phenomenon. A narrative researcher explores individual life stories and experiences and may not provide multiple perspectives and experiences with the phenomenon. The application of a grounded theory design to formulate a theory grounded in data from the field did not meet the objective of the study (Creswell, 2009). Ethnographic research design was not applicable for this study, as ethnographers focus on interpreting and describing specific cultural groups over an extended period. In this phenomenological study, the researcher examined the lived experiences of nurse managers from different hospital settings and departments and not from similar cultural groups.

In a case study design, researchers explore the perceptions, situations, and experiences of a contemporary phenomenon within real life context with multiple sources of evidence (Munhall, 2010; Yin, 2009). The phenomenological research for the current study began with an in-depth inquiry of the meaning individuals ascribe to a little-known phenomenon or problem (Creswell, 2007) rather than studying the issue external to the

individual's experience (Leedy & Ormrod, 2005). Compared to a phenomenological study, a case study research design requires the rich, intense, and holistic descriptions of a single or multiple units or case in a bounded system (Creswell, 2009; Patton, 2002). Examples of case in a bounded system include individuals belonging to an organization, program, process, an event, group, or community (Merriam, 1998). The purposive sample of participants from multiple and varied hospitals, management, and departments was not bound by any process, activity, organization, or time, and therefore inappropriate to satisfy the objective of the study (Creswell, 2003).

Appropriateness of the Transcendental Phenomenological Approach

Moustakas (1994) drew concepts from the writings of the German mathematician, Husserl (1859-1938), who emphasized that transcendental phenomenology is a systematic and valid scientific methodology of deriving knowledge from the subjective discovery of the essence and meaning of the experience. Other phenomenological approaches were considered but did not meet the criteria to satisfy the objective of the study. For example, Heidegger's hermeneutic phenomenology focuses on the researchers' interpretations of the participants' meaning of lived experiences (Cohen et al., 2000). Existential phenomenology is the conceptual understanding of the features constituting a human being rather than the actions of individuals (Solomon, 2001).

Numerous contemporary North American phenomenological researchers examined ways humans interpret phenomena or give meaning to individual experiences (Denscombe, 2007). From a phenomenological perspective, the researcher was interested in the descriptive nature, essence, and wholeness of nurse managers' experiences with improving patient satisfaction rather than learning about the researcher's interpretation of

the phenomenon (Moustakas, 1994). The descriptions of the unique transcendental processes and elements are detailed under the data analysis section.

Moustakas (1994) outlined a detailed step-by–step process for the phenomenological model. The core concepts in transcendental phenomenology include 'epoche', a Greek word meaning *to stay away or abstain*, transcendental phenomenological reduction, imaginative variation, and synthesis (Moustakas, 1994). In epoche, the researcher brackets or sets aside his or her prejudgments, bias, prejudices, and predispositions of the phenomenon and enters into a new consciousness by allowing a transcendental or a fresh and purified view of participants' perspectives of events and experiences (Moustakas, 1994).

Phenomenological reduction takes the researcher back to the source of the meaning of the singular experience with the phenomenon (Creswell, 2007). This process of awareness, knowledge, and reflection of self-thought is known as horizonalization or unlimited experience of the continuous mystery (Moustakas, 1994). The researcher describes in textural language, the totality of the singular experience of perceptions, thoughts and feelings, and then clustering the themes into a coherent description of the phenomenon (Moustakas, 1994).

The next step of imaginative variation encourages the researcher to seek meaning through imagination, approaching the phenomenon with multiple nurse manager perspectives, and lived experiences to arrive at a structural description of the phenomenon from the textural description (Moustakas, 1994). The final step of synthesis in transcendental phenomenology research process combines both textural and structural descriptions into a meaning or essence of the experience with the phenomenon.

Research Questions

The nature of a research question in a qualitative study is exploratory, explanatory, descriptive, and directly interpretive of the research problem (Creswell, 2009; Ellis & Levy, 2009). The central research question and sub-questions provided the framework of the qualitative phenomenological study. The research questions provided the focus of the investigation that guided the researcher to seek the meaning of the rich structural and textural data from the study participants (Moustakas, 1994).

The exploratory open-ended questions revealed the essence of human experience by engaging the research participants to illuminate the comprehensive, accurate, and vivid descriptions of the experience (Moustakas, 1994). Qualitative questions started with words such as *what* or *how* rather than *why* (Creswell, 2009). The study research questions reflected on the purpose of the study to provide a deeper and enriched understanding of the essence or meaning of nurse managers' roles and practices for improving the patients' perceptions of satisfaction with the department, nursing, healthcare facility, and total healthcare experience (Christensen et al., 2010).

The central research question, following the qualitative transcendental phenomenological design asked, *What is the comprehensive, holistic, and changing nature of the projected contemporary nurse manager's role, skills, cross functional practices, and dimensions, that align with the newer dimensions, and expectations of increased patient satisfaction among selected nurse managers in seven acute care hospitals in New Jersey*?

Further research sub-questions (RQs) narrowed the boundaries into the several subtopics for further examination to develop a comprehensive understanding of current

state of evolving roles and practices of nurse managers. These connections provided considerations for newer organizational constructs with demands to improve patient satisfaction (Creswell, 2009). In addition to topical examination, sub-questions also addressed the transcendental phenomenological procedures described by Moustakas (1994).

Sub RQ1. What are the current practices, dimensions, indicators, and expectations for the nurse managers to monitor, measure, or influence patient satisfaction on their units?

Sub RQ2. What were some of the essential themes from past nurse manager experiences that should be maintained with the new nurse manager role, practices, attributes, functions, strategies, or performance improvement initiatives that may continue to influence improved patient satisfaction in current and future times?

Sub RQ3. What is the essence of the new complex and transformative changes in the projected nurse manager leadership roles and trends for best practices in the context of new regulatory requirements to improve patient satisfaction in highly competitive health care environments?

Sub RQ4: What is the overall value or benefit of the newer nurse manager position and opportunities in meeting requirements for improving patient satisfaction?

Sub RQ5: What are the influences and or overall obstacles barriers, or complexities that may challenge the Nurse Manager within the organizational culture to meet requirements for improving patient satisfaction?

Population

The primary goal in a qualitative phenomenological study is to conduct an in-depth exploration of the unknown phenomenon from multiple participants who have experienced the phenomenon (Creswell, 2009). Gleaning information from nurse managers, immediate supervisors, and chief nursing officers provided opportunities to learn about the roles, indicators, and practices of nurse managers. The target or accessible population for this study included nurse managers and leaders who manage and lead various inpatient-nursing departments such as medical, surgical, critical care, and emergency room in diverse acute care hospitals in New Jersey.

The population excluded nurse managers from outpatient departments, ambulatory, sub-acute, hospice, home-health or long-term care centers. The study also excluded department managers of other ancillary health care disciplines such as pulmonary, physical therapy, occupational therapy, speech therapy, imaging, nutrition, cardiac rehabilitation, cardiac diagnostics, fitness, dialysis, laboratory, pharmacy, and radiology. Creswell (2009) recommended criterion sampling to narrow selection of study participants representing the target population who experienced the phenomenon. The target and accessible population for the phenomenological study were front line nurse managers of various inpatient acute care hospital departments who had demonstrated in-depth knowledge, expertise, and experience in improving patient satisfaction scores.

Sampling Frame and Sample

Purposive sampling in qualitative research focused on description and relationships from the sample of this population (Polit & Beck, 2004). In a qualitative study, deliberate selection depends upon characteristics of the sample to enable detailed

and rich exploration of the issue rather than statistical representation in a quantitative study (Ritchie & Lewis, 2003). The focus of purposive sampling or theoretical sampling from a target population of nurse managers and nurse leaders was to ascertain optimal exploration, relevant description, and understanding of the meaning of lived experiences with the phenomenon (Bloomberg & Volpe, 2008; Corbin & Strauss, 2008).

A purposive sample included multiple nurse managers, immediate supervisors, and CNOs who had experienced and can articulate the lived experience with the new contemporary role and functions to influence patient satisfaction (Patton, 2002). In the current study, selection of nurse managers, immediate supervisors, and CNOs depended on their voluntary acceptance of participation of research. The current study entailed a nonprobability purposeful sampling of 21 nurse managers and nurse leaders from seven acute care hospitals in New Jersey to provide a diverse representation of hospitals. Leedy and Ormrod (2005) recommended a sample size of five to 25 participants in a phenomenological study. Creswell (2007) suggested collecting in-depth information with as many as 10 individuals to describe the experience with the phenomenon. Using a larger than recommended sample size for the qualitative phenomenological study might have mitigated issues with participant attrition.

The 2011 and 2012 HCAHPS survey and vendor specific patient satisfaction surveys results provided the basis from which to select a comprehensive sample of expert nurse managers. Selecting expert nurse managers with high patient satisfaction survey scores narrowed the sampling strategy to nurse managers who have experience with influencing improved patient satisfaction scores in their inpatient departments. The preliminary basis for the selection criteria for the nurse manager prior to the sampling

process includes at least one year in the nurse manager position and at least three years of clinical experience.

Industry wide variation in education requirements for nurse managers restricted the researcher from including education as criteria for sample selection. Selection of nurse managers with similar clinical service lines was not feasible, depending upon the availability of volunteers for the study. A small sample size of chief nursing officers in comparison with the number of nurse managers is representative of the governance structure in many health care organizations. The participation of the sample for the study depended upon approval of the institution's individual internal Institutional Review Board (IRB).

The selective sampling also included chief nursing officers and immediate supervisors such as directors, vice presidents, performance improvement supervisors with in-depth knowledge with nurse manager roles and patient satisfaction outcomes. The criteria for immediate supervisors and Chief Nursing Officers (CNO) of nurse managers included at least one year in the current position and an understanding of the environmental contexts affecting (a) organizational and patient satisfaction outcomes and (b) nurse manager issues and indicators for patient satisfaction.

Nurse managers, immediate supervisors, and CNOs with varying experiences, leadership behaviors, styles, different nursing department, hospitals settings, organizational characteristics, and culture, provided a broad representation and maximum variation for in-depth exploration of the phenomenon (Bloomberg & Volpe, 2008). Diverse perspectives of nurse managers from different hospital settings enhanced the reliability of the study findings relating to skills, functions, practices, and dimensions of

nurse managers roles with new expectations for improving patient satisfaction. Nurse managers with practical experience with the day-to-day operations, quality improvement process, delivery of care, evaluation of department-based quality metrics, organizational demands, and assessment of patient and staff needs provided perspectives of required skills and dimensions to improve patient satisfaction.

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In a qualitative design, the rules for sample selection size are undefined, with emphasis on the maximum diversity to display multiple perspectives, adequacy, and quality of the data to attain theoretical saturation rather than on number of participants

(Bloomberg & Volpe, 2008; Morse, 2006; Patton, 2002). According to Grady (1998), a study sample achieves data saturation when new data are redundant of the data already collected. Saturation was achieved with 21 participants.

Permission letters mailed to Chief Operating Officers (CEOs) of 36 acute care hospitals in Northeast New Jersey contained permission to conduct research at premises and identify selective participants for the study. Purposive sampling entailed also using a snowball sampling technique to request permission to conduct research at premises, access expert nurse managers, and chief nursing officers (CNOs) for better insights into the experiences with improving patient satisfaction. Snowball sampling is an appropriate nonrandom sampling method to discover selective study participants through referral networks (Cooper & Schindler, 2006). The New Jersey Hospital Association (NJHA) is a comprehensive network of acute care hospitals, skilled nursing facilities, home health agencies, and specialty hospitals in the state of New Jersey. NJHA sent letters on behalf of the researcher to the Chief Nursing Officers of 50 member hospitals for permission to conduct research at premises (see Appendix B). Several hospitals required internal IRB application approval before consenting to participate in the study (see Appendix J). Other more stringent reviews included face-to-face presentation of proposal to various hospital research committees, executive leadership, and internal departmental meeting, prior to approval to conduct study. By late April 2012, six health care organizations agreed to participate in the study and several hospitals required University of Phoenix IRB approval before consenting to participate in the study.

Informed Consent

The informed consent process ensured the protection of human participants and ethical behavior of the researcher in the phenomenological research study. The permission to use the premises for the research study was approved by the University of Phoenix Institutional Review Board (see Appendix A). The letter sought permission to recruit selective participants meeting study criteria. The letter contained permission to review the preceding 2011 and 2012 Press Ganey™ and HCAHPS patient satisfaction survey scores of the hospital and from in-patient nursing departments with high patient satisfaction scores.

The researcher provided all necessary documentation such as IRB application, research protocol, informed consents, and conduct interviews with hospital research committees to satisfy individual hospital's IRB requirements for approval to conduct research on premises, recruit participants, and review patient satisfaction scores. Informed consent documents clarifying permission to use premises, name, participant, and data were obtained from respective participating hospitals and included in the proposal to the University of Phoenix IRB Review Board (see Appendix C). Two participating hospitals required institutional specific informed consent forms in addition to UOPX Informed Consents 18 years and older for study participants (see Appendix K)

The researcher solicited a purposive sample from hospital leaders of selected organizational healthcare settings with pertinent knowledge and experiences about the phenomenon. An introduction letter with an informed consent mailed to study participants contained information on the selection criteria (see Appendix D). The informed consent process entailed informing participants, over the age of 18, about the

aspects of the study, including the purpose, procedure, risks, and benefits to the participants (Christensen et al., 2010).

For the current study, the comprehensive informed consent letter to study participants provided pertinent information for the participants to make an informed decision about voluntary participation in the study. The informed consent letter ensured that participants over the age of 18 understood the conditions for voluntary participation in the research process providing an opportunity to refuse or participate in the study. The participant signature on the informed consent form confirmed that participants understood the following pertinent information: (a) research study purpose, (b) research goals, (c) approximate duration of the interview, (d) the potential risks and benefits of participation, (e) the level of confidentiality with the data collection and storage, (f) the recording of interview sessions, (g) contact information, and (h) the participant's ability to choose not to participate or withdraw at any time during the study without penalty or loss of benefits.

Procedures clarified ways the participant could withdraw after completion of data collection without penalty or loss of benefits to the study participant. The study participant could request the withdrawal by submitting the withdrawal form or letter in writing to the researcher. All coded data from the participant would be excluded from data analysis, secured, and destroyed to maintained security and confidentiality of data. The informed consent provided an opportunity for participants to ask any questions or clarify any elements prior to the start of the interview.

Confidentiality

The researcher maintained confidentiality throughout the entire process of data collection, analysis, and communication of the results (see Appendix H). An informed consent letter was used to inform the participants that participation is voluntary and the interview responses will be confidential (see Appendix D). The information from data collection was held in strictest confidence and all information collected contained in a controlled environment.

Random identifier codes assigned to the participant responses and the key to the codes was available only to the researcher. To maintain confidentiality, each participant was assigned a 16-digit number identification number. The fictitious anonymous code PNGNTIYEMODYYR was a consistent and efficient method for participant identification throughout the data collection process. The first two letters PN signifies a unique participant leader identifier, GN for gender, TI is the title or role of the participant, EL is the educational level, MO is the month, DY is the date, and YR is the year of the interview. Appendix N (Dissertation Research Participant Identifier Code) contains a template of the identifier codes assigned for the participants. A unique identifier code for each of the participant preserved participant unique identity and anonymity.

Audio recordings and transcribed data included random identifier codes to preserve strictest confidentiality. Data reports only showed summated group data and not individual raw scores or any connection to an individual participant's identity with raw data. The active informed consents, patient satisfaction survey scores, interview responses, and code keys to the responses is secured in a locked cabinet for 3 years

following data collection. Electronic data on a desktop are also archived for a minimum of 3 years secured under two levels of password protection and behind a network firewall. The researcher will destroy all data responses, shred all papers, and erase all electronic data after three years.

Geographic Location

Nurse managers from various inpatient-nursing departments such as medical, surgical, critical care, and emergency room represented the selected inpatient nursing departments from seven diverse acute care hospitals in New Jersey. The selected hospitals differed in size, affiliation, designations, accreditations, settings, culture, governing structures, profit versus nonprofits status, and locations. The dispersed locations of hospitals increased the reliability of the study in incorporating information from nurse managers working in rural as well as urban settings. The hospital typically serves the patient population residing in nearby communities, and towns within a large radius, but the various hospitals also serve differing ratios of patients and constituents from the community.

Data Collection

Follow-up letters with an application to acute care hospitals continued after University Of Phoenix IRB approval. One hospital dropped from the study without any written official notice. Follow up phone calls and emails revealed changes in executive leadership and the current leaders did not respond to multiple requests to provide participants' for the study. Two other hospitals provided consent to participate in the study after rigorous internal IRB application process and several research committee

interviews. The ongoing application process from December 2012 to late March 2013 helped in achieving the desired sample size for the study.

Seven acute care hospitals in the state of New Jersey participated in this study. Executive leaders in participating acute care hospitals provided a list of 31 eligible candidates meeting study criteria to participate in the study. One participant agreed to participate as result of snowball sampling through participants in the interview. Multiple requests to participate in the study were sent to individuals to yield the desired sample size required for the study. The researcher sent introduction letters with Informed Consent forms for Participants 18 years and Older to eligible participants meeting study criteria. Some of the participants responded immediately.

Some participants responded after weeks of numerous emails and follow up phone calls. Many nurse managers and leaders cited organizational priorities and responsibilities, such as employee evaluations, as reasons for difficulty in committing to interviews during the 1st Quarter of fiscal year 2013. Study participants scheduled personal interview dates, times, and locations subsequent to the receipt of signed informed consent.

Data collection for the research study started on Jan 25, 2013 and ended on June 9, 2013. Of the 32 eligible candidates, four participated in the pilot study, and 21 participated in the research study, one candidate refused to participate in the study, and six did not respond to the request to participate in the study. None of the participants dropped out of the study. Most interviews were conducted during weekdays, one on the weekend, and most of them during the latter half of the workday.

The geographic location for participating hospitals in the research extended from North-East New Jersey to South East New Jersey. Participating hospitals varied in long distances from each other, some 66 miles from each other. The location for the all the interviews was at each participant's place of employment and interviews were conducted in private offices and conference rooms. Two participants sought an electronic copy of the interview questions prior to the interview.

The primary data collection encompassed face-to face, semi-structured open-ended interviews with a purposive sample of a minimum of 13 nurse managers, five directors with nurse managerial responsibilities, two vice presidents in nursing, one performance improvement supervisor, and one CNO regarding the meaning of holistic nurse manager roles to influence or improve patient satisfaction. The interview method was the primary source of information because of the potential to elicit rich, detailed, in-depth meaning and essence of nurse managers' lived experiences and perceptions with improving patient satisfaction (Bloomberg & Volpe, 2008; Creswell, 2009). Interviews in phenomenology focus on the description of experiences retain the original texture and appearance of things in the natural setting (Moustakas, 1994).

Prior to the interview process, the researcher engaged in the *epoche* process by setting aside facts, bias, assumptions, and personal experiences to avoid influencing data collection (Moustakas, 1994). The researcher made an effort to create a relaxed atmosphere, trust, and rapport with each interview participant. The interviews began with preliminary introductions, reading the interview protocol script (see Appendix P), and verbally reviewing the informed consent. Some participants signed the Informed Consent for Participants 18 years and Older form at the time of face-to-face interview.

Several forms and templates were used to manage and maintain an efficient interview process. A predesigned log sheet contained information on non-responders, candidates declining participation, individuals dropping out of the study, participants agreeing to participate in the study, or any new participants joining the study. An interview protocol script included a list of detailed instructions and procedures to guide the researcher in the interview process to ensure equal treatment of participants, to provide clarity, and avoid errors in the interview process (Yin, 2009). The interview protocol contained the following: (a) information on how to begin interview sessions, (b) research questions, (c) verbal transitions, (d) descriptive and reflective notes during the interview, (e) concluding ideas, (f) ending the interview, (g) request for follow–up information, and (h) thanking respondents. A *participant notes and observations* form aided in annotating visual observations of the interview participant and surroundings during and immediately after the interview (see Appendix O). Direct observation of each participant's behavior, interview location, unit of control, and hospital environment provided additional information and dimension to understand the study's context and phenomenon in its natural setting.

The participants filled out a written demographic questionnaire prior to the interview. A phenomenological researcher primarily relies on interviews for richness of data. Immersion in the dynamics of the real life context of the phenomenon by observing data and reviewing document sources may create new opportunities for corroborating data, exposing new information, and strengthen the findings of the study (Anderson, 1998). Each interview began with a discussion on the purpose of the study, confidentiality, process of informed consent, and permission to ask questions, and option

to decline from the interview. The data collection process remained in compliance with the requirements for research with human participants (Neuman, 2003). The interview began by allowing the participant to focus on experiences to recreate moments of awareness and describe the wholeness of the experience. The interview process allowed the researcher to interact with participants to capture their experiences, thoughts, and feelings, clarify participant responses, and probe for any additional information (Bloomberg & Volpe, 2008).

The 23 semi-structured interview questions followed a structured pattern to seek in-depth perceptions and experiences surrounding the five research sub-questions. The semi-structured interview questions in this qualitative research ensured that a large number of respondents were asked the same questions, in the same sequence to gather relevant information from all respondents to improve the quality of the study by reducing interviewer inconsistencies and bias (Rubin & Babbie, 2010). Neutral and open-ended interview questions by the researcher provided the flexibility to probe for further subjective meanings and clarifications in the interview process (Rubin, 2011; Rubin & Babbie, 2010). The participant's experiences with the phenomenon guided the researcher's bracketed question and the pre-tested questions altered or varied (Moustakas, 1994). The participants' experiences with the phenomenon guided further probing questions. Brief probes and follow-up queries for each interview question elicited rich information regarding the study.

The audio recording equipment used during interviews was a Sony digital audio recorder with 4 MG memory flash drive recording interviews in an MP3 format for transcription into a Microsoft word file. Use of the audio equipment during pilot testing

minimized any operator error during the actual study. Each interview lasted approximately 60-90 minutes. Some interviews extended to two hours allowing for in-depth exploration of lived experiences with the permission of the participant. Data collection strategy also consisted of researcher notes, archival patient satisfaction survey results, observation of the participants, and environment.

Phenomenology is a pre-reflective exploration of each participant's life world by seeking recollective and retrospective experiences with the phenomenon (Christensen et al., 2010; Van Manen, 1990). The semi structured interview questions were used to investigate participants' experiences and perceptions as they live the phenomenon. The aim of this phenomenological research was to transform recollective lived experiences of the holistic nurse managers' role with dimensions, constructs, and expectations for patient satisfaction into a reflective and reflective textual essence (Van Manen, 1990). Participants' perceptions about their experiences with the phenomenon, is the primary and truthful source of knowledge (Moustakas, 1994).

Accurate Transcription Service LLC conducted transcription of audio-recorded interviews. The company signed a nondisclosure agreement for their services (see Appendix S). Accurate Transcriptions LLC transcribed verbatim audio files into textual form. Each audio-recorded MP3 file was coded with the same 16-digit unique identifier number prior to transcription to preserve participant confidentiality. The interview transcripts were reviewed again with the audio file to maintain accuracy of the document. A repeated review of the audio and transcribed data assisted in a better understanding of the lived experiences, horizonalization, identification of invariant constituents, and grouping thematic clusters and patterns.

Any identifying information in the document was coded to maintain confidentiality. Study participants received a copy of the transcript of the interview to review and corroborate or disconfirm for accuracy. Participants reviewed the document to ensure the accuracy of their meaning of their lived experiences and perceptions. Some of the transcripts were approved quickly; some participants made changes to the documents and others requested specific changes and revised documents sent back for participant approval.

The 21 interviews yielded 500 pages of transcribed documents. After participant approval, the researcher loaded transcribed interviews into the NVIVO 10 qualitative software program for management, analysis, and development of reports on unstructured qualitative data. NVIVO 10 is the qualitative analysis software by QSR International. In a qualitative phenomenological study, the researcher becomes the data collection instrument (Blankenship, 2009).

The interviews consisted of asking a set of semi-structured, open-ended questions to elicit perspectives and experiences of the participants (Moustakas, 1994). While the results of the Press Ganey™ and HCAHPS survey questions were important for determining participant sample selection and to ascertain nurse manager roles and practices impacting improvement of patient satisfaction scores, the patient satisfaction categories and survey scores from the two surveys provided useful information to formulate qualitative research questions regarding perception of lived experiences of the nurse manager to improve scores. Appendix E shows permission to publish Press Ganey™ Inpatient Satisfaction survey and HCAHPS survey for information purposes only. Press Ganey™ integrates HCAHPS survey questions in their survey to meet CMS

requirements for participating hospitals. Copies of the surveys can be found in Appendix G.

The central research question and sub-questions provided the boundaries and contexts for creating the interview questions that link back to each sub-question. The sub-questions were designed to explore the conceptual understanding of the nurse managers' practices and organizational influences that positively or negatively impact patient satisfaction in a highly competitive, regulated, accountable, and transparent health care environment. Further interview questions focused on the nurse managers' experiences with strengths, barriers, or difficulties related to influencing improved patient satisfaction.

Instrument Validity and Reliability

Bias resulting from the researcher is a major threat to the validity of the instrument. Face validation is the least persuasive method to assess if the survey instrument measures what it intends to measure and the meaning of the concept (Grinnell & Unrau, 2008). A variation in the use of interview instruments or poor quality of the instrument may affect the internal validity of the study.

To ensure quality of the instrument, a pretest of the instrument with a small group of participants similar to the study sample, but not included in the study, minimized the threat to validity of the instrument. Pretesting semi-structured, open-ended interview questions with nursing experts provided the feedback on clarity, readability, content, and directions establish reliability and face validity of the survey instrument (Blankenship, 2009; Yin, 2009). The feedback from pretested sessions helped in improving the survey instrument, check the duration, and general flow of the interview protocol to guide the

novice qualitative researcher. The researcher used a transcriptionist service to transcribe audio-recorded interview into textual content for data review.

Data Analysis

The interpretive nature of the qualitative research inquiry required analysis of data describing the participant's' experiences with the phenomenon. Qualitative data analysis consisted of preparing and organizing data for analysis, reducing the data into themes, through a process of coding, and representing the data for discussion (Creswell, 2007). NVIVO 10 is a computer analysis software application that stores and organizes large amounts of transcribed data. Following the coding process, the NVIVO 10 software aided in the isolation of themes and patterns from raw data. NVIVO 10, distributed by QSR International, also assisted with creating templates, locating, and comparing data coded according to statements, themes, meanings, textural, and structural descriptions. The researcher sought additional assistance from experts at QSR International on NVIVO 10 software for understanding software capabilities for data analysis including coding queries. The company signed a non-disclosure agreement prior to assisting with the research (see Appendix T).

Moustakas (1994) presented the modified van Kaam approach as a highly structured approach to phenomenological data analysis and organization of the report. Moustakas provided the following steps to data analysis in the modified van Kaam approach. Figure 1 represents a flow diagram of the modified van Kaam approach.

1. Listing and preliminary grouping: The first step also known as horizonalization involved listing every expression relevant to the experience with the phenomenon. The researcher became receptive to every statement of the participant's

experience and perception of the phenomenon. The researcher provided equal value to every statement contributing to the understanding of the essence of experience with the phenomenon (Moustakas, 1994).

2. Reduction and elimination: The invariant constituent indicated unique qualities of the experiences that stand out for the researcher. The researcher tested the invariant constituents by assessing if the statement describing the experience was necessary and sufficient to understand the phenomenon. The researcher also retained invariant constituent by assessing the abstraction and labeling of the data. The researcher eliminated any overlapping, vague, and repetitive expressions retaining only the invariant constituents that remained in the horizon of the experience (Moustakas, 1994).
3. Clustering and thematizing invariant constituents: The next step involves clustering of the invariant constituents related to the thematic label. The NVIVO 10 computer software application integrated the processes of interpretation and coding with qualitative linking, shaping, and modeling of rich text data. Using the process of phenomenological reflection and imaginative variation, the researcher constructed thematic portrayal of the invariant constituents. The process of phenomenological reflection involved perceiving, imagining, recollecting, and reflecting on experiences aiming at the essence and nature of the phenomenon (Moustakas, 1994).
4. Identifying final invariant constituents and themes by application validation. This step involved checking invariant constituents and themes against the complete

records of the participant for explicit, compatible, and relevant expression of complete transcription of the experience.

5. Constructing an individual textural description for each research participant's responses by using relevant and validated invariant constituents and themes. According to Moustakas (1994), the researcher writes the textural descriptions by experiencing the *what* of the appearing phenomenon.
6. Constructed an individual structural description for each research participant from individual textural description, and imaginative variation. The researcher reflected on the settings and the context in which each participant experienced the phenomenon to arrive at the structural description of the phenomenon. Imaginative variation involved the task of using imagination to vary the frame of reference, employ polarities and reversals, and approach the phenomenon from different perspectives (Moustakas, 1994). The aim of imaginative variation was to arrive at the structural description of the experience by examining the textural description obtained via phenomenological reduction by following the four major steps (Moustakas, 1994). The first step of imaginative variation involved varying the possible structural meaning that underline the textural meanings. In the second step, the researcher discovered the underlying themes or contexts of the emergent phenomenon. The next steps involved considering universal structures that precipitate participant's feelings, thoughts, concerns, and relationships to self and others. In the final step the researcher searched for the invariant structural themes leading to the structural description of the phenomenon.

7. Constructed a textural-structural description of meaning and essences of the experiences by incorporating invariant constituents and themes.
8. Developed a composite description of the meaning and essence of the experience with the phenomenon representing the group of research participants as a whole. The culminating aspects of phenomenological data analysis informed the reader *what* and *how* selected nurse managers experienced the phenomenon in the context of the changing health care environment.

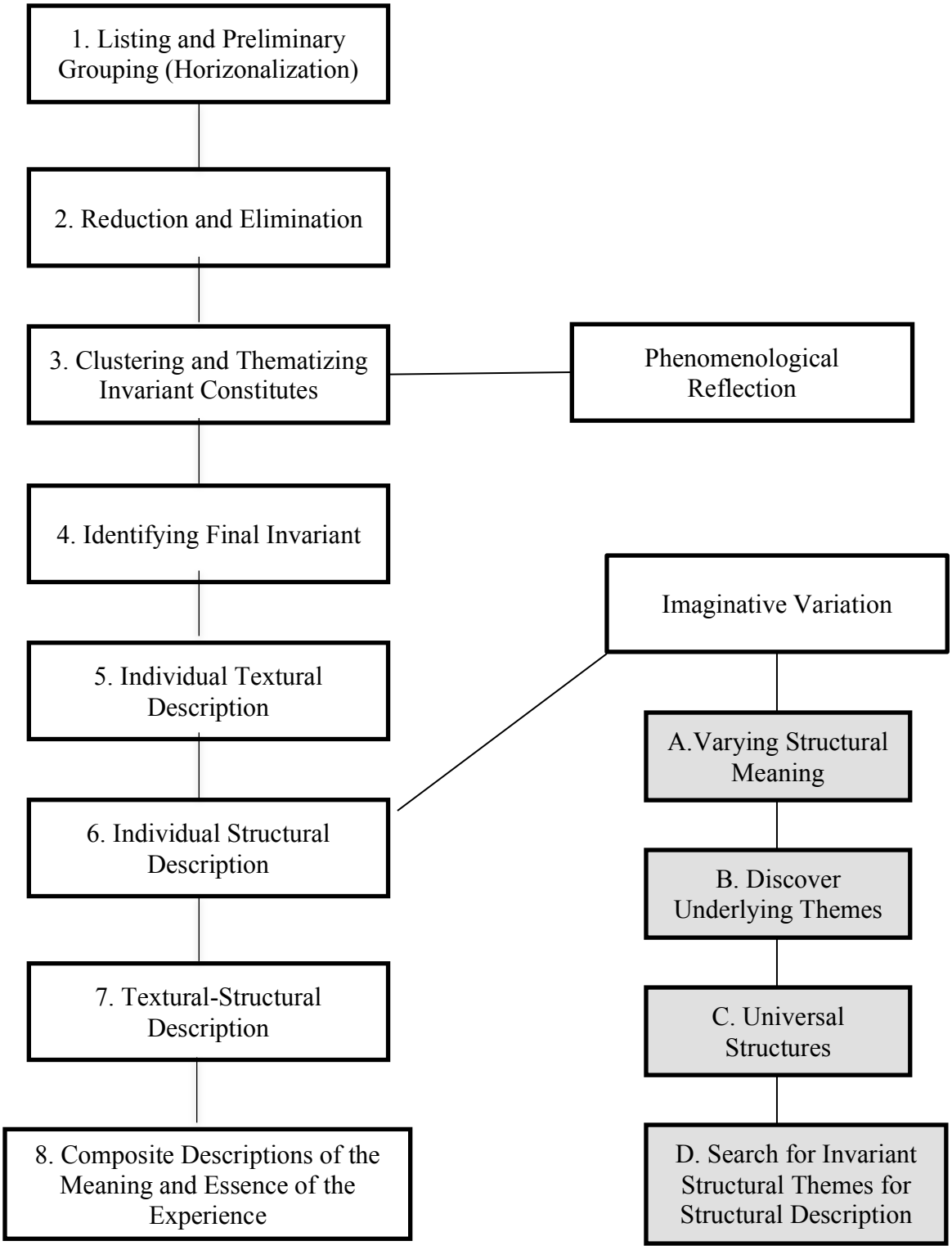

Figure 1. Flow diagram of modified van Kaam approach to data analysis.

Adapted from Phenomenological Research Methods by Clark Moustakas (1994).

Validity and Reliability of the Study

Validity in a qualitative study is a grounded contingent construct within the research process that tests the rigor or trustworthiness of a qualitative measurement or instrument and the transferability of the results of the study to other contexts or settings (Klenke, 2008). According to qualitative research scholars, the terms *credibility* and *transferability* parallel quantitative paradigm of internal and external validity respectively (Macnee & McCabe, 2008). Validity is an interpretive process of assessing the accuracy of the research finding through researcher reflexivity and challenging ideas developed during the data analysis (Creswell, 2007). Threats to validity of a qualitative phenomenological study include researcher bias, lack of proper data analysis procedures, and inaccuracy of transcriptions or textural and structural descriptions. The iterative nature of a qualitative study allowed for validity check procedures during design selection, sample selection, formulation of interview questions, data collection, data analysis, and interpretation.

Role of Researcher

In a qualitative phenomenological study, the researcher played an important role in providing the context for collecting and analyzing data. The researcher's prior knowledge of issues, experience, context, phenomenon, and theory was a potential threat to the validity of the study (Klenke, 2008). Researcher bias might have hindered active listening of participants' interpretive theories or viewpoints, but researcher bias was controlled by bracketing (Klenke, 2008).

In bracketing, the researcher put aside personal values, knowledge, and position by reflexively thinking, controlling, and confronting as the qualitative phenomenological

study proceeded to prevent exposure of bias. Moustakas (1994) explained researchers rarely achieve epoche or perfect bracketing, but the researcher's intention, attitude, frame of reference and the process of reflection and self-dialogue, significantly reduce preconceived thoughts and bias. From epoche, the researcher freshly approached every singular description of the phenomenon with transcendental ego or pure consciousness (Moustakas, 1994). Bracketing allowed the researcher to elicit fresh, new, and rich descriptions of the phenomenon from multiple study participants (Moustakas, 1994).

Triangulation

Triangulation of the study included archival Press Ganey™ and HCAHPS patient satisfaction survey data, open-ended interviews with multiple nurse managers, immediate supervisors, and CNOs, health care organization documents, publically available documents, and use of qualitative software to analyze text content and frequencies of responses (Willis, 2007). Archival records from Press Ganey™ patient satisfaction survey data provided information on patient satisfaction measures within the hospital. Internet documents provided specific information on the type of hospital, the culture, mission, values, designations, awards, governance structure, population served, HCAHPS data, number of employees, service line, accreditation status, ranking, and rating of the hospital by agencies. Organizational documents provided information about each organization's strategies, initiative, structure, process, and delivery system changes to improve patient satisfaction. The interviews and documents from different hospitals added to the reliability to the qualitative phenomenological study by increasing diversity in size, profit status, culture, governance structure, affiliations, designations, and locations.

Internal Validity or Credibility

Any item, error, or condition that affects the believability of the data constitutes a threat to the credibility of the study (Macnee & McCabe, 2008; Yin, 2009). The internal validity or credibility includes the tests for accuracy, authenticity, or plausibility of the findings by seeking congruence between the researcher's conclusions of each participant's responses and the participants' perceptions (Bailey, 2007; Goodwin & Goodwin, 1996). Threats to internal validity generally include history, maturation, observer effects, selection, attritions or mortality, and spurious conclusions (Goodwin & Goodwin, 1996).

The short face-to-face interviews reduced threats to history and maturation that resulted from change in participant responses. The phenomenological study established internal validity by following the concepts and structured process outlined for phenomenological data collection and data analysis. The researcher ensured validity of emerging themes and the essence of the nurse managers' experiences with the phenomenon by accurately collecting and analyzing transcribed data.

Phenomenological and dynamic changes in the health care environment cannot be controlled but was well documented to minimize the threat to internal validity of the study. A selection of highly diverse nurse managers, immediate supervisors, and CNOs from different specialties, departments, experiences, educational levels, and hospital environments provided corroborating evidence to the study conclusions. Other factors such as participants dropping out of the study or untruthful account of information from participants might have affected the quality of the study (Goodwin & Goodwin, 1996),

though the follow-up data collection processes showed that no participants withdrew from the study.

To mitigate threats from participants dropping out of the study, a backup list of potential participants for the study ensured a replacement for adequate sampling for the study. Clear communication about the objectives of the study and potential value of the knowledge from experts about the topic appeared to increase interest and participation for the study. Member checks were used as an interpretive method to ensure the credibility of the study findings by soliciting participants' views and verifying emerging conclusions. Member checking involved taking the data, analysis, interpretations, and conclusion back to the participants to judge the accuracy and credibility of descriptions (Creswell, 2007).

External Validity or Transferability

Threats to external validity affect the accuracy of the study results when the study is replicated with other samples or settings (Macnee & McCabe, 2008). External validity methods can be used to ascertain if the study findings are generalizable beyond the present phenomenological study to other situations, conditions, or contexts (Leedy & Ormrod, 2005). Qualitative researchers who are unable to sacrifice the threats to internal validity tend to focus on the transferability of the data because of a highly contextualized and in-depth exploration of expert participants' understanding and lived experiences of the phenomenon (Creswell, 2007). Replication of the study to another industry or population may produce new perspectives because of unlimited and unending horizonalization of experiences with the phenomenon (Moustakas, 1994). The comprehensive literature review and conceptual framework for nurse manager skills and

competencies in addition to patient satisfaction allowed for connection between study findings and other research studies thereby mitigating threats to the external validity of the study (Merriam, 1998).

Reliability or Dependability

The objective of tests for reliability is that future researchers can arrive at the same conclusion if the qualitative study were repeated (Yin, 2009). Any threat to the internal validity of the study could also affect the consistency or dependability of the study results (Blankenship, 2009). The nature of the phenomenological study clarifying the context of unique experiences of nurse managers with the phenomenon mitigated replication of study in another context.

The method to address shortcomings in reliability was to operationalize many steps and procedures to provide an extensive document trail (Blankenship, 2009; Yin, 2009). Creswell (2009) suggested taking detailed field notes and accurate recording of data. Through comprehensive and intensive documentation of study processes, including data collection, interpretation, and analysis, other researchers could better replicate the study and, therefore, enhance the dependability of the study (Blankenship, 2009).

Summary

Frontline nurse managers are responsible to ensure high quality patient outcomes in the unit of control including patient satisfaction. Leaders of health care organizations expect nurse managers to improve patient quality and satisfaction without a clear direction or meaningful understanding of the specific role and competencies required to achieve organizational goals. Extensive review of literature indicated a gap in the understanding the pivotal role, skills, practices, and dimensions required by nurse

managers with focus and emphasis on improving patient satisfaction. Understanding the little known phenomenon of changing holistic and contemporary roles and practices of nurse managers in relation to dimensions of improving patient satisfaction may provide rich information to health care organizations, graduate education, ongoing leadership, and continuous quality improvement (CQI) programs to develop nurse managers for effective results.

A qualitative research design guided the activity and progression of research from a philosophical or theoretical assumption by inquiring the meaning individuals or groups ascribe to a human problem (Creswell, 2009). According to Moustakas (1994), phenomenology is concerned with examining the wholeness of the different perspectives to seek a unified vision of the essence of the experienced phenomenon. The purpose of the qualitative transcendental phenomenological study design was to explore the meaning and essence of lived experiences of nurse managers' holistic roles, skills, practices, and dimensions with the expectation of providing information for improving patient satisfaction in a highly competitive, accountable, and regulated health care environment. This qualitative phenomenological research design entailed an in-depth exploration from multiple perspectives to describe the meaning or essence of lived experiences with the complex phenomenon within its real life context (Creswell, 2009).

The transcendental phenomenological research design described by Moustakas (1994) contains a systematic approach to data collection, data analysis, and detailed guidelines for assembling textural and structural descriptions of the phenomenon (Creswell, 2007). The first area of focus was an in-depth and rich description of the lived experiences nurse managers' roles, practices, skills, and contextual relationships affecting

the patient satisfaction construct. The second focus included the nurse managers' perceptions and understandings of new roles, practices, responsibilities, and skills required in an emerging phenomenon of improving patient satisfaction. The third focus of the study centered on emerging contextual relationships among the hospital culture, strategic initiatives, regulatory requirements, and quality improvement initiatives that influenced the nurse managers' role and practice.

The qualitative transcendental phenomenological study design with a modified van Kaam approach for data analysis was most appropriate methodology of choice to understand the projected contemporary holistic roles, skills, practices, and dimensions for nurse managers to improve patient satisfaction. The modified van Kaam approach for data analysis was a structured and systematic approach to collect and analyze data on nurse manager's experience with the phenomenon. NVIVO 10, a qualitative analysis software tool, enabled the researcher to conduct content analysis of transcribed digital recording from interview data and field notes.

Chapter 3 entailed an overview of research design methodology, design appropriateness, study population, informed consent, confidentiality, geographic location, and instrumentation. Discussions within the chapter included information on data collection and data analysis concerns with validity and reliability of the study. Chapter 4 provides a detailed description of the data findings from the sample selected for qualitative phenomenological study reinforcing emerging and consistent themes and patterns extracted and categorized from participant. The emergent themes were intended to answer the research question and provide relevant contexts for contemporary nurse manager roles and practices for improving patient satisfaction.

Chapter 4

Introduction

In an era of health care reform, health care leaders experience pressures for enhancing patient experience and improving patient satisfaction scores from market and regulatory forces that directly apply to more rigid health care reimbursements for hospitals and other health care facilities. The purpose of the qualitative phenomenological study was to explore the lived experiences and perceptions of the comprehensive, holistic, and changing nature of the projected contemporary nurse manager roles, cross-functional practices, and skills that align with the newer dimensions and expectations of increased patient satisfaction. The qualitative transcendental phenomenological approach entailed the use of a modified van Kaam method by Moustakas (1994) to explore the lived experiences and perceptions of nurse managers with new, different, or contemporary approaches for improving patient satisfaction. The parameters of the central research question, reflecting the purpose of the study, is the exploration of the lived experiences and perceptions of the comprehensive, holistic, and changing nature of the projected contemporary nurse manager's role, skills, cross functional practices, and dimensions, that align with the newer dimensions, and expectations of increased patient satisfaction among selected nurse managers in seven acute care hospitals in New Jersey.

Chapter 4 entails a review of the pilot questions, sampling procedure, and data collection, analysis techniques, and description of the findings of the phenomenological study using the modified van Kaam approach by Moustakas (1994). Chapter 4 also includes early consistent themes and subthemes derived from the analysis of textural and

structural data to effort to gain an understanding of the holistic roles, skills, practices and functions of front line managers with new dimensions and expectations of improving patient satisfaction. Semi-structured and open-ended interview questions allowed the participants to describe their rich experiences and perceptions of nurse manager roles, skills, cross functional practices, and dimensions for improving higher expectations and regulatory requirements for patient satisfaction.

Demographic Data of Participants Based on Selected Hospitals

A supplemental demographic questionnaire enabled the collection regarding gender, position, department, years in position, scope of control, highest education level, and certifications, which reflected patterns among respondents (see Appendix Q). The demographic questionnaire also included questions regarding organizational characteristics such as hospital type, bed capacity, and presence of Magnet designations, shared governance, and patient centered care.

For the current study, publically available information on hospital mission vision was retrieved from the hospital website. Of the seven acute care not-for-profit hospitals participating in the study, five were community hospitals, two medical centers, and one of the community hospitals as part of a health system. Because participating hospitals differed in size, designations, affiliations, settings, status and locations, diversity and dispersed locations of the hospitals increased the reliability of the study by incorporating nurse managers and nurse leaders from different settings.

Hospitals participating in this study have a wide range of bed capacity that signifies the size of the institutions. One of the hospitals has less than 100 beds, one

other hospital has between 201-300 beds, 4 hospitals have the bed capacity between 301-400 and one large hospital has bed capacity greater than 500 beds.

Four of the seven participating hospital in the study have Magnet designations. The American Nurses Credentialing Center, a subsidiary of the American Nurses Association (ANA), designates Magnet status to hospital that meet excellence standards in quality patient care and nursing professional practice (ANCC, 2013). There are 24 Magnet designated hospitals in the state of New Jersey (ANCC, 2013).

Shared Governance in hospitals is a conceptual model of empowerment, and accountability with supporting structures for shared decision-making (Anthony, 2004; Porter O'Grady, 2001). All participants claim to have a formal and informal process of Shared Governance. Magnet designation hospitals require adoption of a formal model with structures and process for Shared Governance. All hospital participants responded positively to the survey question on adoption the patient centered model, however evidence of formal models is difficult to evaluate in any of the hospitals. One hospital formally adopted a model known as Relationship Based Care to help improve the delivery of quality nursing care.

The following tables (see Tables 3-6) provide specific demographic data on the sample of 21 study participants. Of the 21 participants, 18 were women and 3 were men. This demographic is closely related to the general gender distribution of males and females in the nursing management profession. According to the United States Census Bureau (2013) report, the proportion of registered male nurses in nursing profession has increased to 9.6% in 2011 from 2.7 % in 1970.

Of the 21 participants, 13 hold positions as front line nurse managers, five individuals have director titles but also have nurse managerial responsibility on the unit of control, two nurse leaders were vice presidents, one in a supervisory and performance improvement role and one Chief Nursing Officer (CNO). Many current organizations with lean management governance structures have nurse manager and director roles merging. They have direct responsibility for the health care personnel in patient care areas with assistant managers to assist the nurse manager/director with clinical operations. The demographic data for this study support current findings and literature review on decentralization of management with nurse managers absorbing many middle management and administrative roles. The study sample met the original proposal of at least 15 front line nurse managers and at least five participants as directors, supervisors, and chief nursing officers.

Table 3

Titles of Participants in the Health Care Organization

Leader Titles	Number of Participants
Nurse Manager	11
Directors/Nurse Managers	5
Supervisor/Performance Improvement	1
Director	1
Vice President	2
Chief Nursing Officer	1

The demographics of the study participants also include question on the specialty patient care areas in the hospital. Two participants in this study are nurse leaders and they are accountable for the nursing practice in multiple patient care areas of the hospital. Nurse leaders managing diverse and multiple departments offer a broad representation, diverse perspectives, and experiences for in-depth exploration of the phenomenon.

Table 4

Participants Working in Various Patient Care Areas of the Organization

Clinical Practice Department	Number of Participants
Nursing Practice	2
Geriatric/Psychiatry	2
Psychiatry	1
Medical Surgical	5
Inpatient Geriatric Unit	2
Acute Rehabilitation Unit	1
Maternity/Obstetrics/Infant Care	3
Perioperative Units	1
Emergency Room/Intensive Care	1
Critical Care/Progressive Care	2
Oncology	1

All of the nurse leaders in this study meet the study criteria for having at least one year experience in the current role. Many of the participants have varied years of employment experience in the current leadership role.

Table 5

Years of Experience in Current Role

Number of Years	Number of Participants
1-5 years	9
6-10 years	3
11-15 years	5
16-20 years	2
>20 years	2

Span of control is the number of employees that report to the nurse manager, directors, vice presidents, and chief nursing officer. Two of the participants in the executive role have the nursing division that reports to them. The direct reports for the executives have middle and front line management with direct span of control over front line nursing employees. The participant demographics support current practice among

health care organizations with lean governance structures and greater span of control due to downsizing and current financial conditions.

Table 6

Span of Control

Number of Employees	Number of Participants
0-20 employees	1
21-40 employees	2
41-60 employees	3
61-80 employees	6
81-100 employees	3
>100 employees	5

Highest degree earned among all the study participants for nurse managers, supervisors, directors, and CNO include the following: one participant has earned an associate degree, 11 participants have a bachelor's degree, eight participants have earned a masters degree, and one with a doctoral degree. The recommendations from the American College of Nurses recommend that nurse managers possess a bachelors degree or higher. The selective sampling of expert nurse managers who appear to excel at improving patient satisfaction currently have a bachelors degree or higher. Nine of the participants have certifications in various nursing specialties.

The publically available HCAHPS survey data scores for data period were retrieved from the Hospital Compare website from the Department of Health and Human Services. HCAHPS published on the Hospital Compare website indicate variances in patient satisfaction Six of the seven hospitals in the study participate in the HCAHPS program. The overall score included patients who gave their hospital a rating of 9 or 10 on a scale of 0 (lowest) to 10 (highest). Of the participating hospitals two hospitals

scored higher than national average on the overall score, and only one hospital performed better than the NJ average. The category of *Likelihood to Recommend* included patients who reported YES they would definitely recommend the hospital. Participating hospitals ranged from low 70's to 80's in the category of communication with nurses Domain. Hospitals that do well on domains such as communication with nurses, communication with physicians, responsiveness, and pain management also have comparatively higher scores on medication information, and cleanliness but not necessarily on quietness at night questions.

HCAHPS Question Domains include the following descriptors:

1. Patients who reported that their nurses *always* communicated well.
2. Patients who reported that their doctors *always* communicated well.
3. Patients who reported that they *always* received help as soon as they wanted.
4. Patients who reported that their pain was *always* well controlled.
5. Patients who reported that their bathroom were *always* clean.
6. Patients who reported that the area around their room was *always* quiet at night.
7. Patients who reported that they were given information about what to do during their recovery at home.

Overview of the Data Collection Process

Letters for permission to conduct study and access publically available data were sent in early 2012 to 36 CEO's of acute care hospitals in the state of New Jersey. The names and addresses of the CEO were gleaned from Directory of the American Hospital Association (AHA). Purposive sampling also entailed snowball-sampling technique to gain required selective sample size for the study. The New Jersey Hospital Association

(NJHA), a comprehensive network of healthcare organization in the state of New Jersey, sent out 50 letters to the chief nursing officers of acute care hospitals on behalf of the researcher.

By late April 2012, six health care organizations agreed to participate in the study using selected groups of employees, and several hospitals required University of Phoenix IRB approval before consenting to participate in the study. Three of the seven hospitals required submission of the research application for institution-specific IRB review requirements in order to approve recruitment of participants and collection of research data for the current study. The requirements from institutions also included submission of dissertation proposal and other supporting documents. One hospital required proof of National Institute of Health (NIH) research training certificate as part of approval process. The application process for many hospitals included internal departmental reviews by nursing, marketing, patient satisfaction, quality and performance improvement departments. Other stringent approval processes included institutional specific research application forms, follow up telephone interviews, face to face interviews with department heads, and presentation of proposal to institutional research committees.

After receiving approval from the University of Phoenix IRB and ARB board in December 2012, the researcher mailed letters to hospitals participating in the study to recruit participants meeting sample criteria (see Appendix L). The letters sent to Chief Nursing Officers (CNO) and Chief Executive Officers (CEO) of each hospital participating in the study, entailed a request for a list of participants meeting selective selection criteria. The 2011 and 2012 HCAHPS Survey and Press Ganey™ survey

patient satisfaction scores among selected acute care hospitals in New Jersey provided a basis for selecting nurse managers with high patient satisfaction scores.

The participants were at least 18 years and older, full time employee, and had at least one-year experience as a nurse manager of an inpatient unit. The criteria for immediate supervisors and Chief Nursing Officers (CNO) of nurse managers included at least one year in the current position, an understanding of the environmental contexts affecting organizational and patient satisfaction outcomes, and nurse manager issues and indicators for patient satisfaction. Based on sample selection criteria, hospital leadership provided 32 names of expert front line nurse managers, directors, supervisors, and chief nursing officers. The researcher e-mailed selective sample of individuals, requests to participate in the study with informed consent forms. Twenty one individuals consented to participate in the qualitative phenomenological study.

Pilot Test Results

The preliminary pilot test or mock interviews were essential to gain knowledge and feedback for the interview questions for use in the actual research study. The researcher conducted four pilot interviews in the same manner as the actual study and tested the semi-structured and open-ended questions for clarity, flow of questions, and any missing content (see Appendix M). At the end of the pilot test, each pilot test participant provided written and verbal feedback on each of the test questions and suggestions were incorporated into the actual study. The mock interviews were sent for transcription and transcribed interview sent to the pilot participants for review and approval, similar to the anticipated processes used for the actual study interviews.

The four mock interviews were critical in development of necessary skills and practice with conducting interviews and in the understanding of the process for conducting face-to-face interviews. The mock interview process was helpful in practicing *epoche* or bracketing presuppositions and prior understanding of the phenomenon and focusing on the phenomenon as described by the participants. The sub-questions assessed for researcher bias, and if prior understanding of the phenomenon might cloud, lead or limit the subjective descriptions of the participants.

The use of pilot interviews helped identify areas of in-depth exploration to gain insight into the research question. Pilot interviews were helpful to gain confidence in conducting interviews, develop the skill for listening, communication, and probing for further exploration and meaning of the phenomenon. The interview process was helpful in practicing the use of audio recording equipment, timing of the study, use of field observation notes, and any potential transcription issues. Feedback from the participant led to rewording some of the questions for improved participant interpretation and response. Two interview questions added, three interview questions deleted, and three interview questions re-arranged for better flow.

Researcher Epoche'

The application of the Epoche' known as mind mapping or phenomenological reduction before and during the interview, assisted in achieving a sense of naiveté and open mindedness about the phenomenon (Sokolowski, 2007). An iterative use of bracketing throughout the data collection, transcription, and analysis phase infused objectivity by minimizing influence on the in depth exploration of the holistic nurse manager role with improving patient satisfaction.

Data Analysis

Phenomenology is a study of the life world, by gaining a deeper understanding of the phenomenon, as it appears to be, rather than conceptualizing, categorizing, or theorizing the phenomenon (Moustakas, 1994; Van Manen, 1990). According to Moustakas (1994), Husserl proposed a descriptive phenomenological approach to scientific inquiry by understanding the essence of the meaning of the subjective lived experiences and perceptions. Twenty-one research participants provided rich and descriptive accounts of the lived experiences and perceptions of the holistic role of a front line nurse manager with new dimensions and expectations of patient satisfaction.

The intent of the data analysis was to identify and describe the themes from the transcribed interviews to derive the true nature of the phenomenon. Husserl described the process of ideation to mingle what appears in consciousness or reality with the object in nature or learned product to create meaning (as cited in Moustakas, 1994). The essence or meaning of the essence describes the true nature and the phenomenon behind the problem.

The Dequesne School or Empirical Phenomenological Research, operationalized by many psychologists including van Kaam, entailed a phenomenological approach involving a return to the experience of the phenomenon by participants to arrive at a structural statement through reflective analysis to the essence of the phenomenon (Ehrich, 2005; Moustakas, 1994). The empirical phenomenological approach uses a strict data collection and analysis process that relies on data from the participants for the purpose of examination and explication of the meaning of the essence of the lived experiences of the phenomenon (Ehrich, 2005).

For the current study, a modified van Kaam approach by Moustakas (1994) entailed a systematic process of arriving at the meaning of the essence of the phenomenon (Moustakas, 1994). The core processes of transcendental phenomenology included the Epoche', Phenomenological Reduction, and Imaginative variation. After Epoche' the process of Transcendental Phenomenological Reduction assisted the researcher to derive the textual description of the meaning of the essence of the phenomenon (Moustakas, 1994). Imaginative Variation also assisted in grasping the structural essence of the experience (Moustakas, 1994).

Manual review and NVIVO 10 software assisted in analysis of the transcribed interviews by applying the modified van Kaam approach by using the following steps:

1. Listing and preliminary grouping: The first step in data analysis if to list every expression and statement that contributes to the understanding of the essence of the phenomenon (Moustakas, 1994). In horizonlization each interview was scrutinized and every expression relevant to the research question coded under a node. The initial coding process involved coding according to research questions and sub-questions. Expressions relevant to the study emerged and were coded as free nodes.
2. Reduction and elimination: This iterative process began after initial coding by re-reading and re-examining each transcript for relevance to the research question. Irrelevant expressions that could not be abstracted and labeled were eliminated.
3. Invariant constituents or horizons are significant, unique, and relevant descriptions or qualities of the experience (Moustakas, 1994). Qualitative software NVIVO 10 assisted in the data analysis through assessing frequency of

words and patterns. The following Figure 2 represents word frequency analysis as the first of many processes in the software to arrive at the study meaning and themes.

Figure 2. Word frequency analysis.

Experiential themes begin to emerge as commonalities in the various descriptions (Van Manen, 1990). Review of coded tree and child nodes led to clustering of invariant constituents into eight core themes. The following Figure 3 is an example of the cluster analysis of tree and child nodes within the qualitative software to derive essential meanings and themes.

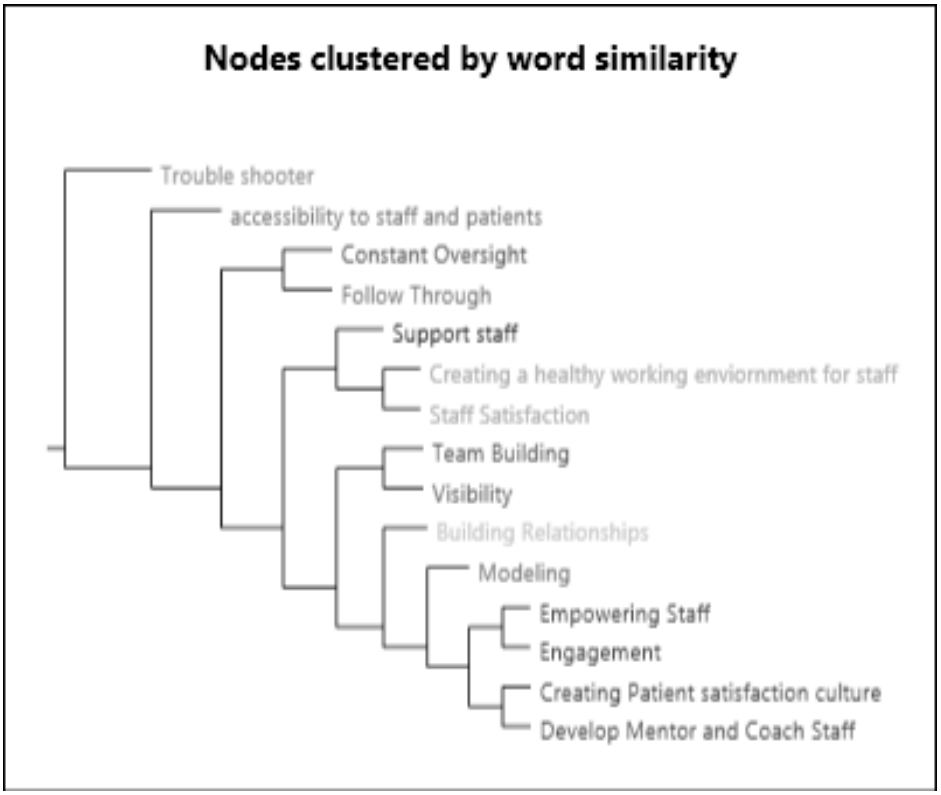

Figure 3. Example of analysis of clustered nodes for development of themes.

4. Each of the invariant constituents and themes were validated against the participant transcripts.
5. Textural descriptions resulted from themes and horizons of each participant's expressions. The textural descriptions of the participants provided supporting documentation for the core themes. The structural description for each of the participant was constructed. The individual structural description is the underlying dynamics of the experience, the themes, and qualities that account for how these thoughts and feelings are connected to the phenomenon (Moustakas, 1994). The structural description is an understanding of the underlying structures that account for experience as it is lived by the participant (Moustakas, 1994).

6. The invariant constituents and themes integrated for a textual-structural description for the meaning for the experience for each of the participant. The outcome of this approach was a general statement or a text that represented the essential structures of all of the specific lived experiences of the phenomenon.

Emerging Themes from Data Analysis

The modified van Kaam approach for qualitative data analysis as described in the above section resulted in nine major emergent themes from the interview data to explore the phenomenon of interest. Data coding, reduction and elimination of the 257 free nodes resulted in the following major 8 theme: (a) expectations for the nurse manager to improve patient satisfaction, (b) building a patient caring culture, (c) leader rounding, (d) creating a healthy working environment, (e) staff engagement and empowerment, (f) change agent- continuous quality improvement, (g) impact of organizational focus and culture, (h) challenges-sustainability; lack of interdepartmental and interdisciplinary teamwork.

Theme 1: Expectations for the Nurse Manager to Improve Patient Satisfaction

Theme 1 evolved from the findings of the study as currently existing in today's changing health care environment impacting health care organizations and particularly acute care hospitals. Theme 1 emerged from the central research question on the new dimensions, and expectations of increased patient satisfaction among acute care hospitals in New Jersey and sheds light on the new emerging phenomenon. Theme 1 provides the background and validates the research problem to understand the complex and evolving phenomenon. Theme 1 provides a foundation in the understanding of the rest of the themes through recollective experiences of the participants.

Health care organizations particularly acute care hospitals are under pressure to meet evolving customer and regulatory demands for high quality care. The Value Based Purchasing Program (VBP) under the Affordable Care Act 2010 administered by the Centers of Medicare and Medicaid (CMS) is driving force for better quality of care. VBP is payment methodology that rewards safe, quality, and efficient care through payment incentives and transparency of quality metrics including patient satisfaction measured through the Hospital Consumer Assessment of the Heath Care Providers and System Survey (HCAHPS). Leader 14 described her understanding of new changes in health care namely Value Based Purchasing with a simple yet powerful analogy.

> A simple answer to that, if I go to ShopRite or a CVS or any like Raymore and Flannigan Furniture store. If I want to get a sofa, and if there is a tear on the sofa, I would still take it probably to the person at the register and I say "I would want a discount because it is torn," and he might give me a discount or I would say, "Nah it is my new house, I do not want torn things, so I do not want it at all." That is the same way. We have to bring that to quality health care. If you are going to tell me as a CMS agent, let us say I am the CMS agent, you are going to tell me 40% is the best we could do. I am going to tell you then you keep the 40, I will keep the 60. That is what is happening. People are not getting it. You are providing a less than quality. You will get paid for a less than I have done, that is. That is very basic. You want the best, you want 100% reimbursement, give us 100% quality. That is it. That is Value-Based Purchasing. (Leader 14)

Many study participants in this study have expressed that changes in the health care environment is shifting the focus of health care leaders due the threat of financial

penalties (Leader 01, 07, 11, and 14). The following selected texts of nurse managers highlight the nature of regulatory changes impacting health care organizations to improve and enhance the patient experience.

> I think, years ago, they (Administration) talked it (Patient Satisfaction) about being a priority, but did not put much behind it. Whereas, now, administration has put a lot of effort, time, and money and people behind it, to drive it. Whereas, before, there wasn't a real good plan. I think it (Patient Satisfaction) was an afterthought, you had things to do instead, so that was put on the back burner, whereas, but now it is a priority. (Leader 01)
>
> I really feel that it is putting the patient, and a lot of people, obviously it is tied to money, so people always talk about the money, we are only doing this for the money, like each and every question is tied to money. I mean it is tied to the patient, and what has happened is- it has got the attention of administration to say that these things need to do get done, because it is going to affect our pockets. So, it give you more leeway; A: to get things that you need, you have new patient information boards, in the rooms the white boards are all new, designed very nicely. We have patient education pushed through the TV services. There is no doubt that since that drives HCAHPS that it will, help drive to get them done and that it brings that into attention. So the other thing I read is, staff do, what leaders are watching, so since they are watching this, this is what is getting done. (Leader 07)
>
> Now, CMS is much smarter than us and changed their route: "Focusing on task is not going to get you the payment anymore." So when they hit dollars and cents

now the organization started to think broadly, “Oh! That is not going to work, I cannot just finish my job and go, I want to change things around, to make it a quality, at least the time that I am here.” So, when that happened. Okay, then it was like first couple of years was, like okay, change the quality, change that, change this, but because there was no pressure was put on us or because no money was taken away from us, we still went with the task thinking “Oh! We are doing the right thing, we are doing all this initiative.” Even after the initiative, nothing happened. You know till CMS finally said 1% cut if you do not make 80% or higher that is when we definitely want to change. So the organization put together RBC (Relationship-Based Care), TCAB (Transforming Care at Bedside), which is I think is all great initiatives.

With the HCAHPS the most important now is reimbursement. Like I said before, we cannot deny the fact that these numbers are now representing our existence in this organization and the existence of the organization itself. So, I cannot stress it any more that the significance of it, I cannot stress it any more. So, now that I know it and now it is a constant communication within the organization. It is about money, money, money, money, money, so this is how we are going to be paid. We definitely want to let our staff to know. And I think I am more communicative to my staff about these numbers and how much these numbers means to our reimbursement. (Leader 14)

Consumers in today's health care environment are driving changes through new expectations and demands for better quality outcomes. Greater transparencies of quality metrics including patient satisfaction scores are drivers for customer choice. The

following selected excerpts from Leaders 12 and 15, provide insight into understanding of the impact of consumer driven health care choices on acute care hospitals facing increasing competition.

> I just say I do not think it is it was as much as it is currently, but may be 30 years ago, lot of people they would come into the bed, they would have surgery, they would be there for two-and-a-half weeks and then they go home. May be the environment is different. But at the end of the day we are providing a service, and if those patients are unhappy with our service you know they will go on to the community and they are going to say, "I was at (name of the hospital) and this did not really work for me, the food. I called on the call bell and it took 20 minutes for somebody to come." So if their needs have not been met, they are going to express that. There are a lot of choices (name of hospital) that is like 8, 9, 10 miles down the road and we have (name of another hospital) that is not far from here. So as a consumer I kind of go back, and it sound simplistic, but equated to when you go to a restaurant. If you do not get good service or the food is not that good, you have choices. You are going to go somewhere else and make it simplistic like that, because we are dealing with human beings but indirectly it is like that. And I think that we need to be able to build good relationships with patients learn from them, and we have to meet their expectations, so it is a business. (Leader 12)
>
> Because especially now a days, people are more educated. They look at the scores; they look at which hospital is good. If you do not have that rating up there! I always say and I preach to them (Staff) and I need to be able to practice it

that, if you do not have happy customers, you are going to go out. There would be no one you know to take care. Because especially now a days, people are more educated, they look at the scores, they look at which hospital is good. (Leader 15)

Faced with increasing pressure of providing value in the face of dwindling resources, leadership in health care organizations are now expecting the front line nurse manager to be responsible for the delivery of care that enhance patient experiences and ultimately patient satisfaction outcomes (Leader 01-20). The crux of Theme 1 is the new expectations and demands on nurse managers in today's changing health care environment to enhance the patient experience. Analysis of clustered nodes provide a basis for Theme 1 representing distinctive descriptions for the new nurse manager role and accountability to improve patient outcomes including patient satisfaction survey scores. All 21 participants in the study validated the importance, impact, and meaning of the changes in the health care environment in the context of the health care organization and the new holistic role of a nurse manager through their recollection of lived experiences. The following excerpts from Leader 09, 11, 12, and 15 provide insights that support the theme.

Because you are a nurse manager, it is your unit, as was I told I am a president and CEO of my unit. We have gotten our jobs threatened, "If you do not bring the scores up." (Leader 09)

And that is the part of their (nurse manager) expectations, and also part of their goals every year that they maintain certain level with their HCAHPS scores and their Press Ganey™ scores. It is part of the performance evaluation, so I think; it just is incorporated in the daily work. They (nurse managers) have to understand

what is important, what the organization is looking to do. They (nurse managers) have to be able to take the organizational strategic strategies and their goals and incorporate them into their own goals, so that they meet what is happening, and so they are not behind. (Leader 11)

They (nurse managers) are just as responsible as I. Yeah, and it is even the HCAHPS scores, as you have seen, we have tried to structure that and set incremental goals. With the HCAHPS scores and it is actually, it is on the performance evaluations also. So not only the shift supervisors, but also we are trying to get that down to the level the staff. So that everybody is queued into the process. (Leader 12)

Everybody else is trying hard and I will tell you, this organization, because it is a topic every day, if I say every day, it is not an exaggeration; we are spoken to all the time. That is the expectation and that becomes sometimes a challenge that makes you really feel down, because of your score. And that is (Patient Satisfaction Coordinator) has said, "Do not be so engaged with it, but focus on the things that what you can do, when your score is low, that should be a more challenge to you." (Leader 15)

Leader 17 described the new role of the nurse manager to transfer organizational expectations for service excellence to the front line staff by monitoring and evaluating employee behavior and patient satisfaction surveys.

I know from the past experience that we used to do, we use to educate our staff or employees in things like that about the importance of satisfaction. But lately in the past years, we had made that a part of their performance evaluation something

with the service excellence that has been incorporated. So they have to conduct themselves in certain way, and it is not something you know that they have an option on this, an expectation. So when we do their annual reviews, we assess to see how courteous they are, to their response to needs, and in the practical manner? Are they attentive, are they demonstrating those behaviors among co-workers? (Leader 17)

Nurse managers in this study expressed that changes in health care such as Value Based Purchasing, accountable care, and customer driven choices have enhanced their role and created meaning as a manager in influencing staff behaviors for a better patient experience. The following excerpts address the alignment of the expert nurse manager's drive, mission, and philosophy to provide high quality satisfied care with external forces mandating health care changes. Some study participants expressed that the changes in health care, even with its multiple complexities are a welcome change. Examples of the following excerpt from the transcript of Leaders 01, 02, 06, 12, 14, and 16 highlight their feeling and perceptions on the changing focus of the health care environment on the holistic role and responsibility of the nurse manager to provide high quality care.

Well I think people that are in health care are in it, because they truly want to be. It is, and we were proud of what we do, we want to help and I see this as a good focus. (Leader 02)

I understand it (Value Based Purchasing). I think it has the right outcomes in mind, because the reality is, there are so many things in health care today, still, that we probably do not do as well as we need to do them. In terms of getting positive outcomes and they are still medical errors and there is still -tons of people

die everyday from medical errors. I think that it is geared in the right direction. I think that, because it is one of these things that everybody is trying to do, but it has so many moving parts, even so much of it I feel is quite subjective. I think it makes it difficult sometimes, for us, you try to operationalize things. But at the end of the day if you do not get that right perception or because some of these things are so subjective, somebody walks away, and they are not always satisfied. Most of the time, they (patients) are satisfied. (Leader 12)

I would not call it (Value Based Purchasing) a barrier. It really, I would say it opened my eyes, if anything, and opened my staff's eyes towards quality care. Because it was always a talk, "Oh! We need to treat our patients nicely." Nicely was the word. Now it is elaborated to courtesy, to respect, to listen, to communicate. It is elaborated that niceness into much more in numbers that we are now reimbursed. So, yes it is a very, very significant part, patient's satisfaction for me. Enhanced as a result of this initiative that the CMS has given out. Definitely, it is never a barrier. It made me a better leader. I have to say I have a focus; I really have an aim on why I am here. (Leader 14)

Because this hospital, you know although it has always been part of the mission to provide really good patient satisfaction. It has become more intense because of the HCAHPS. The reimbursement issue, not that we do not care even more about that, caring, about our patients, but it is still there. On the other hand because of changes in medical managed care. That had kind of influenced some of the changes-compassion. (Leader 15)

Nurse leaders in health care organizations with already narrow financial margins and facing possibility of penalties through Value Based Purchasing program, addressed negative feelings about new expectations to improve patient satisfaction scores (Leaders 01, 03, 09, and 12). The ambiguous perceptions among nurse managers regarding health system changes are reflective of managing change in the health care industry. The following verbatim excerpts from study participant experiences underlines the complexity with mixed feeling and perceptions about health care changes and its effect on health care organizations.

> Well, we always did things, as nurses that are right, and that we are in adherence with our regulatory standards. I mean we are used to Joint Commission and the State, but now it is so financially driven, based on HCAHPS and our reimbursement- that it has really narrowed the focus in many respects. It is kind of is like all encompassing. You started the interview by asking what percentage of time and its like that is a large percentage of our time and ultimately it is because it is fiscally driven. I mean . . . being a nurse for longtime you always put the patient first, but now it is like a mandate, but you do that, which is in some ways is insulting to professionals. (Leader 06)

> I think to a certain degree with the economy and everything else that is going on. It is making it difficult for facilities, sometimes smaller facilities, to be able to, they cannot take it, that hit, of not getting the 1% or the 2% whatever they are going to end up. At some point deciphering too, taking those penalties. I think, it is not to say that we have to step away from it. (Leader 12)

Previous roles and responsibilities of nurse managers required a focus on daily operations and delivery of care through resource management. Leaders 20, and 21 in this study alluded to the multiple roles and responsibilities of the nurse manager including and not limited to; human resource management, budgeting, regulatory and safety compliance, ensuring patient safety, and coordinating various disciplines and departments to deliver quality care that is safe, and timely. The following verbatim excepts provide a glimpse for the holistic and comprehensive role of the nurse manager.

> I manage people. I think the dynamics of my job are, I can tell you, I have fiscal responsibilities, I have quality responsibilities. All of my direct, the people who report to me, they are people, so I am very involved with even if there are personal issues. I am now their person who helps them in those aspects. Some people need help on the outside as an employee you want them to be guided and supported. What else? I have a lot of responsibilities. Staffing, discipline, hiring and fire, there are a lot of dynamics to a manager. And middle management is like I said, I have five different groups of physicians that would come to me if there are issues. I have five different departments that I run, which all different skill mix and different regulations and different policies, that is another very significant part of my job, making sure they are all up-to-date. Is everything we are doing evidence based? And then, I have senior in leadership, you know, it is many different levels. (Leader 20)

> The nurse manager is great influence, because the same, I would say if that is the traditional way; is that it seems to be, the nurse managers are in charge of the unit. I like the triad model where doctor, quality, nurse manager, operations, quality,

patients, yes, but the same accountability to all the key members of the team. So that they take care of the unit, but right now where we are, and the traditional and more common model is that the nurse manager in-charge of the unit right? (Leader 21)

Participants in this study described the new role of the nurse manager is changing with expectations to change and enhance current processes and structures with greater focus on the outcomes of patient care. Leaders of organizations now rely on nurse managers to realize their expectations for improving patient outcomes such as patient satisfaction scores (Leader 01, 03, 05, 07, 09, 10, 11,12, 13, 15, 16, 19, 20, and 21). The following excerpts from selected interviews highlight the important and dynamic role of a nurse managers with expectations to improve patient satisfaction.

Well, they (nurse managers) are the leaders on that unit. I mean they set the pace. They show everybody else how to act and that is just way it is. So obviously they have to be important. (Leader 01)

Because from the nurse manager's perceptive, especially with the HCAHPS and Value Based Purchasing, I do not want to be the unit that is going to cost the hospital money. Okay, so you tried and it starts really, really do your best and have your staff do their best, and motivate, and engage your staff, so that the unit that lost us two points, I do not want to do that. (Leader 09)

100%. Yes, it is looked from our president's level. It is critically important to our single leaders that the patients are satisfied and the families are satisfied and we will never will have to answer to somebody above us something that we did not address, we want to make sure that we are addressing these issues and we

want letters of appreciation to go to our president our CEO, and VPs, yeah they all take it very seriously. (Leader 10)

I think it is still important to be as a manager. I am not saying is because I am a manager, but I think it is important that you have someone that would lead a team. I think the role of a manager is still vital no matter what direction we are going in where we are bounded by the HCAHPS scores. But I think for an organization to be successful, you have the key people, who are running it. I believe with the unit you are taking care of patients, you need that person to direct to do that coaching and directing staff. I do not see nurse managers role whether the title will go change or not, the job description is still there, to be able to really do direct people and manage. Someone has to be responsible to be able to be in charge of a unit, whether it is one or two. (Leader 15)

I think that it really is my responsibility for all of it, number #1. Because it is ultimately the buck stops here. So what I can say, I think that the most that I can control which is within my scope of practice here in the unit is the nurses. So it is call bells, it is pain, its explanation of medications, courtesy and respect, listening, communication. What I do with an overall. (Leader 16)

It is kind of tying in the expectations from the leaders, the expectations of our staff, the expectations of our families and everybody else. Who is, I kind of feel, like- I am in a role where I kind of have to absorb a little bit of everything. And then from there, trying to simulate what is important to everybody and, kind of, make sure that everybody are aligning with meeting everybody's needs. For leader or management, from the top, feels this is a priority, then I have to kind of

see, where we could blend then everybody else's vision too. So it is kind of connecting my staff's satisfaction, my patient's satisfaction or leader satisfaction so kind of blending downs and then out. (Leader 17)

Theme 1 emerged from the analysis of coding clusters of descriptive free nodes and child nodes as listed in Table 7. High frequencies of data sources and number of references signified a trend for the theme on new expectations of nurse manager to improve patient satisfaction.

Table 7

Coding Clusters with Data Frequency Patterns

Theme	Free Nodes	Number of Data Sources	Number of References
Theme 1: Expectations to Improve Patient Satisfaction	Perceptions on Transformation in healthcare	6	15
	Value Based Purchasing	16	45
	Patient Satisfaction Surveys	14	40
	Perspectives on Nursing	10	21
	Perspectives on Patient Satisfaction	21	74
	Perspectives on Nurse Managers and Patient Satisfaction	16	43
	Health care Organizations and Patient Satisfaction	13	28
	Organizational Goals	6	7
	Expectations of Patient Satisfaction	13	26
	New Manager Role	21	90

All 21 participants in this study described their lived experiences and perceptions of new health care changes, and expectations to improve patient satisfaction in the multiple free and child nodes. Theme 1 includes study participants description of their

experiences and perceptions of health care changes and resulting changes in the new nurse manager role and responsibility. The assessment of the expectations for improved patient satisfaction of nurse managers provided the foundational understanding of the following new emergent Themes 2-8.

Theme 2: Holistic Nurse Manager Role: Building a Patient Caring Culture

The patient satisfaction surveys provide information that health care organizations need to do a better job in meeting patient's expectations. Some nurse managers were aghast to find a variance between clinical quality metrics and patients perception of satisfied care (Leader 01). This assumption by many nurse managers supports previous studies on differences in the perceptions of patients and nurses on satisfaction of care.

> It was alarming to me because I wrote the Magnet document. It was alarming to me that that our scores reflected, that patients that the skill of our nurses was like 40%, any unlike, wow, I mean that was like an eye-opener for me. Like this is really horrible. I know we have skilled nurses. So, something is not coming across that, you were not communicating, their skill to them or patients do not know whether they have skilled nurses or they do not have a skilled nurse. It is something they are reacting to something and they are interpreting that to be a low skill level, so it is probably rudeness or I do not what it is. But we are got to find out. Just because I was appalled. I mean I am taking an honest personal project just because I was so appalled that there are numbers that it did not make sense to me. So, I am not sure what works. (Leader 01)

Leader 14 in this study expressed disappointment in the underlying loss of a culture of caring within the context of the professional nursing values, and health care organization's vision and mission to deliver high quality, caring, and compassionate care.

> It is unfortunate somebody have to tell us what to do. This should have been a piece a cake for us, caring is in nursing. It is not something that you buy. It is not something that you create. It is who you are. It is who you are as a person. When you care for patients who are now completely sick in front of you, who are debilitated if you cannot talk to them in a caring way, forget nurse, you are not a person, you are not a human being, you need to be in touch inner core and see where you stand, where do you want to be, do you want to be in that bed and somebody who is rude treating you, put yourself in that situation, so anyway with all this initiative, I am grateful. And it is unfortunate that our organization as huge as this had to purchase this million dollar initiative and teach to the staff. When if you really read into it, it is very basic. We now spent a million dollar to learn the basic steps. We spent million dollars to walk. If those are basic you just naturally do it. It is not you do not need to sit in a classroom and learn how to walk. If you have two legs and have the energy to walk get up and walk. That is just it should not be thought about, but unfortunately, our health care system not just this organization, the entire health care system was going towards a trend of focusing on the task. (Leader 14)

Some study participants articulated that health care employees in organizations get very task driven with focus on clinical indicators, often forgetting to integrate the interpersonal aspects of caring and compassion when interacting with patients.

Everybody gets compartmentalized . . . the gall bladder down the hall, we forgot about that, he has got a family, he has got to support people. He does not have health insurance, he does not know how he is going to pay his bill, and he does not know who is taking care of his family, while he is laid up. There are issues, there are so many things.

I do not know I think we get to the point where this should never happen, but we get annoyed with the patients, they are annoyed with their families, I mean "They are pestering us, we cannot get our work done because we are doing some busy work," instead of looking up putting down your pen, saying, "Okay, what you want to know," sometimes you just the really easy question, just takes three minutes of your time to make them go away, I mean if you are giving them an answer, they are not going to come every three seconds, people do not want to bother you. They just want to know- information, and I think we get to the point where they are bothering us, because we have to finish this charting, we have to finish, we forget, what we are there for. (Leader 01)

We get that task driven. Through the curtain, "Do you need anything?" Get a half job. Get the whole connection. And it is developing those relationships. You care for each other. You can care for the patient. (Leader 13)

Study participants attributed issues to the clinical focused training received by nurses and physician. According to Leader 12 focus on clinical information within learning and practice environments, often supersedes building interpersonal relationship with patients and customers.

Yeah. It is not that it is hard to understand. I think, recognizing that, nurses that were taught 20 to 30 years ago, and even myself, when I came out of school there was nothing really tied. I have not been in this for million years but there is nothing really tied into this, satisfaction pieces of it. I think when it comes down to medical training, nursing training, or things like that, it is really get us taking care of the patient what are the clinical things you have to look at and those types of things. I do not think it is really built into people who are providing care, the customer piece. And I think, we get so inherently tied into what we are doing, that these very simplistic things like looking up, if you are the secretary, or you are the nurse and you have been sitting there on the computer and if somebody comes to the counter. These are the basic human things that you need to acknowledge a person.

If you kind of see the guy, at the corner of your eye and you continue to type, I mean it seems simple enough, but that is going to be a negative experience for that family member or the patient whatever it is. So, I think sometimes we are so deep into like what our process is or what we are trying to get accomplished or what task we are trying to do, that we have never really had to think about how the person was going to perceive it. (Leader 12)

Leader 12 felt that fundamental changes are needed to change hospital cultures, to seek patient perspectives, and have more open communication combined with providing good clinical care.

I do know, I just think sometimes you are so built around, I got to follow this algorithm in order to get this done, but like you are going in there provide

medications, you can have a conversation with the patient. You talk about anything, I tell staff all the time. Like- look around and we have a magazine about hunting. You may not know anything about hunting, but you could spark a conversation with them about that and then engage the patient into what you are doing or not doing. You have to involve the patient more in the care. It is not we are doing it to them. We need to explain what we are doing to them, educate them on what we are doing to them, then all the basic courtesy type things and meeting their needs and their expectations those can all be part of the clinical piece. It is just something that we have not been built like that. (Leader 12)

Nurse managers with high patient satisfaction scores are building and sustaining new patient centered culture by closely aligning follower ideals and values to core organizational and professional values.

But we have to get back little bit to the basics. Sometimes I almost think if that maybe a hospital that had moderate scores in quality indicators and high on this (patient satisfaction) might be more successful, than a hospital who has incredible clinical scores, but forgets this big piece. I say it is either equal, or almost. I maybe rare, and who will say this, the emotional piece may be even slightly more important than the clinical. So it is changing our focus, not just in general or society, we need to take a look. And move away slightly from the technology side we are developing so fast in the world. Technology, but we are losing the human component here. That is clearly evident in the scores that we have, and again what we are trying to do we want to fix the scores with computer stuff. We want audit tools, we want action plans.

> In the 1800s with Florence Nightingale- she did not have an action plan and her group that she brought together did not create PI projects. But they based, what they did with the limited clinical expertise that even allow to have, on a nursing model of caring, caring! So that is what my argument is, that is what I want to see us move slightly back to . . . I am a techno nerd. I love computers, I love growth, I love it. But we have to maintain a healthy balance. And I do think we do that well in our hospitals right now. I think that we are going to continue to struggle with this issue until we find a balance. (Leader 08)

Nurse managers participating in this study and at various stages of their journey had to rebuild a more caring culture centered on the health care organization's philosophy, mission, and vision.

> We did lose it for a while. I think we did. I think it is good they were going back to that as the way we deliver care; it is about the patient. It should have always been about the patient. (Leader 19)

Figure 4 is a representation of the participants articulating lived experiences with creating a patient caring culture in their departments.

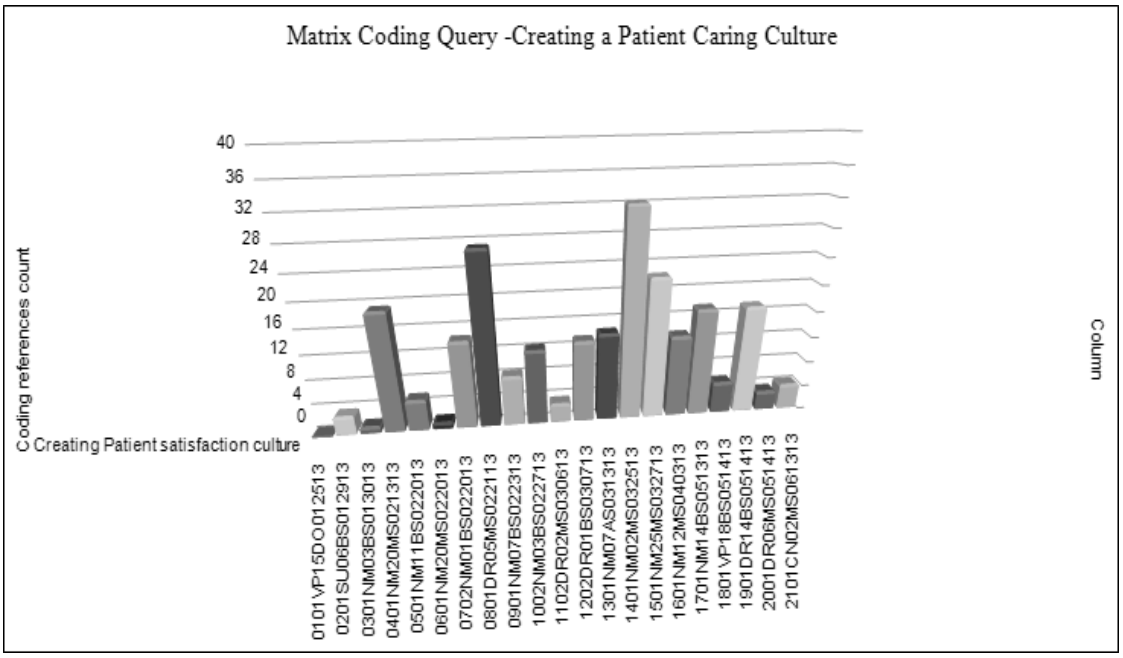

Figure 4. Matrix coding query: Creating a patient caring culture.

The following verbatim excerpt from Leader 08 highlights a need for change in the organizational or department culture to meet expectations and demands to improve patient satisfaction. The following selection of the verbatim excerpt of Leader 08 represents the nature of change management at the micro level of the inpatient hospital department. Leader 08 experiences recounts remodeling of staff culture to align with the vision for providing caring, respectful, and dignified care to patients and family members. This selection contains Leader 08's philosophy in creating and molding new cultures and provides a foundational understanding for Theme 2.

> I want this to become second nature, and create a culture of caring that is not forced and we are not doing because the manager or the director or the CNO said so, we are doing it because we want to be good human beings. Can I mandate a change? Yes. But again, when you mandate things you will get immediate

change. So I may raise my scores for a quarter or two quarters, but those changes are short-term if people do not understand the why. If they do not have the emotional buy in, change does not last. So then I am going to have to do continue cycling, cycling, cycling to ensure that I have change instead of may be going at a slower pace, making them understand why we need to do what we do having them grow emotionally. Become more empathetic and sympathetic with their patients, so that they will drive their own change and it will come from within, and I will be able to step back. I would not have to constantly monitor, audit, check, and discuss. It will just turn out to be, (my goal) is it will just be how we do business. It will be great and this is how you see runs, this is what is expected and they will please each other and they will take pride in knowing that they are group, work cohesively. And all have the same values, and those that don't will probably end up moving out because of the discomfort. I am hoping that they are going to build that and just change it themselves with guidance. I am definitely trying to help them guide, that is just my goal and then that is when I know I can retire that I have made a difference. I am going to have 175 employees, but if you can change even half of that then I have done a good job and they have done a good job. (Leader 08)

Nurse managers demonstrating success with high patient satisfaction survey scores, were able to meet these expectations mentioned in Theme 1, through change management, Nurse managers aligned their philosophy, values, roles, responsibilities, functions, and practices to realize organizational goals for improved patient satisfaction. Nurse managers in this study articulated a firm foundational philosophy and passion for

patient satisfaction and customer orientation. Nurse managers considered experts by their respective organizations expressed their passion, philosophy, drive, and ownership to improve patient satisfaction as necessary elements for their success (Leaders 04, 07, 08, 10, 13, 14, 17, 19, and 20). The following Figure 5 represents the number of participants with corresponding number of references who recount their reflections of a patient centered philosophy.

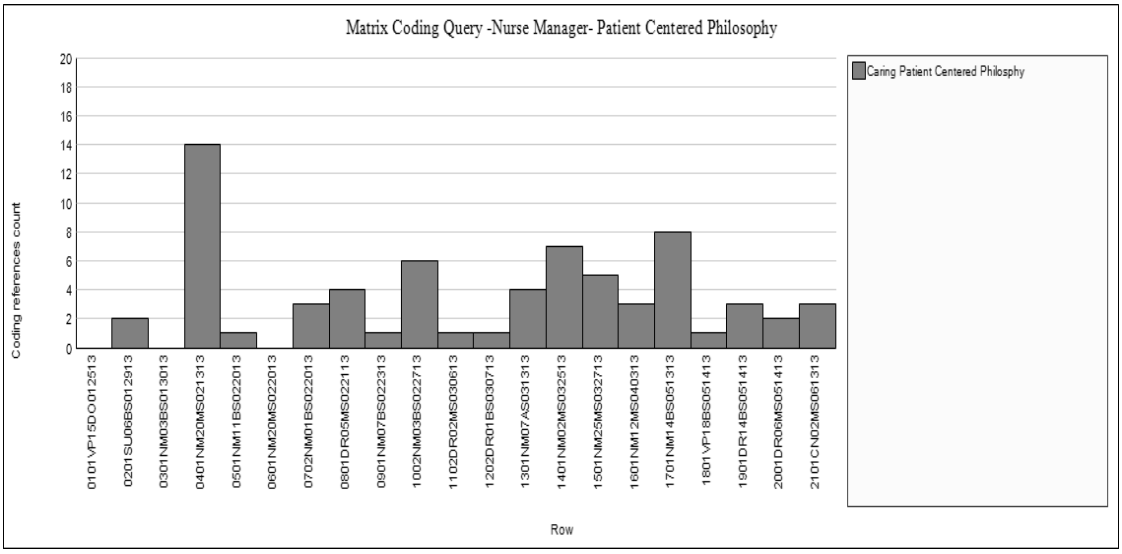

Figure 5. Matrix coding query: Patient centered philosophy.

The selected verbatim excerpts from the nurse managers represent the clusters of meanings and expressions into this core theme

> Leader 04: I mean I own it 24 x 7 that who I am that is what… I live breathe it. I pull my surveys from home, on the weekend before even I get here.
>
> Leader 07: Again I feel I am here . . . my only goal, my main goal, and my mission, is to make sure that the patient still gets the good patient care.
>
> I think it kind of fits into my style, who I was, even before I came here, and why I got into this business. I think maybe I was a good fit for this job because I was

always focused on keeping the patients and families happy and that was one of my strengths. And I came here and I am doing the same thing here on an inpatient basis and welcome having a family meetings and see what I could do using my experience to help them, get the need, get through the whole experience with the positive feeling at the end. (Leader 10)

For me specifically, I mean at the end of the day, I want to make sure, it is a whole reason why I got nursing. I want to make sure that the patient has a positive outcome. But the reality is also for somebody who gets that you know 30,000 feet view sometimes. It is not only a business, but it is very much a customer driven environment. May be it was not like that, even I have been a nurse 13 years. (Leader 12)

The demands on what they have to do now versus, what they had to do then, are completely different, and the focus is switched. We are not in health care to serve people. We are in the people business giving them health care. (Leader 13)

The patient is always been my focus and any of the care even before I became a manager. I always believe in that old restaurant theory. You are not going to go back to some places you have bad service; I mean I do not do it now. So it is not a difficult concept to get. Value Based Purchasing, it makes sense. The patients they are the consumer. And I have kind of based that all along in my philosophy in the delivery of care. (Leader 19)

Excerpts of Leaders 07 and 08 provide a glimpse of the visionary attributes and capabilities for managing change.

Leader 07: You have to have a vision because if you do not have a vision, you are blind. Where the heck are we going? So all of that stuff while it seems like a little bit of like sometimes, they can come in just reading, and in a philosophical world. Really makes a difference. (Leader 07)

I have a vision, I know where I want to be, and I do have some concrete steps what I am trying to do. And I see baby steps of improvement. But in my opinion it is a very important area that needs to be worked on. (Leader 08)

Leaders 10 and 17 found their role intrinsically rewarding, as they were able to fulfill their vision and purpose by seeing better patient outcomes.

You have to have it (passion for patients), I think, or else you cannot do it every day because it is if you think about only the negatives, and the stressful times it will drive you out of the line of work. And having the right personality has helped me in being able to leave work at work, and enjoying the satisfaction I get of having those at directions that I do with the patient. (Leader 10)

Because, there is no better big reward, I have to say than to see that somebody that came here, not what knowing you expect, and at the end it feels like, there is a purpose for them being here and that they, benefited from it. Mental health is a very complex field to work in, and emotionally it, could be very distressing for the family. But if we know that there is something we could do to help them, relieve that stressor, to relieve that fear, that tension, ultimately, that is the best reward ever.

Do I think and I have seen that at the end, it motivates to continue to do, because we know it works. We know that there are times when family members

might come in such a distress, they have absolutely no faith, no belief in anything, that somebody is going to get better, and the trust with treatment.

We just discharged a patient that had struggled for a while for years and we stabilized her. So much so, that her daughter wrote a letter back saying, "I wish that I would had found you guys thirty years ago. Because I feel like, I finally have my mother back." And her mother is older now. "But I never knew my mother- this nice, this stable, in all my life." So, knowing that, we do make a difference, it is important and it motivates us also. Yeah, it is nice thing, it is, it is I tell you, yeah. (Leader 17)

Most of the nurse leaders have a patient caring philosophy and convey it to their followers to impact satisfaction outcomes. Nurse managers (Leader 08, 09, 13, 17, and 19) in this study described their lived experiences in creating an alignment with organization mission and patient caring philosophy to the staff by articulating a clear vision, expectations, goals, and objectives. The following excerpts from Leader 17 and 19 are examples of the resonating theme.

Regardless of where we are, it kind of brings you to the fact that if it was not for our patients, we would not be here. And ultimately, we kind of have to adopt ourselves a lot. What we do to make sure that we are meeting their needs. So things change so fast, but at the end of the day- it is them.

What matters and they are the ones who are here for a reason. And it is our responsibility to attend to them so with that whole saying that "they are our customers." And they are regardless of how we are, we have to make sure at the

end of the day they are our priority at all times, there is no other way around it. (Leader 17)

I think our whole approach was, it is "all about the patient." That was the approach we took with the staff. That whatever we were doing, "Is it in the best interest of the patient?" So even when we started doing the door-to-physician time, the staff was like, "You know, can't they sit out there for a little longer?" "What would be the best interest of the patient, what would be the best thing for that patient? Because if it was your mother or father sitting out in the lobby, what would be the best thing for them?" "Well to get them to the doctor!" "So then, every patient is your mother or your father, you should be moving that patient to the doctor." So us, as managers that was how we had to change the culture of the staff in thinking that, we are there for the patient not the patient is here for us and that was the approach that we took. That every patient is treated like their family member which is says when you go in to say good morning to somebody you go in and you say "Good morning, how you are doing?" You have to smile on your face that is what; if you were going to say good morning to your family would you go in grouchy, no you would go in with a smile on your face. Every patient has to be treated like they are your family and I think that is, the staff just kind of adopted it.

You treating that patient, like it is your family member and if you do not, they are going to tell you. That is the kind what I have been doing for a long time. So, I think it is the way to go. It is a business. And you know I know that sometimes the patient's, staff is like, "We are not a business. We take care of the

patients." And I say "Yeah I know it is. It is a business and the patients expect to be cared for, so if you are not taking care of them, they are going to tell you." (Leader 19)

Leaders 04, 05, 08, 09, and 17 understand the importance of their leadership capabilities by impressing on the followers expectation of high patient satisfaction. The following Figure 6 is a representation of a coding query in the qualitative NVIVO 10 software with participants who clearly articulated a drive for excellence.

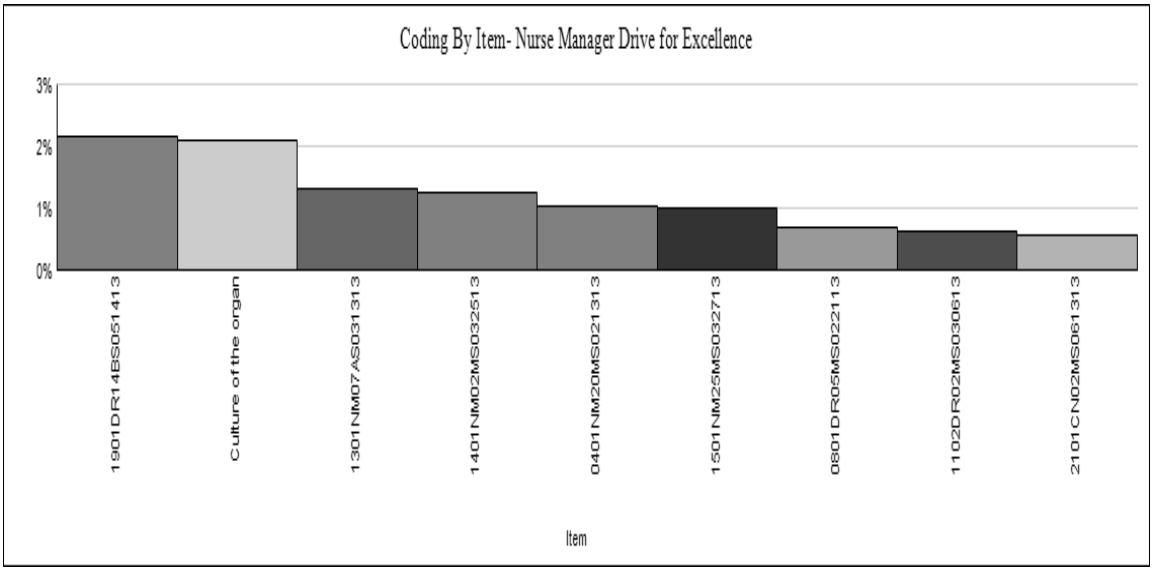

Figure 6. Coding query: Nurse manager drive for excellence.

Nurse managers in the study were able to articulate that vision by setting clear expectations, goals, and objectives for a more caring culture.

Leader 04: And what your tolerance level is, you would not tolerate something, because that is reality, what somebody else may put up that, I do not put up with. Everybody needs to be pleasant, everybody needs to be respectful with patients and the customers. The customers are not only the patients in the bed, but the family at the bedside. It is the department that you are calling when you need

something. It is everybody; it is internal or external customers. Everybody needs something from everybody in order to be able to make the patient have a good hospital experience. (Leader 04)

You have to let your staff know your expectations and hold them to it. If there is bad behavior for any reason or any inappropriate behavior towards a patient it is never acceptable and we actually have them sign contract for "Always" behaviors. When HCAHPS came out and we had all of our staff sign a contract that they will always be courteous to every body in the building not only patients, at least, that they know what our expectation is. (Leader 05)

Leader 17: It is my responsibility as a manager to address them and to kind of let them know why certain things are expected to be done, in the correct way. Because if the impact of not doing something right at the beginning could snowball into something else. So setting the expectations for the staff to know what I expect of them, and what, and why. (Leader 17)

Nurse manager's new holistic role is to translate organizational expectations for improving patient satisfaction to the staff by communicating a clear vision to build a caring culture.

Well. I would say that every institution has goals set, so and being a manager, I am very goal driven. So if someone tells me, I want you to be the best ED, I am going to do that. So I think, setting the goals and what the expectation is, which is what I am very clear with my staff, I have very clear expectations. If they make an error, it is because, I was not clear in what I expected of them. So I think they (organization) are having clear expectations, and where they want your goals to

be, where they want you in Press Ganey™ is probably very helpful, because then, you know what they want, what the expectation is. (Leader 19)

Nurse managers in this study are goal oriented and articulated their vision to their followers through their words and actions thus translating their vision for high patient satisfaction in every staff-patient interaction. The underlying qualities of commitment, consistency and diligence to the vision were manifested in some nurse manager's experiences.

> We had a situation years ago, where the patient tray did not come up; they called down to dietary and it did not come up. Dietary did not bring the tray and what I had heard about the patient complaint; it had been the patient was waiting three hours for the tray. I had find the nurse in the lounge eating her lunch, to talk to her about this situation. And I told her, I said, "I do not want you going on a break without this patient having her tray." And I do not care if dietary has a hard time then, if they did not come up it, then what we think as a reasonable amount of time -20 minutes, half-an-hour, that is something we agreed upon with dietary, that if the patient called down, we did get that tray to them. If it is not here within 20 minutes, half-an-hour, I am going to call down to the supervisor and we are going to say that, "Make new turkey sandwich with no mayonnaise." You go down and get it. Because that is what the patient needs for her experience. I will deal with dietary later, but the patient experience- she needs to be fed, she needs to be pain free, she needs have the information, and you know this is the patient, we own the patient experience. I will deal with the departments as those breakdowns come.

So, I think if we can get the house, or others to kind of get that. And I think some of it is there; it just how do we get that first step. I think there is an awareness of it. They all get it; it is just how do you put it into practice. And that if I can help them, and I will be at the bedside and turn the patient. "You know what we just had three discharges and Mr. Jones is waiting in the ER. Let's go out and meet him before he comes up." If I want to be able to give them one thing that is unique about the patient, that I might not know because we are the favorite football team like high school, what is it? And how do we get them a one WOW. Let's do one WOW for every patient. They know it, the patients. We need to operationalize it. (Leader 13)

Leaders 08, 12, 15 recollected their experiences and reflected on the their leadership capabilities as authentic leaders, inspiring followers to emulate caring and authentic behaviors.

I think it is also the leadership around here I think we are authentic. You are watching you are boss, you want see is she authentic, is she, you know, do they really mean what they say or that is just a silly little speech that she gives at the staff meeting and then she goes home and bad mouths everybody. (Leader 08)

Leader 12 stated "Visibility, sincerity, open communication for families, patients, and staff members. It is about the biggest part of it".

I think you have to that attribute -the caring, if you want to advertise, or you want your staff to be cared in then you need to be able to demonstrate that it has to come from you from within. It is not something that you do it because it is needed for the job, it is a passion. I would say it is a passion that you have to do –

> commitment, commitment you have to be committed on what you do, I aspire for good outcomes and although there are some negative outcomes sometimes, but I could not see those as a challenge. (Leader 15)

Nurse managers with caring patient centered philosophy are intrinsically motivated and drawn to the health care profession and influence followers (Leaders 03, 04, 05, 08, 09, 10, 11, 12, 14, 15, 16, 17, 19, 20, and 21). Successful nurse managers influenced followers by leading by example to provide excellent high quality care. The intentional modeling of the caring philosophy is essential to convey the importance of achieving high patient satisfaction. Nurse managers with high patient satisfaction scores in their organizations are visible to the staff and patients to convey the importance of patient satisfaction. The following excerpts of Leaders 10, 11, 16, and 17 exemplify nurse managers' demonstration of a patient centered philosophy through interactions with patients and staff members.

> I guess it's a critical role. We set the example for the staff. Modeling, showing how I would want them to interact with the patients when I go into see my charge nurse every morning, there is always an opportunity to talk to the patients, say hello, model an interaction in front of the staff and I have done a lot of that with them and I think that has helped them to understand how I want them to interact with the patients and hopefully which would lead to let them being more satisfied being here, with the patients understanding your patients and what brought them here and where they are in their illness. So it is a lot of modeling and it is what I have done showing them how I would do things by doing it, we are not just telling them how to do it. (Leader 10)

It has to be an example at the top. There has to be people that set those expectations and set the goals and set the marks. And they have to be able to perform in that way in order for anybody else to be the same way. So, you have to lead by example, and if you do not lead by example they are never going to pick it up, they are never going to understand. They are going to say you are telling us do this, but we are doing something totally different. So it has to be altogether. Everybody has to be together in it. I think, you know when you lead by example and that is probably the biggest piece in terms of influencing. (Leader 11)

I think role modeling, building relationships with patients, is probably one big ones. It was for me to go into the patient's room and become very friendly with the patient and have them ask for me, it shows the staff that there is relationship building there, and it think that they know that it is serious business. It is not just, if I am willing to walk my talk, that they are to do the same thing. (Leader 16)

You have to demonstrate that you care, and you believe in the fact that satisfying like your patients and families, it is what we are here for. And so first and foremost I have to believe in it and I do believe it you know to make sure that how important it is for us to continue to have more patients come back, if they are satisfied. (Leader 17)

Building a Patient Caring Culture emerged as major theme from the clusters of related horizons or meanings. Theme 2 emerged from the descriptive names and coding clusters of free tree and child nodes listed below in Table 8. High frequencies of references as well as meaningful references indicate a trend for clustering the data.

Table 8

Theme 2: Coding Clusters with Data Frequency Patterns

Theme	Free Nodes	Number of Data Sources	Number of References
Theme 2: Building Patient Caring Culture	Describe Experiences to Improve Patient Satisfaction	21	144
	Caring Patient Centered Philosophy	21	79
	Drive for Excellence	9	12
	Goal Oriented	13	26
	Setting Expectations	15	40
	Creating a Culture of Caring	16	248
	Story Telling	7	12
	Modeling	19	49

Theme 3: Nurse Manager Functions to Improve Patient Satisfaction: Leader Rounding

Hospital leadership expects nurse managers to be visible and accessible to patients and family members to solicit and address any concerns (Leaders 01, 11, and 21). The previous nurse manager function is shifting from the management of staff and clinical practice to improving patient satisfaction outcomes. The new function and has taken priority with these subset of nurse managers to meet the organizational goals. Nurse managers in this study believe that rounding behaviors and functions have contributed to their improvement in patient satisfaction scores. Figure 7 represents the results of the matrix-coding query in the qualitative software, depicting the references of participants who recount their experiences with leader rounding.

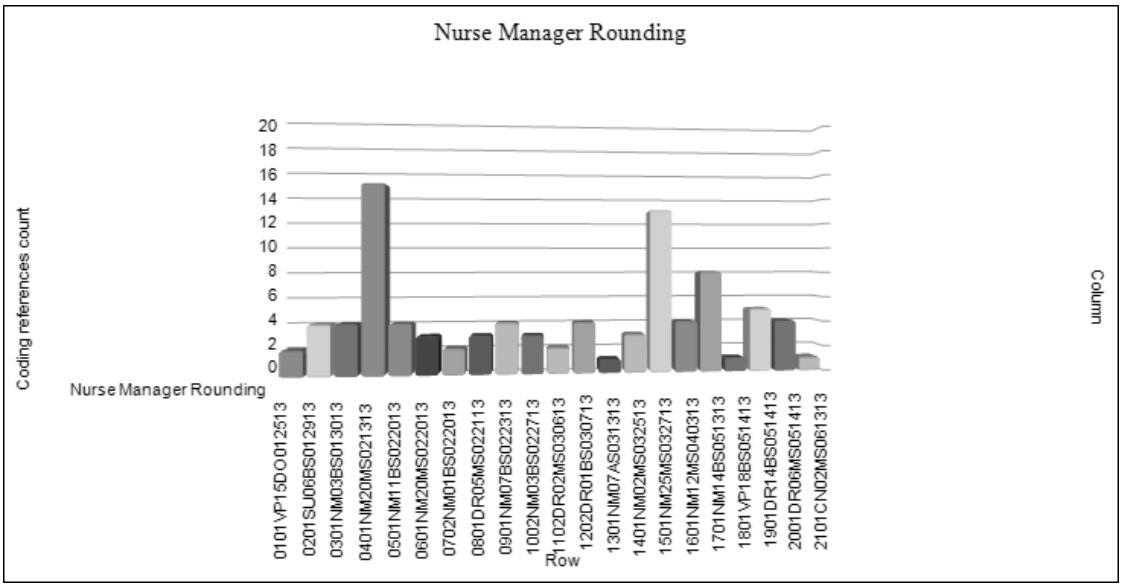

Figure 7. Matrix coding query: Leader rounding.

The following example highlights the organization's new expectation of the nurse manager do perform leadership rounding.

> It is the expectation that they get into the room and they round on their patients, that way they are out there in touch with what is going on, on the floor, listening to the nurses concerns, may be the physicians concerns are of where the barriers are, that are not accepting them to get the best care that they want to give.
>
> Well I think that they need to be not so much in their offices, but out on their unit, seeing what is happening and really trying to identify the barriers that they are seeing. And then, creative thinking- out of the box. "How do we fix them?" It takes them away from some other things that they wanted to do, yet most of your manager still going to be out their with the patient. So I think it pushes them out there again, and really to touch base with those patients and really see things are happening, be able to control their environment a little bit

more, but they do worry about this other stuff while we are here, but sits here on the desk. (Leader 11)

Some of the previous administrative and clerical nurse manager responsibilities and functions such as attending meetings, staffing, and payroll have taken a back seat to the new focus on improving patient satisfaction scores.

Leader 01: They (nurse managers) are very, very busy. We put a lot on them, we really do. But this is, still they got to learn how to do this (nurse manager rounding) and do other things too. Hopefully we are taking all this baloney stuff off of their back so that they can spend quality time with the patient. Every one is doing busy work. I know there is a lot of other things, but if we give them enough help you should not have to worry about it. There was always going to be some patient care issue that arises and is going to take over for the time. Most of their time has got to be devoted to going into those rooms, seeing those patients, talking to them, evaluating them themselves. (Leader 01)

Absolutely, I do not have as much time as I would like but I look at issues on the unit, incident reports (medication errors) and do that and get in to see the patients. I focus on that. I would say things like budgeting have taken a backseat for me. Is that good? I do not know. But I think that the budgeting piece has taken the backseat. Staffing has been handed off, so I am not as involved in that. Just having that time I want to spend out in the middle of the nurses station and may be even collaboration with physicians has gone a little bit off for me because I am spending more time in the patient rooms. (Leader 05)

Leader 16 articulated her leadership style as a servant leader to influence staff with authentic, caring, and service attributes.

> I do not know if this is too general. I mean I really believe in servant leadership. I believe that I am a servant leader. I think that to really be able to listen to the staff and see what the issues are. To really come from a place of empathy and compassion is. But I mean I think that is one of the attributes that are like- super important. I think without the ability to do that, to just proceed because, of what you think is right and what your perception is without really understanding the perception of others. It is I do not know that you are going to get buy-in and for whatever projects your changes you are going to make. (Leader 16)

Nurse managers in this study solicit patient feedback, seek patient perceptions, addresses any patient or family concerns in real time, allow for service recovery, and implement strategies to meet their expectations (Leaders 02, 17).

> What definitely going to each patient in the morning seeing them and talking to them you know, like my PI work to make sure that you know they are getting what they want that their expectations are being met, and again just supervising them seeing that they are safe. Safety of course is the primary as always number one. Their environment to say the environment is comfortable, is it peaceful at night? And they are able to sleep or they warm, are they too warm, are they cold so I will try my best to do it that they are pleased with having to be here, I mean hospitals are not happy places. (Leader 02)

Participants described rounding on the patients and family members helped them focus on issues surrounding the HCAHPS survey questions to seek feedback and provide

an opportunity for service recovery. The following excerpt is one example of the participant's recollection of her experience with leader rounding and perceived benefits.

> And I round on patients real time, I address HCAHPS questions real time, fix the issues real time, but earlier today, my rounds on patients, I asked them about their experience, "Are we keeping you comfortable? How do you feel the nurses are communicating your medications? Do you feel they were adequately communicating with you? Is there anything that I could do for you while I am here?" I am being able to solicit those kind of open ended questions as well, but if there is any inkling, that they may not score this as an Always, but I can make the difference real time on the floor, so that they (patients) can leave here basically complete. You are soliciting the feedback, because you want to make sure that you are getting the Always and it is.
>
> "So if there was any one thing that I could change well for the day, or if there is any one thing that we can improve, what would it be?" Again the open ended question try to solicit some sort of a response because again, you are never perfect and you are always looking, because what they may be afraid to say, they may say if you propose the question like that, because somebody else may have the same issue. (Leader 04)
>
> So from the manager side, the things that I am finding most informative for me is, talking to the patients. So, since HCAHPS is based on the patient experience, they (patients) are the ones who are going to be able to give me the most information. Really does not matter what everybody else thinks, and what I tell my staff is, "It do not matter, It's what they say, and it is an "ALWAYS"

question. So we have to figure out why these people are not saying always, what are the things we should be doing to say always.

So contact and communication with the patients is probably the best source of the information. I can get to see what is going on with my staff and their interactions with them. I am not really sure, that the information I get from the patients would not correlate necessarily with the data; it is a very interesting thing. (Leader 07)

According to some nurse managers, leader rounding entailed a considerable amount of time and energy.

I am going to say it takes up about 60% of my day. I mean I can give you my schedule. I come in the morning, the first thing I do is check and make sure emails there is nothing urgent that is going on okay. There may be something in there patient satisfaction wise the patient is not happy with the room, not happy with the roommate, the things of that nature you immediately take care of all that. And then I do staffing because I would like to know in the morning that I am going to be short I mean if some call outs or whatever so I do that to make sure I have staff. And then start seeing patients and that takes about a lot of time, that takes a good two hours of morning okay just to see the patients. Sometimes I would not get all through, it depends on what is going on, in each room. I mean I will get through in one, then I have to do some more in the afternoon, it takes a lot of time. (Leader 07)

Purposeful nurse manager rounding exemplifies the importance of patient satisfaction through modeling, ensures delivery of coordinated quality care, provides

visibility to the staff. Leader rounding provides an opportunity to validate staff behaviors for improving patient satisfaction, through real time feedback, rewards, and recognition.

> Leader 15: I think patient rounds are so important. Because when you do your patient round you get the first hand information from pateints. I do not only wait for my staff to say, "Oh (name of manager) can you just go and see this patient because you know they are complaining that kind of thing? " Although that is my priority in the morning. If my staff comes to me, and say "(name of manager) see I have a patient that has been complaining last night." That is somebody that I would like to kind of address right away. Patient rounds are what I see beneficial -sitting down sometimes and even no matter how simple and short that encounter with the patient, it is more meaningful. (Leader 15)

Some leaders focused on building relationships with patients and family members through leader rounding practices. The participants recounted their experiences and the personal satisfaction and benefits of building meaningful relationships with patients and family members. The following examples from Leaders 6, and 17 effectively highlight the meaning of this experience.

> I think role modeling, building relationships with patients, is probably one big ones. It was for me to go into the patient's room and become very friendly with the patient and have them ask for me, it shows the staff that there is relationship building there and it think that they know that it is serious business. It is not just if I am willing to walk my talk that they are to do the same thing. So that has been huge. My rounding definitely has helped. (Leader 16)

But I try to connect with every family member at some point especially at the beginning of the admission. So during visiting hours I will try to make myself available so you know, meet the families and introduce myself. We kind of let them know where we are, so through the beginning when they come in we kind of establish a relationship with them. So that they could come here at anytime and feel comfortable to ask questions, they know the staff, they know that -if my staff is busy they have my number, I give them my business card so will get voice mails from them at different times you know, and I always try to make that our priority that I will call them back. Address, whatever concerns they have at that time. They do not have to wait until the end of discharge if they have any concerns, or anything.

I want to hear about it I want to know what is happening here. So I try to connect with them as much as possible, on daily basis when I am here, with the families in the mornings rounding with them seeing how things are going, how the visits are going, sometimes providing them with so much support because they come here, they think it is a psychiatric setting, it is very scary, so trying to help them- know that it is not that scary, that it is a safe place to be in, we are all strangers to them. And we have to build that trust with them. They are leaving their loved ones with us, and their loved ones can't speak times, can't express their needs, so we have to kindly give them that reassurance that, we are here for them. (Leader 117)

Leader 05 has the following positive feeling about rounding: "I think that it (nurse manager rounding) is good really; for the most part because why we are here? It is for the patient experience, and make the patient better" (Leader 05).

Nurse managers are visible and accessible to staff and patients thereby contributing to their success with improved patient satisfaction scores. Executive leaders expect nurse managers to be accessible to the staff (Leaders 02, 09, and 11).

> Our nurse managers are very much involved with not only managing what has to be managed but also with the patients they know our patients, they know their families, they know what they are here for, it is not just strictly sitting at a desk. They are very involved. (Leader 02)

"Visibility, accessibility, I am accessible 24/7, they have my cell phone number, they have my home number, they can always get hold of me. If there is a problem, they know that they know I am there for them" (Leader 09).

> Well I think that they need to be . . . not so much in their offices, but out on their unit, seeing what is happening and really trying to identify the barriers that they are seeing. Absolutely. You cannot sit behind the door and not know who your staff is, you have to be out there and you have to know who they are, who your workers are, what they do for you. You have to be visible; you have to very visible and accessible. (Leader 11)

Leaders recount their experiences in being visible to staff and patients, and stakeholders. Leader 11 related an open door policy to signify accessibility to staff.

> One of the ways that I became more visible, please keep the door open. I do not care if anybody comes in here. My door was always open for people to come in if

they had a question. They knew that. That was set from day one when I walked on to that floor as the nurse manager and never be afraid to come talk to me about something I am here. I can stop what I am doing. If I am really busy I will tell you. (Leader 11)

For Leader 17 and 18, visibility meant having a meaningful and impactful presence in the department by assisting staff in times of crises, facilitating resources, addressing challenges, and removing any barriers in their workflow.

And I work side by side with them, it is not like I am the manager and I am here to talk to the families. If I could respond to our family needs, I expect for them to do the same way. If could do it, of course they could do it to. (Leader 17)

I think two things- communication, and being out their with the staff with your other managers. You have to be visible in order to succeed, and as you could see I am wearing scrubs. I wear scrubs everyday and I am here at the beginning of the day and that it is important. Because I believe that the staff sees that I value what they do. I value that they have to be here early, so do I. But I think it is important that you out there, you see the challenges that they are facing. You the see the physicians want to see me, they might you know talk to the staff and say well you know "Did (name of Director) know?" "Yes, (name of the Director) knows," because I am out there. So I think that has been throughout my whole career. I have always been visible. And I think that that adds to it and communication, I think I have to be honest. If you are not getting something you have to be upfront and say it is coming, but I think you know communication,

visibility, and honesty, is I think that is how I achieved, and adds to the success of my role. (Leader 18)

Leader 14 addressed staff issues in real time, encouraged teamwork, and coordinated multidisciplinary teams in the department for improved patient satisfaction.

So my presence on the unit when they are running around is very important. To make that things happen for them, because now, everybody is running around. You see people sitting at the nurses station, you see people probably picking up orders, it is okay, but what does she need now, probably she is coding, probably she needs to transfer that patient to the unit and you are doing your chart help her out, probably sometimes the manager needs to be out there to tell them that, to remind them of team work because tomorrow it could happen to you. (Leader 14)

According to Leader 14, the attributes of visibility, servant leadership, and going over and beyond for staff and patients, are hallmarks of a great leader.

There is particularly probably one manager that she amazes me, at times you know when there is a difficult situation on her unit the way she deals with her staff the way she is transparent on the unit she is not at all hiding from them. She is definitely helping them out. Great leader is her presence on the unit. She is really if it is a storm happening she is in the storm with them. If hurricane Sandy happened she is sleeping over with them. If a thunderstorm or snowstorm happening she does not leave the department. If her staff calls out, they make every effort to call another staff and they can, and the place is bombarded with patients, she comes in. It does not matter 3 in the morning, 4 in the morning she

comes into help them out. See for me that is a great human that is not a part of her job, but she takes that extra step. (Leader 14)

Theme 3 emerged from coding and analysis of clustered themes for the new emergent theme named Leader Rounding. The coding clusters and frequencies displayed in Table 9 provide trends for the clustered data.

Table 9

Theme 3: Coding Clusters with Data Frequency Patters

Theme	Free Nodes	Number of Data Sources	Number of References
Theme 3: Leader Rounding	Nurse Manager Rounding	21	99
	Seeking Patient Perspective	13	22
	Meeting Customer Expectations	9	12
	Service Recovery	9	14
	Accessibility	6	10
	Building Relationships	9	19
	Visibility	18	37
	Team Building	12	33

Theme 4: Holistic Nurse Manager Role: Creating a Healthy Working Environment

The role of the nurse manager in improving patient satisfaction is evolving to a more dynamic and comprehensive role. Nurse managers in this study understand the role of their staff in operationalizing values of caring, empathy, and respect to build thriving and vibrant work cultures. Participants perceive building healthy workplace and satisfying employees may ultimately contribute to the delivery high quality care. The following Figure 8 is a representation of participants describing their experiences and insights with building a healthy working environment.

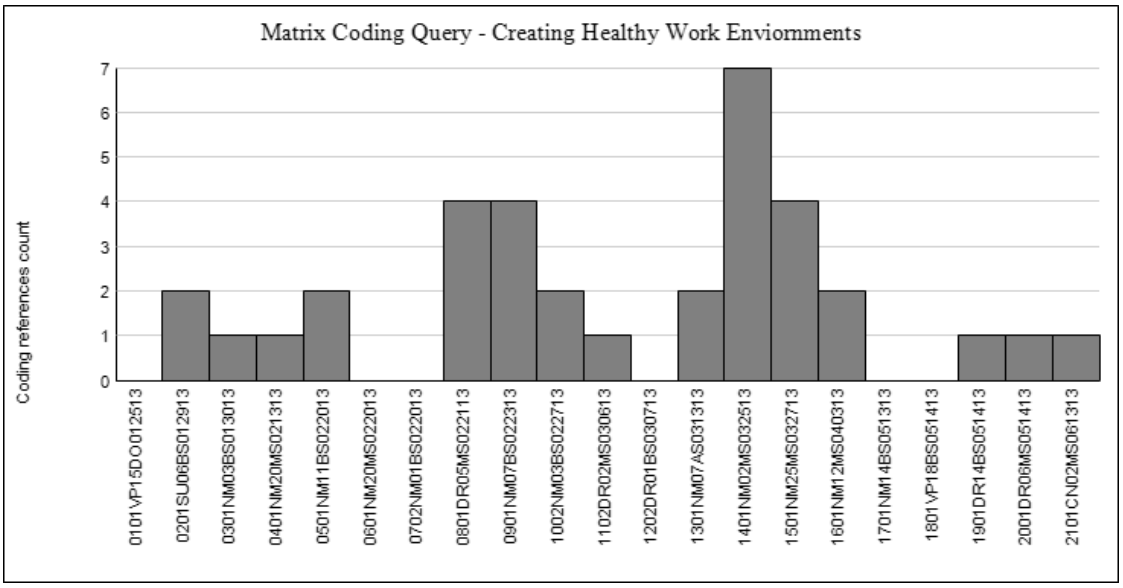

Figure 8. Matrix coding query: Creating healthy working environments.

The following examples from interviews of Leaders 11 and 15 provide insight into important dynamics and relationship between a leader and the follower. The excerpts highlight the role of the nurse manager to build a vibrant work environment based on their perceptions and lived experiences.

> And to build a culture, to develop that culture, where the nurses were the bottom, I should not even say they are the bottom, they are really the top. The nurses are the ones that are moving their practice, moving how they want to see things done, and how they want to care for their patients. And honestly any nurse will tell you that they just want the best care and they want to treat their patients, I think, they will be treating their own and if you think give them that ability do that, you are going to have the best satisfied patients and nurses and your staff satisfaction. (Leader 11)

> But to me, the nurse manager's role is so important and it becomes a key to have a successful department. You have to have a good follower team; the followers are so vital also as well as having leader. To me, it is a big factor because it is important when no matter how good you are as a manager if you do not have followers that are not good, your role cannot be as effective. But the essence of your role is that you have to be able to lead your staff, the people that reports to you into the right direction. But if you have good people that work with you and that is what I have to be thankful for. I think it means a lot, to you for, for the success of the department. (Leader 15)

Leaders in this study verbalize the need to influence the inner core values of each individual employee working in their unit to change a culture based on values of caring and respect. Participants in this study influence and motivate followers to create a culture of caring, respect, empathy, and high emotional intelligence. The following account of a participant's lived experience captures the nature and focus of the essence of building new caring cultures.

> But if you do not have the stable foundation, the house will crumble. So to me the foundation in the roots of the organization is a nursing unit. So, if we can get our act together, and if we can create teams that understand the importance, not because I lecture, but because I truly understand the value of treating someone the right way, and with respect and dignity. If you can develop that, then I do not need to read this line-by-line, because we respect, empathy, sympathy, compassion. If you intrinsically practice that, we believe that and treat somebody with human dignity and respect. Most of this of scores will go up because they

are all based on those morals and values. So then I think it is time to bring up the reports to show the success. And then reports do not have negative connotation then you start looking forward to the reports at the staffing meeting. Because then you doing the right thing and you were proud that you were doing the right thing and cannot wait for the director to come after the three months to show your success. And then each win reinforces the value for what you are doing and then I think it becomes embedded. (Leader 08)

Nurse leaders articulated that when nurse managers, concentrate on creating a healthy working environment, developing staff, and staff satisfaction, patient satisfaction will soon follow (Leaders 04, 05, 09, 13, 14). Selected excerpts of the following participants exemplify participant's philosophies about staff satisfaction and its impact on patient outcomes. Nurse managers in this study claim to achieve staff satisfaction through staff participation, engagement, compliance, and sustainability of patient satisfaction initiatives.

You know that is what our goals are and that is the unit that I run here and I just keep in the nurses happy, and we can again me not being available to them, is not giving them their answers any quick an hour. Here again, happy nurses equal happy patients, does not take a lot of rocket science, just to figure it out. We do a lot of initiatives here, the nurses have self-schedule, because if you are scheduling yourself the way you want then, you should not come into work miserable. And I mean overall, I think the staff really getting there, truly do get it. (Leader 08)

Culture is very important especially when it comes to HCAHPS questions. May be two months ago or so, I started to feel the culture changing, and that is

important too as a manager. And that is, what a lot of that reading that has helped me to look into, if my culture turns upside down, it will wreck that. So to watch the culture it is very important. To make sure that the staff is staying happy, the staff has to want to be here, because they are taking care of people. If they are not happy, they are not going to perform the same way with the patients and if they are having a bad day they are not going to perform, so culture is very, very important. (Leader 07)

You know, for me personally, I truly believe that it's the staff satisfaction that is more important. That is my personal philosophy, because I think, that the staff that goes into health care, in a caring profession, they want to do a good job, right? It is our job to interview the right people for that job. But they all want to provide something; it is about supporting them in their vulnerable time, it is about caring. I can care for their cares they can give a job and that comes with, whether it is a process, the paperwork, the electronic record that they have to struggle with, if it is this, if it is a quality. If those things I have to address, then I have to address. And that then spills to the patient because they can provide with a need to the patient. (Leader 13)

The invariant meanings and theme of the nurse manager holistic and comprehensive role to change the culture are depicted in the experiences of the group as a whole. The holistic role of the new nurse manager is to shape a healthy work environment focusing on improving staff satisfaction. Nurse managers claim to achieve staff satisfaction by modeling behaviors of courtesy, respect, support, listening,

communication, engagement, building relationships, value staff contribution, facilitating resources, and removing work barriers.

> They (Staff) have to feel, they are valued. They have to feel they are respected. You cannot shut them down in a meeting. You cannot tell them well that is not going work or you cannot tell them "Well you have been saying that all the time, so I do not think that is working." If you say those kind of negative words in a staff meeting or any kind of meeting, they did not like, "I might as well just shut my mouth, it does not matter what I say." That is their feeling, so you are never going to get anything out of them and you need that person, you need that person to work along with your ideas.
>
> So to improve their courtesy, respect, and all that, I respect my staff, I mean not that I give them what they want it is really trying to facilitate to make it happen for them to make their job easier and if I cannot, I am very honest about it to my staff. (Leader 14)
>
> I think so, I mean just as not just as a servant to the patients, but just as the nurse takes care of the patients so I am to take care of the nurses. So if the nurses have issues that they bring to me, it is really my responsibility to help them overcome those. Whether they are work barriers or administrative issues or personal issues, they would then be better prepared to take care of the patients.
>
> So it is so important that if I am asking not just me, but if Health Stream™ is asking about clear communication of the nurses, I myself have to have their communication. If they are asking do the nurses courtesy and respect, I have to

have courtesy and respect, so what really is all depends from what the patients' perceptions are.

You know it rolls downhill. So, however my mood is in the day or what I am reflecting on often filters down to the staff and therefore the patients. So it is so important to be mindful everyday when you walk in the door, for me I know to center myself to say I am here to be a blessing to others and to be blessed by others and if I can just carry that forward it seems like the rest of the staff follows. (Leader 16)

Leader 08 had different perspectives on the nurse manager role to improve staff satisfaction and staff ownership of work satisfaction.

I am a firm believer that I cannot make staff happy. It is not my job to make them happy. It is my job to support them to give them what they need to grow, it is my job to mentor if they want to be mentored, and create a safe environment for them to work in. Just as, I cannot intrinsically make someone nice. I cannot make someone happy per se. Happy, how do you judge if someone is happy? Because I used to hear that from staff, "I am not happy here." But what they need to figure out why are you not happy, what is it, and the shared governance piece comes into. You were the creator of your destiny for the most part and they have little trouble with that ownership. (Leader 08)

Leader 17 verbalized an insight into the conditions and situations needed for leader-follower relationship to affect patient outcomes. The following textural description of Leader 17 provides meaning to the uniqueness of the health care job

environment with the right type of individuals and the right fit to meet the demands of the profession.

> It is a very unique setting where we work and people have to feel like they are making a difference and it is not just any of the tasks that they doing, any other job, it is a very unique, so they have to feel like that they believe in it too and be able to. It all stems back to like what we believe in, as the organization, so somebody have to want to be here, and want you believe in that, to kind of make it happen, then I think that makes, if you believe in it, it makes everything easier. (Leader 17)

Nurse managers in this study are developing new caring cultures by interviewing, and onboarding motivated, and caring people. Nurse managers in this study influence and motivate caring staff members to a vision of service excellence.

> I think and we strive to find the people that have them, as their nature and it is much easier to teach someone, who has that as their nature than someone who is not naturally caring, kind, passionate, and all the things we look for. Sometimes people interview very well and three months after their employment they change, so those people get weeded out. We have a very good screening process; we are very upfront with just what we are saying when I interviewed people. I will tell all the time, this is what we do, this is what we expect, the job you are going to take is hard, we are going to hold to standards, we tell them upfront everything. And I said many times, if you do not think this is for you, you should not work here, for me that worked. I have had very few employees that we hired that I have interviewed that did not work out and that I feel it is a good philosophy. I

read from my handbook to them some of the standards we expect from them. And we say directly, "If this is not for you then please do not continue the employment process, but if you think this somebody you could fit in, welcome. We would be happy to have you." Straightforward like that, and that makes a big difference I think. (Leader 10)

I am a little strict when it comes to interviewing and selecting my staff. I have because of the patient population that I have with is geriatrics. I cannot afford to have somebody with no passion or when they say "Oh I just want to have something to work on to get into the institution." That turns me off, because I need someone who really has that goal. I am very particular when it comes to asking them what their goal is. And they have to have that passion of caring for the elder population because that is important to me. So usually part of my interviews, I would give them a little scenario of what I have in the unit and then ask them some questions about that would pertaining to the elder population. (Leader 15)

Leader 03, 05, 06, 09, 13, and 18 verbalized success at building healthy work cultures and value staff contribution to patient satisfaction. The selected statements capture nurse manager's sentiments about their followers. "I think that the staff really empathizes with the patient that they get. I think they really do care about the work that they do, and about the patients they take care of" (Leader 03).

I think the nurses in this organization are held to I think, they are excellent nurses. We are Magnet facility. I think they were held to a very high standard, which the nurses step up to the plate and work to that standard. (Leader 09)

> And I think, our staff are professional, like you said, they are close knit, they become personal with their patients and it is really, it is very, you could see it, and they take pride in what they do. And if I take my mother to a facility, I expect the same care, and you either see it, or do not. And it is recognized, if it is truly, if that person really means it. And another thing, I think that it is important, you have to love what you do. You can't be good at what you do, if you do not love it. So that is proven of everybody that has been here for a number of years. (Leader 18)

The hospital department consists of many different yet unique personalities with diverse goals, values, work ethics, levels of engagement, and performance. Participants (Leaders 08, 11, and 14) know their staff, unique strengths, and weakness. The following selected examples illustrate the composite textural structural description for this theme.

> To get those ideas, to nurture the staff, to develop the staff. When I look at somebody as an excellent high performing nurse manager I think of (name of nurse manager) I really do, because she reaches from down below and really tries to pull people up, she tries to encourage them, she tries to get that education going, she wants to see the unit and the staff do well and she gets in touch with those staff members. And she knows what makes them ticks, she knows what makes them work, and she knows what makes them shine off, that they do not want to do something. (Leader 11)

> Rather now, I learned my staff, I really know what their strengths are, what their weaknesses are and I work with that and really it is a phenomenal. If you really speak to them and get to know them but at the same time you bring back to work.

> You hear them out, but you bring kind of twisted I got that knack. I guess with these two-and-a-half years of major challenging experience I had on the unit I only have very few like around 40 staff compared to other nurse managers probably they might have 100, but even with that little amount of people I got it all . . . with the personality; it is a 40 multiple personalities and it was not an easy, it was a very challenging role for me and I have to say I learned from my staff to be a better manager today than I was yesterday. Really, my staff taught me so much. Nurse managers they definitely need to look into their high performers and who are their low performers. Do not focus on the low performers, focus on your high performers, focus on the middle performers because they can go either way and that is the vast majority of your staff. (Leader 14)

The new role of the nurse manager is to build caring and empowered cultures by developing informal leaders from within. New cultures sprout from the foundations of shared knowledge for process improvement. The role of the nurse manager is evolving in educating staff regarding changes in health care and impressing the necessity for change. Leaders 05, 08, 11, and 16 articulated the value in educating staff and its importance for improving patient satisfaction. The following excerpt from Leader 12 represents the clusters of the delineated meanings of the new role of the nurse manager to educate and develop staff for new healthy working cultures.

> When I became a nurse manager when really the focus on the value-based purchasing started to come into play. Like I said, we always shared our Press Ganey™ scores, we always shared our comments with our staff, at staff meetings, we posted on, we still do, I mean that has not changed, but we began to

start really teaching about what it is all about, educating our staff on what value-based purchasing was, educating our staff on what we did well and what we did not do well and how could we change and what kind of suggestions, and we really starting to look at how we practice on our units. And I think that getting in touch with your behaviors. (Leader 11)

I definitely had to teach the nurses about patient satisfaction, about scores. I tried at first just to hang up the scores, and what I have decided to do is to take the time for people who may be- would not otherwise take the time to really study what the scores mean, and looking for my patient satisfaction. I kind of lay it out for them and the way that they can understand, so for example this is the scores that I get weekly. So it is a little bit more manageable. And then I put the goals on the top so identify, what the organizational goal is, but also as far as what we rank, and what we will get reimbursed for. So I will let them know so this is a part of the language they know, that they have to hit 50% or above so that we could preserve a reimbursement. And then for people may be who do not even take the time to do that I write something like really quickly, good job here bad job there. And we could do a little encouragement and I do this weekly and then I post it in the break room. We talk about it at staff meeting. So definitely there is a shift in focus, or more attention spent on patient satisfaction, discussing it, working on the projects to increase it, than there ever was before. (Leader 16)

Study participants communicated and impressed upon the staff, the value of patient satisfaction, through meaningful real life patient experiences.

I feel that the best way to motivate staff is through their experience with the patient, and that is probably be the most holistic things, you have. Right! So whenever I see a problem I try to transform it into something that they can understand "Why it is important they switch it," and their caring for the patient is the main motivator that I have to motivate them. It is them caring is what motivates them. (Leader 07)

I think you provide people, provide them some education about that. I think it is also wrapping it around patient safety, it is wrapping it around the satisfaction piece. May be even use experiences from the past I like to kind of build a story around it in terms of not something that I may make up, but more around, we have this occurrence. And I think if you make it real for someone, because it has happened before, so we would share those types of background to the information to set the expectation. (Leader 12)

The following excerpt from Leader 12 evokes a clear message of the nurse manager's vision of a caring culture and influencing staff through real life stories.

I told the staff a story a month ago, but it is a cherry pie story. And it is true story; it is about my father when he was dying with cancer when he was in (name of another hospital). I brought him there, because it is one of best cancer centers around. And they kept him alive for a very long time. But towards the end he was on floor there, and he could not eat very much all, and all he kept asking for was a cherry pie. He wanted a piece of a cherry pie and I would work a full day, I was here 12-14 hours, I have to hurry up, rush get over hospital. And I kept forgetting to get this cherry pie. I would start getting very frustrated. I was doing

home-hospice. I was very sleep deprived. I would apologize and then I would forget again the next day, come in and he said, "I just want a piece of cherry pie" and the man was not eating, he was dying. I came in one day, and there was a nurse sitting there, she went out and she brought cherry pie and he was lying on that bed, all 90 pounds skin and bones. He had cherry pie streaks on his face. My father was an Architect, Type A, very neat. He had the biggest grin that I have probably seen in ten years. So when I brought him home he had also had a big surgery. We had a special spinal surgeon come in from the Long Island. They did, he is videotaped, and used as a teaching tool. They actually put titanium cages in his back because he had tumors all down his back. So he literally did not have a spinal column in certain portion of his back. And when they did that, he became paralyzed from the tumors, he couldn't walk, and it was very risky. We knew the risks, but he came through this miraculous surgery, and he lived another three years. So the reason why I called the cherry pie story is (name of other hospital) had high clinical scores also, and PI, and they are very big with their Core Measures. But every time we would have the family gathering, he'll tell everyone "My daughter is a ICU nurse, she is administration, she is . . . I wanted to talk to all everybody and brag about (name of other hospital) about the technical surgery." But my father will cut me off at the knees and say "Tell them about the cherry pie, and tell them about the nurse who brought me the cherry pie." That was biggest deal to him as a patient. And I always remember that. And the reason I remember, and I tell the staff that- is "You can save someone's life, and sometimes it is a big deal to them, but more often or not- it is the human

component. That is why emotional quotient-emotional intelligence is so important, because my father never talked about this miraculous thing that this, incredible things the surgeons did." He talked about that nurse, he never forgot about that nurse, he remembered that nurse's name. He remembered that cherry pie, and that is the piece that we miss sometimes. That's the emotional piece. This stuff that we are not doing so well on, is so powerful and it is as powerful as your clinical components. Because many times, it is not the incredible, fancy surgery that will bring someone back to the hospital. It is knowing that they are coming home, they coming back to place they remember the nurses that cared. And the nurse were compassionate and they fluff their pillow and they brushed that woman's hair, even though they have 25 other things to do. And they brought them special snack. (Leader 12)

Another knot in the web of the underlying essence of the new nurse manager role to change culture was to develop staff through ongoing coaching and mentoring. The following Figure 9 is a coding query in the qualitative NVIVO 10 software representing participants with lived experiences in coaching, developing, and mentoring staff.

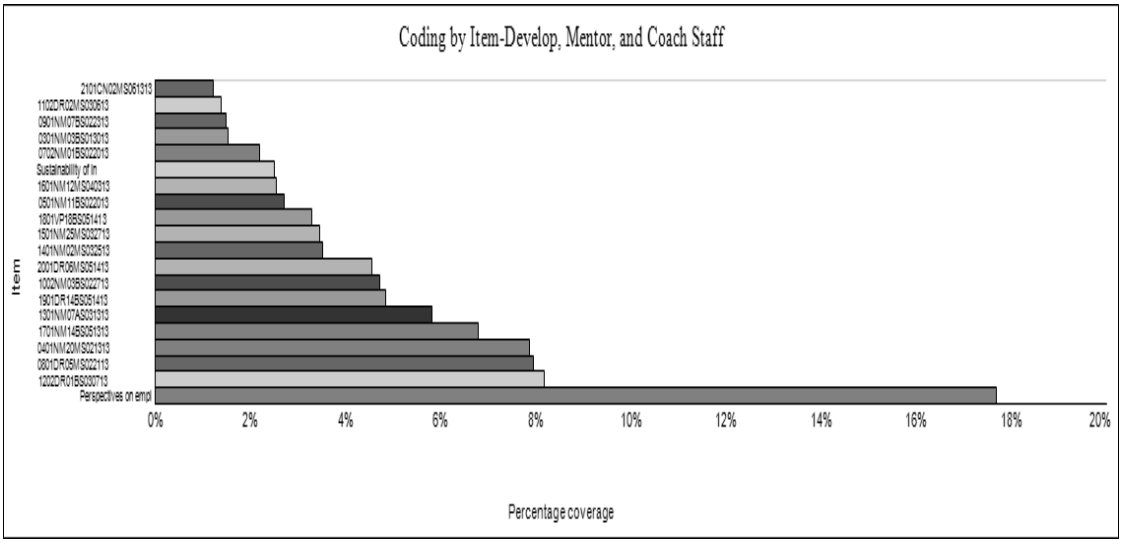

Figure 9. Coding query: Develop, mentor and coach staff.

Selection of perceptions of Leaders 05 and 11 represented the focus for this theme. "The essence of the role is constant coaching and mentorship . . . building your staff, growing your staff to be more autonomous along with your assistant nurse managers" (Leader 05). "I guess coaching, more of a coach to them, guidance and as a leader. They (nurse managers) need to be the leader and show how to do it then others will follow" (Leader 11).

Nurse managers in this study explain learning, developing, and coaching is an ongoing process in a learning environment. The nurse manager function is to mentor, develop nurses, and provide feedback. The coaching and mentoring occurs through addressing issues in real time.

> Yes. It is okay not to always be great. People for me, like that is how- people learn. You know and that is all part of my responsibility, as a nursing professional and as a nurse leader is to bring those new nurses up . . . to prepare

for succession planning or their roles in leadership. I mean that mentoring processes my responsibility as a nurse leader. (Leader 16)

Nurse managers realize the front line staff is influential in achieving high patient satisfaction scores through ongoing caring interactions with the patients and family members.

A good part also is mentoring staff. I have a lot of new employees. Mentoring my assistants too. I think a big piece of it is mentoring and the rest of the day is coaching as you have seen. I try to keep an open door policy so my staff feels totally comfortable coming in and saying what is on their mind, which is good. That can be time consuming. (Leader 05)

I actually had a group of people that needed communication skills and I send them to my patient representative, the director of patient representative because they said you need to help them learn why their act, the way that say things, are not the correct way to say things and how can you help them say it better and she did. She coached them, some did very well with it. (Leader 11)

Study participants 01, 04, 12, 17, 20, and 21 fostered personal and professional growth of the employees by coaching and mentoring through a reflective and reflexive process of the employee-patient interaction. Following are some examples of the textural description unpinning the structures that support the theme.

Leader 12: Then as managers, I think, we need to follow up with those individuals and make that episode of learning opportunity, make that constructive, and hopefully we can facilitate the next time, that they have that interaction, and they can do it better. (Leader 12)

Nurses are smart people, they are educated. Every nurse comes to work I believe everyday to want to do the right thing. So if you educate, you guide, you coach, on-going. It helps you have good outcomes and then there is always the few that are outliers that may not comply, you have to address that differently. But I think nurses if they feel supported and it is a non-punitive type of environment that they will be more receptive to follow through and comply. (Leader 20)

They (nurse managers) mentor and coach their the staff, they sit down and say how could you have done it differently rather than that you did not follow procedure, right so they do this reflective process. So if they saw that (name) was rude from the patient satisfaction survey, they sit down, let's say (name) sits down with (name) and says, "This seems not to be you, as the patient is saying or the patient perceived you as being rude, let's look at what happened, tell me what happened." So Judie will say the patient came in very agitated whatever right, so what happens? I asked questions that will initiate the reflective process with the person involving that interaction then, I would analyze that as the nurse manager and say, "Okay that was not probably appropriate," but instead of saying that was not appropriate, I would say, "How could you have stated it differently."

Coaching, approaching, identifying. Coaching #1. (Leader 21)

Nurse leaders attain a sense of fulfillment as a leader, mentor, and coach by visualizing positive and genuine changes within their employees to effect cultural change.

I like to see people grow. So, anything that I can be a part of, I am always looking for a succession plan. I like to see people coming on and watching the nurses develop and grow and mature and I think there are stages to it. So the

nurse when they graduate they are not magically a polished nurse, they are not critical thinkers, necessarily, they are very task oriented. You we know move to do better stages I would like to watch that from novice . . . all the way up to expert. I can see the gamut and you can also see the emotional growth.

I take pride in that when our scores go up. But it seeing the nurse develop and watching and wondering what role they will be when they grow up, and it is watching people smile.

It is not a body in the bed with a medical ID number, it is a real person and so if you can develop that concept and again I say intrinsically. . . The patient is not stupid and family members are not stupid and they know when you are not being for real, and they know when the emotions are genuine and when it is not. But to see a nurse interact in genuinely care with the patient that is priceless. And then hopefully if that is happening this (scores) should go up. (Leader 08)

Nurse managers identified and developed staff champions to assist them in attaining their vision. Successful nurse leaders know their staff, understand the strengths of each individual, and develop leaders from within.

You know, most roads are not a straight path. In geography there is really no exact straight path, but you still get to the destination regardless of which highway you take. It is same thing, and it so that is what I want to see for my leadership group. I want them to take on that challenge and be excited because it does not matter if I fail the first time. We will change the route and we will get to the destination. So I think it is having a leadership group too when I am not here, be the cheerleaders of change.

The leadership portion comes from within, and regardless of what we call you, you still need to develop that role and that trust and that respect. And it is a mutual respect, this is not a communist state here. And so they are learning that they need to develop the techniques to get people to buy-in, to help us increase these scores. It is not a "Do as I say because I said so" -anymore society It is just is not and they certainly would want behind a receiving end of someone saying "Do it because I said so." So, I think that is going to help drive these scores too, because I cannot be everywhere on every campus, on all of my units, it is impossible so I have to start at that level first to go up and then hope that it is going to trickle down.

You almost have to exude more positive energy when you are interacting with your patients and families. And they will feel it, and there is a different charge, and it is different electricity in conversations, and it comes out- it exudes--the excitement is there. And it is not something you have to sell them. I have some nurses that have reached that. And I hoping that they are going to spread like a virus, and all I need is a few champions. You can spot the authentic nurses a mile way. (Leader 08)

So, yeah, absolutely, leadership skills and learning about how to deal with people and speak to people, talk to patients, talk to doctors. I mean it is important and that is why even without nurse practice council I said, "You are the mentors of the new staff." "Well I do not precept them myself." "I did not ask you if you precept them, you to mentor them, you are mentoring them every single day, you work side by side with them, they are your little sponge and they are watching

you, and they are soaking up everything that they are seeing that you do. So, if you are good role model and you give good patient care and your patients are happy what do you think they are going to do? They are going to watch what you are doing and do the same thing." (Leader 19)

According to study participants, preserving a new patient caring culture is an ongoing process, taking up considerable amount of energy, focus, and diligence to maintain a consistent approach to achieve high patient satisfaction.

You have to believe in it. You have to feel that it is important you have to be consistent with your routine every day and make sure that you are seeing patients each day asking your nurses how they are doing. Ask the techs how the day is going too and addressing issues in a timely manner no matter what they are whether it be a practice issue or patients concern, we have to address things in a timely manner. (Leader 05)

Leader 07 stated "So I have always said I just got to keep the train on the tracks" (Leader 07).

By being thorough and consistent. With the goals and the initiatives that I have set forth for the staff and follow up. I think that is it has to be consistent. Not when they are doing this and they were doing that or change next week or try something else. It does not work like that. Once she gets the staff acclimated to doing things a certain way when it becomes ingrained in the culture and this is how we do things. (Leader 09)

And then it is really going to come down to being vigilant with it. I standing there one day, and the call bell goes off, and I see three people around and

> nobody looks at it, or everybody kind of shoots off. And that is when you will have to grab those individuals and catch up, and say, "Listen we are working on this it is really important for the patient's safety, the call bell went off and I saw three people all of a sudden go by, and not pay attention, whatever the situation is." (Leader 10)
>
> With our setting, like right now, we have been at the top so now it is like the expectation is that we are going to continue to sustain our scores. So it is, it is knowing, that, we have to keep up that gain. It is important, so with new employees coming in, people leaving, and things like that we have to make sure that we are not missing anything that everybody it is going to pick up where we are right now and be able to understand that and support what were are doing already and we do not want somebody to come in and that would be taking a little longer for them to adapt to the changes and to everything else that is happening. (Leader 17)

All 21 participants in the study verbalized the need for ongoing feedback, rewards, and recognition for positive patient centered behavior as essential to sustaining a caring culture. The following Figure 10 represents participants who have recounted their lived experiences with positive feedback and reinforcement to maintain positive patient caring behaviors.

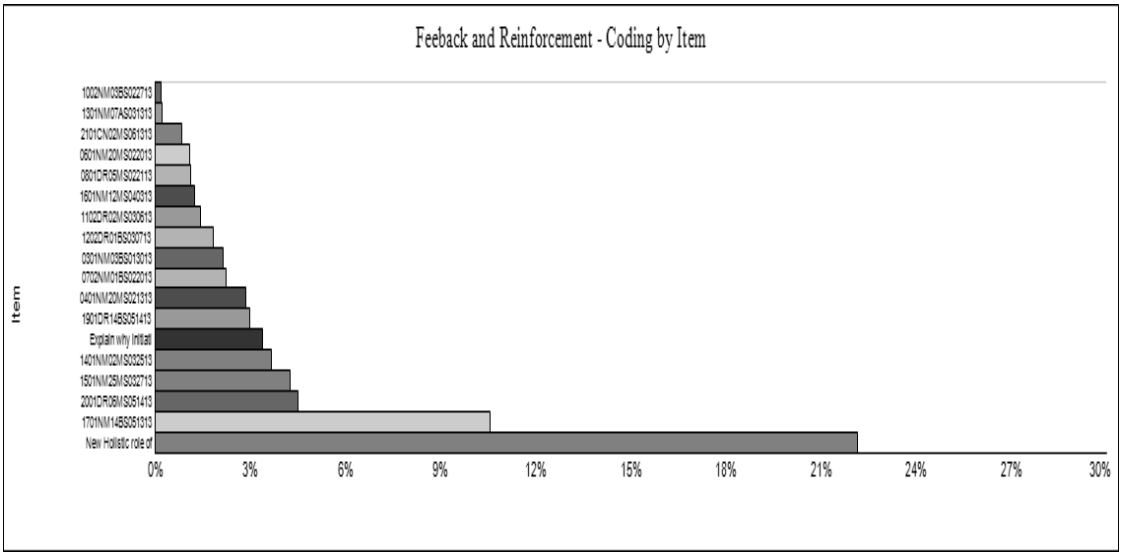

Figure 10. Coding query: Feedback and reinforcement.

Leaders 04, 11, and 19 verbalized that followers in a healthy environment develop and maximize their potential through positive reinforcement.

> You know being able to be fair, nonjudgmental and non-punitive, being able to evaluate something and provide feedback or some type of a resolution, in a non-punitive kind of therapeutic environment. (Leader 04)
>
> They want to hear from you that they are doing a good job. And when they hear the patients are saying they are doing a good job whether it is through patient letters, comments that come back on Press Ganey™ we are just seeing their scores being as high as they are. They want to see that, when they do not see it, they go, "Why? I was in there all the time." (Leader 11)
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> And I think they (Staff) see the end result that the patients are happy, I mean people walk out and say this was amazing, "I was in and out in an hour or two hours!" We read them their comments, "I was sitting in the lobby for two minutes and I was brought back, I have never seen anything like it!" So I think when they

see the comments and how happy patients are they feel good about it, so it makes them buy into their own way of doing something. That makes sense. (Leader 19)

Nurse managers solicited feedback from patients regarding their experience in the hospital. Nurse managers share patient's expectations, perceptions, and patient satisfaction scores, and survey comments with staff for aligning staff perceptions with patient's expectations. Leader 12 viewed constructive feedback as opportunity to learn and grow.

> Myself or shift supervisors, because I think that by providing feedback you really can say, and even when you go in and visit patients. When they share things with you. But if they provide us feedback, then we are responsible to take that feedback say it is about the staff nurse, may be it is the way they approach them, and may be felt that they did not get in there as quick as the patient would have expected. Then as managers, I think, we need to follow up with those individuals and make that episode of learning opportunity, make that constructive, and hopefully we can facilitate the next time, that they have that interaction, and they can do it better.
>
> Setting expectations, maintaining the accountability and be there you know it is not only when I say accountability I do not mean like, it is going to be negative. It is more of providing the feedback, it is celebrating the positive, it is taking a side one has not worked and talking about it, but it needs to be consistent. (Leader 12)
>
> You have to teach them first, let them be aware of that there is an issue or else they will never learn and then again it is follow through. If you cannot follow

through then, anything you have done would be meaningless. Because I think once you have done something with the staff member, you need to acknowledge either the growth, or not at some point and it is going to be in a timely fashion or it would be meaningless; it just losses its value after time. (Leader 20)

Leader 04 used the feedback from patients to praise and recognize staff for positive reinforcement of caring behaviors.

Rewards of recognition, when you have staff, like I ask patients, "Is there any staff member or members you would like to recognize, that provided extra special care to you?" And if they tell me they are all wonderful, but so and so was just amazing. I will give them a $5 coupon and reward of recognition in real time. I say thank you. I buy hallmark cards, "thanks for all that you do our patients" because that what keeps them going too. So being able to reward and recognize, and being able to, thank them all again. And again in evaluation time, and I put in a lot of time, to pull all the stuff and writing for their evaluation, and being able to provide them with that positive feedback. The feedback may be did not have had a chance to tell them, that day. You just sit there, you put it all in writing, and tell me them how much of an asset they are to your unit and unit success with a 99 percentile success. Yeah, I guess that is it. (Leader 04)

Nurse managers recognized staff and praised them in real time to reinforce the goals for service excellence.

I believe that by listening to the staff, and by acknowledging, what they do influences them, of how they get things done. So if I am walking around the floors and I see something good or I mention something to someone, that they are

doing a good job they are going to continue to do the good job. They watch, they listen and they want to see what they want to please their bosses. (Leader 11)

Transparency in the unit, and definitely praising them for their accomplishments or sometimes even doing the right job, doing a good job, or doing it right and praising that, in front of people, in front of staff, at the nurses station. And if you have anything negative, not negative like if you have a constructive criticism to let the staff know bring them in behind the closed door and very professionally talk to them. That is something that I definitely think can change a whole lot of perspective on the nurse. If you are really looking for an improvement from them you definitely want to praise them. And that is my motto in life. If I would not appreciate, sometimes we just live with it, because we have no chance, we have no choice sometime. But if you are the person who is constantly telling me that I am not doing it right, I am not doing this right, I am not doing this right, I was just complaining, complaining, complaining, and never have a positive word out of you. You are just a negative person. I mean I would never like I will do it probably because I am scared from my job, but that is not efficiently, but if I have a person who comes and tells me (name) great job in doing that meeting, (name) great job in doing that. So, praising that takes a long way. Really that brings a best in anybody because not just praising for no reason, if you praise them for particular things you have to be very specific in what you are praising. (Leader 14)

But there is something that also came about as a satisfier not only to outpatient but to our staff also, because they see results. When you see results, positive

outcomes, the patient outcomes and you share it with the staff. I think it kind of give you the edges of staff wanting to do better. That is something I developed through the years and I have seen through as effective. Through the years that when people are working in the department knows what is going on, they will be able to participate better. Whereas if you are leaving them in the dark. Believe me I am good into posting things and you would say, "Did you read?" what they said you said so I would spell it to them. And that we are trying to kind of put them all together because this is so much coming from the email, coming from the slow mail, you name it, voice mail. Is just overwhelming for the staff to observe so to me prioritizing them is so important and educating the staff.

So trying to encourage them to be more . . . but when they see you getting engaged, I think they kind of adapt that, again with the results if they see good results then that motivates them to even do more.

Like the last quarter of last year, it was such a pleasure to see that in spite of the beginning of the year, we struggled. But to close the year in a better note it was like, we provided, we had a celebration with the staff. Invited (name of CNO) and (name of Director) and they all, they are kind of reinforce that. Yet the challenges will still going to be here, but we should not stop doing the good things that we do for our patients, so that was really good. (Leader 15)

Validating them, to know that if they do something great or send out or send themselves to go and help somebody, that you do reward with them that. And it is valued so then taking that time to give that feedback to the staff, "Hey, by the way, you did a great job with this, you saved this night, you saved something that

happened." So letting them know that, so we appreciate that. I think it is important. (Leader 17)

High performance, one of the things also is the ongoing I think communication and feedback to the staff. They do recognition very intentionally, recognition to their staff openly; I am not saying the others you have to coach them to do it that is like kind of a natural, they do it in different forums. (Leader 21)

According to nurse managers, they have a responsibility to ensure accountability for high patient satisfaction. Some of the managers had to engage in disciplinary action to align followers with expectations patient satisfaction. Nurse managers as change agents take on this necessary but often unpleasant task, to ensure a high performing and high caring, patient oriented culture. Study participants conveyed the importance of sustaining a patient caring culture by maintaining behavioral attributes of consistency and diligence (Leaders 01, 03, 05, 07, 12, 14, 15, and 16).

I have disciplined staff, for not doing what they are supposed to do in regarding patient satisfaction. Or typically what will happen is, some have the same complaints about the same staff from other staff and that is when it is time to call them in, have a conversation with them, and discipline them if necessary. (Leader 03)

But almost I am manager too and there is staff that will tell me, "(Name of manager), so and so, she does not take care of the patients like we do." And we had to manage them out, because you just do not fit in to this environment. They just do not fit into the culture. There are times I could be on vacation for two weeks. When I stick my key in that door, if people bombard me with issues or the

patient dissatisfaction with employees, I let them go, because I cannot have this. This is no more margin for this at all. In the hospital environment it is challenging issue, because it is everybody. Like I said the pain, when I first came here I mean, I have terminated the people because they just did not get it. I mean I would be at the nursing station, and the patient's family will be like, "Please, please my mother has been calling for two hours for pain medication." And I used to see the nurses say, "I am busy, I will get there when I get there," And I would like this isn't going to be. So, if you could ask what to do with your own culture that you want to have in your department. It starts at the top and kind of trickles down.

My scores in the cancer center are in the 99th percentile for patient's satisfaction as well. But again I think it has to do with you know the accountability what they are being held accountable for the staff. And what your tolerance level is, you would not tolerate something, because that is reality, what somebody else may put up that I do not put up with. And again, everybody needs to be pleasant, everybody needs to be respectful with patients and the customers. The customers are not only the patients in the bed but the family at the bedside. It is the department that you are calling when you need something. It is everybody, it is internal or external customers, everybody needs something from everybody in order to be able to make the patient have a good hospital experience. (Leader 04) Everybody needs to be responsible. Everybody needs to be accountable. If you cannot do that job in the expected way of doing, it you definitely need to look into it. I really now make them accountable. This is the expectation, come back with

an action plan within two weeks. If I do not see any improvement, we will see again. You know, and that is how now I go about with it and that is much easier. (Leader 14)

Nurse managers expressed thoughts on the disciplinary process as a constructive last step for individuals resistive to change, to transform work cultures.

We involve our human resources when it comes to disciplining a lot. So those are some things that we can just left things slide if you allow thing to slide people think that you really did not care they can do whatever they want to. But when you do follow up I am very into that because when my staff ask me to do something and I know that I have to follow a patient complaint or something from another department I do it. I said to them, one sits on my desk- I can assure you, that will be, better be followed up, I cannot just say that okay I read it and I put it under the table, that kind of thing. (Leader 16)

Leader 19 discussed lived experiences with a transformed patient caring culture.

Somewhat. This is longtime, so not everyone could do it. Many of the ED nurses had the old way of thinking that, the patients can wait until I am ready to take care of you. So we did do lose some staff in the very beginning of the journey and that was many years. I think because it is the culture now, they know what the expectation is. When they are oriented, they are oriented to the expectation, so they just buy into it because they do know any different. We have many new nurses, many new graduates, they never worked anywhere else, so they have nothing to compare it to, so they think this is the only way to do it. And I think they see the end result that the patients are happy, I mean people walk out and say

this was amazing, "I was in and out in an hour or two hours!" We read them their comments, "I was sitting in the lobby for two minutes and I was brought back, I have never seen anything like it!" So I think when they see the comments and how happy patients are they feel good about it, so it makes them buy into their own way of doing something. That makes sense. (Leader 19)

And, people do not end up staying for very long because it is not what they are not used to . . . if they are used to do what they want, when they want, how they want, and not really following a philosophy of the patient's satisfaction and quality care unfortunately, it is really not a lot of people now, it is either in you or it is not. (Leader 10)

Table 10 represents coding clusters and data frequencies that constitute Theme 4.

Table 10

Theme 4: Coding Clusters with Data Frequency Patterns

Theme	Free Nodes	Number of Data Sources	Number of References
Theme 4: Healthy Working Environment	Staff Satisfaction Affects Patient	9	13
	Staff Satisfaction	18	32
	Support Staff	10	17
	Educate Staff	18	42
	Mentor	21	63
	Story Telling	7	12
	Feedback	16	47
	Rewards	10	17
	Accountability	14	57
	Addressing Issues	13	26
	Consistency	10	17
	Healthy Work Environment	16	39

Theme 5: Holistic Nurse Manager Role: Staff Engagement and Empowerment

A majority of nurse managers articulated their collective yet unique experiences and perceptions of staff engagement and empowerment in their journey to build a high performance culture. According to the Participants 05, 08, and 10, employee engagement creates positive outcomes such as buy in, compliance to initiatives, staff satisfaction, sustainability of patient satisfaction and performance improvement initiatives, and ultimately patient satisfaction. Figure 11 represents the matrix coding query specifying the percentage of references for participants describing lived experiences with engaging and empowering staff to meet expectations for improving patient satisfaction.

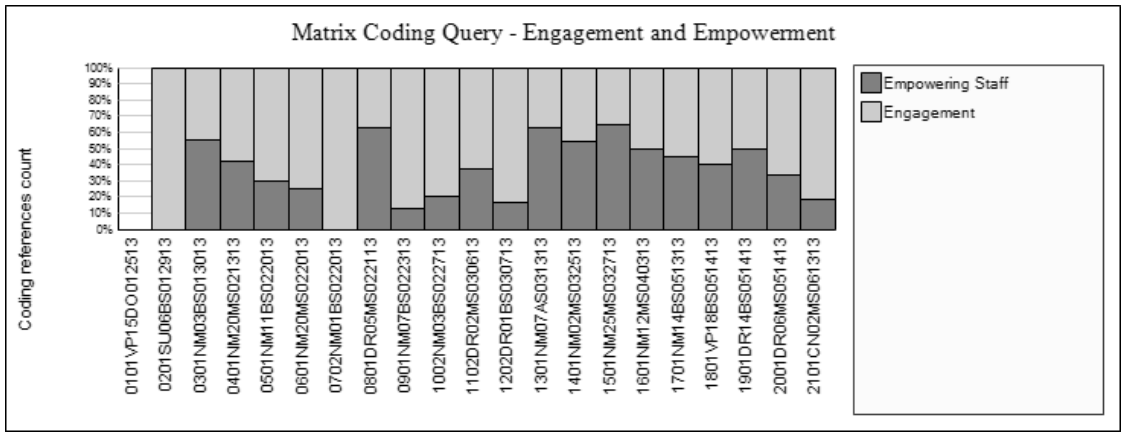

Figure 11. Matrix coding query: Theme 5 Engagement and empowerment.

Leader 05, 08, and 10 provided their reflections of positive outcomes such as buy-in, compliance, and sustainability of initiatives with employee engagement. “That is not the manager that I am, you wanna have your staff choose things themselves, because it is obviously if it is their idea, you have a more of chance of them being compliant” (Leader 05).

> Let them involved and listen to their feedback and point out to the action to get them involved, I think that is the big difference and their willingness to participate and make a change, giving them a say. Really getting them (staff) involved I think makes a big difference and let giving them a say and how we could make a difference. These are things that were said in the surveys, what do you all think about, how we could make it better. It puts them little bit on the spot and they could never say you never involved me in making this change, so they are more invested in it. (Leader 10)

According to Leaders 04, 06, 14, and 18 engagement and empowerment of staff contributed to improved staff satisfaction. The excerpts from Leaders 04 and 18, captures the impact of empowerment and engagement with staff satisfaction. "So giving them a lot of autonomy and empowerment, I think make a huge difference, because they own it. They feel good about it" (Leader 04).

> And I think again, put peoples in certain positions or charge responsibility, I also have a nurse from Same Day Unit that comes with me to the patient satisfaction committee meeting, and she offers her opinion, so they feel the valued, so that is another way of them feeling valued, that they feel they are making a difference. I think the staff needs to feel that too. So that is how you get them to buy-in but because she is to going to the meeting with all managers and multidisciplinary people, and she is talking in a meeting, so she is equally as important. I could not do this job alone, so everybody, you have to have that sense of value, and making them feel like they mean something, and they made a difference in order for them to continue making changes. So I think that what I do and I think also (name of

CNO) has really stressed that part as well, as making going to meetings now, and having staff representation at meetings. (Leader 18)

Leaders 13, 19, 20, and 21 engage and empower their nurses because they believe it can lead to better patient satisfaction. The following selected textural descriptions of the experiences of Leaders 19 and 20 provide insight and understanding of the underlying structures that account for the experience.

> Well, I have engaged the charge nurses may be a little bit more than the other managers have, I am not just discounting what they are doing, but I think a four charge nurses that I have are extremely aware of, the patient's satisfaction initiatives and they will not hesitate to reach out to me or to (name of patient satisfaction coordinator) or whoever if they need assistance, with the patient that is unhappy or may be even, for saying that there may be foreseeing issue with the patient or patient or family member, they want the nurse a little more often and they will communicate that with the frontline staff so, that might be the difference.
>
> I think that if staff really feel that they are engaged, and feel like they are valued, and part of a team or a unit, that they will go their way to do something. And I find that all a lot here, on both the units. That the staff really have a good working relationship with each other and will go out of their way for each other and in the end I think that it will and it does, I think, it boosts the satisfaction of the patients. The two, I have two, like on each unit that are very engaged in patient satisfaction and go to the committee meetings and will bring stuff back to the unit practice counsel to discuss. So those two, more than anybody else on the

unit, but you know I think the majority of the staff know . . . are on board. (Leader 02)

So again I have to bring back to the unit council, the fact that we are not addressing this and we are not targeting this, so we are not "Always" discussing medication side effects. Now when this was our topic we give to the unit council, we automatically peaked up we stayed up. (Leader 04)

I feel that I do better and I learned better with the again, it is shared governance, learning, and getting peoples buy-in and it is an approach, you approach people in a different matter you will get more positive outcomes in the end. (Leader 20)

Following are participants' recollection respective lived experiences in engaging and empowering staff for greater participation in patient satisfaction initiatives. The collective experiences of Leaders 04, 05, 10,12, 13, 18, 19, 20, and 21, represent the clusters of horizons into this core theme. The following selection from the transcripts of Leaders 12, and 19 provide few examples of nurse managers' experiences with engaging and empowering staff.

I think even from my perspective it is I meet with my shift supervisors. I will meet with them like here and there when we are out and about, but I also bring them together. So if this is the message or this is what we are looking to get accomplished, we will talk about it and we will talk about what are the barriers on the different places. And we just had a meeting on Wednesday because where we want to do some work around bedside report, because we have tried to implement and it is kind of fallen on face, and we are kind of stabbing on it again, but you

got to be able to continue to communicate, and be available, even to answer questions, provide feedback, and those types of things. (Leader 12)

We got them together and kind of say, "This is our goal, this is what we want to do, and we would likely want to hear what your ideas and what do you think about it." And most of them are, "Wow! Good, that would be really great!" (Leader 19)

Study participants attribute staff engagement and empowerment for success in changing department culture.

I think we have gotten smarter at (name of Hospital) about this. Many of these initiatives are driven now, I kind of release the reigns, so to answer your question I am doing less now. I am more proud than I was when I was even doing the work myself, because we do the work on shared governance model- they need own this. (Leader 08)

And it is really, it is driven by the staff, I mean I could help make these things, and say, this is I think this works and they come up with these things. They are so creative, and I think that is in my area, creativity it is a big thing. So I think it is important. Of all the things the staff participates, processes are definitely are important. (Leader 18)

All study participants claimed autocratic leadership was ineffective in influencing staff to change current department culture. Study participants practiced a more participative and transformational leadership. The following excerpts from Leaders 01, 03, and 06 provide examples of the democratic and situational leadership style practiced by successful nurse managers.

I would like to think that I am more democratic and very flexible, there are some things that need to be done and the way it is and this is the way it has to be, but I think for the most part I am very flexible. And I think that they know that. (Leader 03)

So, and I try to be participatory -that style I think that I am approachable, I mean there is always a learning curve when you have a new manager, but I think that no one is really not able to come tell me what there issue is. (Leader 06)

Leader 21 espoused the qualities of a transformational leader to change the unit culture to improve patient satisfaction.

And, we read in the literature that are better in terms of styles of leadership, transformation leadership, that is way it is a key role in patient satisfaction. But we have to have the ability to engage the whole team so that you are on this together.

I would say: participative, transformational. Okay because they need to be also innovative and creative those things. So what more so in that characteristics of a leader is somebody who is really to have those styles of leadership I think would be very key in terms of influencing positive patient experience. (Leader 21)

Many participants in this study recounted experiences that describe the embodiment of the various substrates of transformational leadership style. Leaders 04, 14, and 21 clearly identify their leadership style as being transformational. "To improve patient satisfaction my leadership style again is transformational". (Leader 04)

So that I do not think I started off as transformational, but I grew into a transformational leader. I read so much on leadership. So this is something. When I read it, I am like I am not really practicing that, so it is like the transformational leadership was written with my character. I see my character in that. I need to polish a lot I am not saying I am that, but as I grow, I definitely think, I can definitely be that 100% transformational leadership. I totally believe in that autonomous, shared governance, and a collaborative environment, at the same time challenging your staff. (Leader 14)

Leader 01, 11, 13, 14, 16, and 21 stated that the transformational leadership qualities are important to influence and motivate staff to create buy in and change the culture to deliver high quality and satisfied care.

I would say as a leader, as someone who is influential, and someone who is able to do the job as anybody else. So you will say see one do one, manager sees and does it the others will follow and do it also. So I think that is really important to have that as an influential leader. It is really it is all about leadership, it is all about the same things that you would talk about a good leader, being able to influence being able to speak well, to make changes happen. (Leader 11)

"You have to be persistent, you have to be engaged, you have to able to motivate others, and keep others engaged. You have to be able to inspire" (Leader 16).

Leaders 09, 11, 17, and 21 recounted their experiences in engaging staff participation through organizationally adopted structured models such as unit based practice councils, shared governance models, and Transforming Care at the Bedside (TCAB). Magnet designated facilities require the presence of shared governance and unit

based councils as conditions for continued designation. Unit based practice councils are vehicles through which the nurse managers engage staff nurses for continuous quality improvement.

> We stayed in this unit we were chosen by our CNO to do TCAB -Transforming Care at the Bedside, which was a phenomenal thing that we have participated in and was put up by the New Jersey Hospital Association. There was a new way of looking at things. So as staff, as a team, I was more of the guide, than the leader. What the staff would do is they would develop these initiatives to help improve care and they ran with it I mean they just did a phenomenal job and we are sustaining it. (Leader 09)

> They (Staff) do unit counsel and that is when they come up with their ideas, what they want to do, what they want to trial, and then they run with, and then I will watch it with them, if I am invited. If not, it is something they will do and they present me with data so that I can follow up with it and if it works, it works, they will leave the way it is, or keep it. I really think a lot of good has come out of that. (Leader 09)

> Each unit has practice council. The unit practice council, that is made up of some units to techs and nurses and some just do just nurses. Staff meetings are very open area to discuss things. There is a lot of, some of my managers doing a lot of emailing information back and forth to the staff and they email back with suggestions or questions. Suggestions boxes, team leaders, selecting team leaders or team players of the week or the month and some of the units have things like that. And I actually ask the nurse managers if they would like to have a tech

meeting, because the techs are important too and some of the units have their own tech meeting, but as a forum for all the techs, I have a tech meeting to discuss the HCAHPS and stuff. And that is to trying to pull something out of the workers to see what they see on the floor where is their challenges. (Leader 11)

Leader 21 articulates the role of the manager and the leadership style as being instrumental in engaging and empowering employees to build a new culture. This account is valid and clear, bringing to life the universal dynamics of the nurse manager's experience with engagement and empowerment.

Overall, I would say that it is very important for the nurse manager to be able to engage the whole staff in this endeavor for patient satisfaction. The nurse manager has to be able to align, again the mission in the vision of the organization in context lets say patient satisfaction, the nurse per se to articulate that vision. And part of that the vision is really to deliver care to the, we have a whole mission, but to provide care that is satisfactory. And service excellence is the focus. So based from that the nurse manager's challenge to be innovative and creative and engage the whole staff for that. The nurse manager cannot be dictating, has to facilitate that process that there is some collaboration with the interdisciplinary team to provide care that is satisfactory, efficient, and timely. But engaging the staff so that there is a buy in and then making that plan unit based plan if you will, will give them the freedom to explore resolution to issues.

And evolving a culture in time, but I think the style affirms that of evolving a culture of the patient's safety and that starts with non-punitive all is to delivery of that the execution of leadership. And the style of leadership, because

to influence that, you have to really have those qualities that would influence and gain the participation of your whole staff, because otherwise they will hate you. I feel that will not respond to you, it is. But focus on the high performers. (Leader 21)

According to study participants, a nurse manager engages staff by demonstrating attributes of respect, risk taking, open door policy, and hard work. The following selection from Leaders 09, 13, 14, and 21 present the nature of and focus of the experience. "They (Staff) come up with new initiatives. If they come up with an idea, I never shoot it down, let us trial it. I am a big trial person, we will trial anything" (Leader 09).

I think from me, it is a not being; I am not a micro manager because I want to come from in here, the heart . . . I see some nurse managers who are kind of- like you are going do this, you are going to do that, you are going to do this! To me as long as the outcome as where we need to be, and I think it's so important for the staff to have control over that. If I cannot allow them to do it because of whatever it is. From the top of my head, lets say it is state reg. And I cannot let you to lunch at noontime, how can we work it out? It's a win-win! And that is so important to me. (Leader 13)

"Because you need your staff to participate in that. If you cannot bring it to you staff and sell it, you cannot get it" (Leader 14).

So I think and that is from the managers again kind of facilitation, engaging, and empowering the staff to be a part of the process, So even in staff meeting I think we model that also in the meeting so that we are not just saying everything, but

> we only ask the question so that the staff can answer it for us. "Why do you think that patient satisfaction, communication has stagnated for the past three months right?" So they have to think why. We know the answers right? But we have to spend that time, that is a little bit. I said you have to be willing to spend the time in that, I know the answers, I know it, but I am not going to tell them they have to realize it right? When they can figure out I usher them to get there. But I see that in the staff we see that too, that it is happening slowly, but surely, we are not there, there are so many things that we need to focus on, but I think importantly to start up and that was part of the first six months, first year and now we are going to focus really hard on the things that we need to improve. (Leader 21)

Leaders (05, 07, 09, and 11), stressed the importance of effective communication skills as necessary building blocks to inspire, motivate, engage staff, and collaborate with interdisciplinary teams. Communication skills are essential to articulate the importance of patient satisfaction to stakeholders, build relationships, and seek patients' perceptions for positive patient outcomes. Figure 12 from coding query conducted in the NVIVO 10 software represents number of references by each participant in the study, emphasizing the need of communication skills.

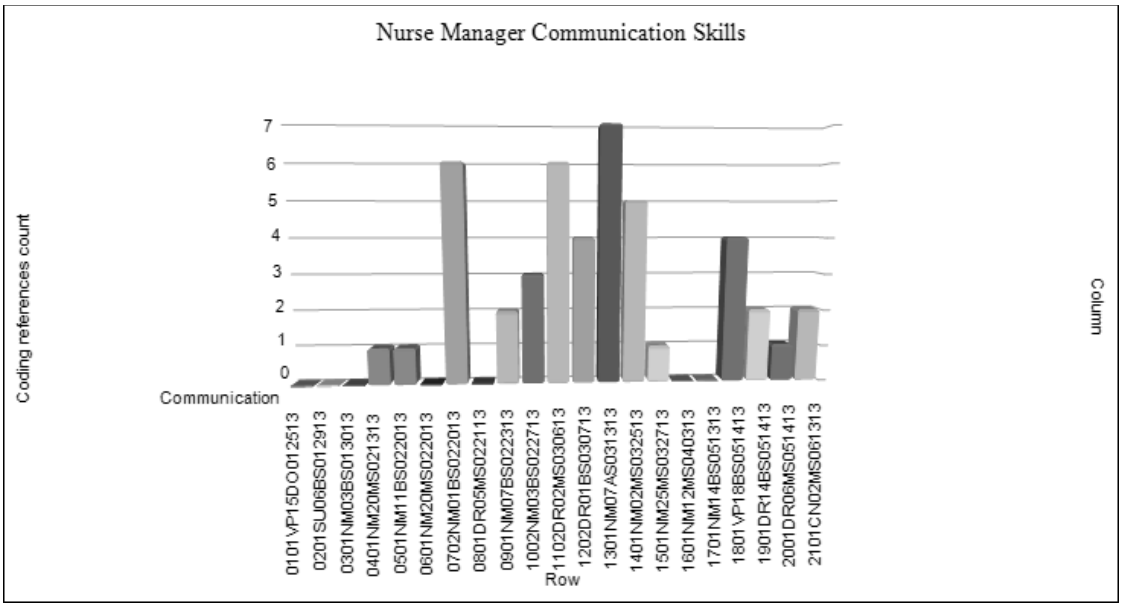

Figure 12. Matrix coding query: Communication skills.

Leaders 07, 11, 12, 13, 14, 18, 20, and 21 express importance of nurse manager attributes such as honesty, sincerity, transparency, respect, and visibility. The attributes are necessary elements for communicating vision for patient caring culture. Following are few examples of the textural description for the underlying structure of the theme.

> You have to be a good listener, you have to be able to speak well and communicate well, and share the information that you are seeing, and you have to allow the staff to come up with ideas and be able to implement those ideas, whether they are successful or not. They need to communicate, skills sets . . . that is hard one because it is really it is all about leadership, it is all about the same things that you would talk about a good leader, being able to influence, being able to speak well, to make changes happen. (Leader 11)
>
> It has to be somebody that is going to have good qualities around communication. You have to have enough awareness around-you are going to be able to do the

nonverbal queues and the verbal queues and a lot of it comes down to communication with most things and patient satisfaction specifically. (Leader 12)

Honestly, transparency, talking about the issue, communication, like I said it is not going to be a 100% all the time. I value communication, eye contact, relationships, "tell me what is going on with your daughters play, tell me what is going on with those things?" and I think in turn rubs off on them. The same, with my relationships with my peers. They are some that I would not say are my best friends, but I am respectful of that situation. You know what I mean. We got to do and you know I do not have to like you, but you have to respect each other. (Leader 13)

So open communication, supporting communication, and valuing the people within the organization and the people who you report to, people who reports to you, needs to be equally respected to have a very creative work and environment. (Leader 14)

They have to have effective communication, collaboration, coordination the management of teams and its skill in terms of managing teams. Not just their own staff, but the team so that is inclusive of the interdisciplinary team very, very important. Communication, I mentioned that because you have to be able to influence positively when you are communicating effectively and able to articulate and able to navigate through. So I think it lies where leaders have influence to that so we can articulate, we can provide the discussion and that is when the challenges that we face. (Leader 21)

Leaders 10, 11,14, 16, and 19 explained that listening is the most important element of skillful communication, because it fosters staff engagement, trust, and creates a healthy working environment for staff.

> I think that motivates people letting them now they have to say and that just we are trying to do being very open to hearing that they are saying, listening to what they are saying, and making them feel comfortable coming in and just venting they have to vent about things because that truly opens that. It has got to be someone who is a good listener and someone who has a calm sense about them. We deal with a lot of different things, patients, families, staff, administrations, you have to be flexible, you have to be thick skinned and not take things to heart so much all time and be able to hear things and not to let it affect you, It takes I think, the right persons to do this. I take the time to listen and think more than react immediately and process things with the people that are working with me and for me, may be that has helped. (Leader 10)

> It is also my role to listen to the direct caregivers, the nurses, to hear what they have to say, what they feel their barriers are, and what can improve the patient's care; because they are the experts and then to support them and follow through with whatever their needs are, their directives for me. (Leader 16)

Nurse managers in the interviews recounted their experiences with communication of patient satisfaction surveys and quality improvement projects with staff. The following selection of verbatim excerpts of lived experiences effectively captures the essence of the theme.

I think that being in contact with the staff constantly, sharing information with them, sharing the scores, sharing the successes, sharing the failures is important because from the staff they want to hear good. They want to hear from you that they are doing a good job. And when they hear the patients are saying they are doing a good job whether it is through patient letters, comments that come back on Press Ganey™ we are just seeing their scores being as high as they are. They want to see that, when they do not see it, they go why? I was in there all the time that I knew. Sharing specific patient complaint is a really good one because then they start to get to see how could we have made this better and let them start telling us how to do things because it is them, it comes from the staff. (Leader 11)

We definitely want to let our staff know and I think I am more communicative to my staff about these numbers and how much these numbers means to our reimbursement. Again, I use the word existence and I keep reinforcing that to my staff not just in staff meeting, monthly least staff meeting anymore, now it is every Monday. (Leader 14)

When you see results, positive outcomes, the patient outcomes and you share it with the staff. I think it kind of give you the edges of staff wanting to do better. That is something I developed through the years and I have seen through as effective. Through the years that when people are working in the department knows what is going on, they will be able to participate better. Whereas if you are leaving them in the dark. Believe me I am good into posting things and you would say, "Did you read what they said, you said?" So I would spell it to them.

So a kind of as much as it takes a lot of your time it is good, because you can get that personal information and bring it back to your staff. I think what is good is that when you get all of this monumental information, it is so important for you to bring that information to your department. (Leader 15)

I have a patient satisfaction board in the operating room. And besides posting our ambulatory service we do post HCAPHS and we talk about it. We have been in the 90 percentile. And it is a team approach, the physicians, the nurses, everybody has got a role in making sure that those scores stay up there. We talk about it everyday. We huddle in the mornings with the staff and we kind of, do like cheerleading and say this is what we got today, we are going to get our patients back, we are going to get them in, we are going to smile and so we had to keep that consistency going. And keeping them informed where they are, so they are the big buy in, we just gave them the tools on how to keep that success going, but they are really the drivers of it, the staff is. I think that is what our role is, our role has to be telling them and letting them know what our patients want and that we need to treat them as like their family. (Leader 19)

Theme 3, Staff Engagement and Empowerment, emerged from the clusters and descriptions of invariant constituents horizoning the experience of the participant. Table 11 lists the clusters and the descriptions with number of sources and references that contribute to the meaning of the essence of the theme.

Table 11

Theme 5: Coding Clusters with Data Frequency Patterns

Theme	Free Nodes	Number of Data Sources	Number of References
Theme 5: Engagement and Empowerment	Communication Skills	15	46
	Listening	10	15
	Engagement	21	95
	Transformational Leadership	12	67
	Democratic	15	33
	Recruitment	6	10
	Communicate with	16	45
	Respect	6	11
	Open Door Policy	11	13
	Shared Governance	15	23
	Patient Centered Care	15	34
	Unit Councils	12	17
	TCAB	6	11

Theme 6: Role of the Nurse Manager as Change Agent- Continuous Quality Improvement

The function of continuous quality improvement is shifting from the realm of the quality improvement department to front line staff with nurse managers in a pivotal role for planning, implementing, monitoring, and evaluating processes for delivering quality health care. The following excerpts from Leaders 10, 16, and 21 provided a glimpse of the nurse manager role in researching, planning, and evaluating best practice for improving patient satisfaction.

> I guess it's a critical role. We set the example for the staff. We have to create and follow through on the action plans and then receive feedback in our subsequent surveys. See if the patients are saying the same thing that was said in

the previous surveys, and if they are what did we do about it, did we not follow through on our own plans, so it is a critical role. It is leadership role, we have to take that information, take that action plans and give our supervisor some talking points to help make sure that we want to improve and is addressed from a leadership level, on down. We want everybody to know that we are all on the same page from the nursing administration and these are the main things we want to address. We are going to make sure that all the staff receive that communication and that direction from us, that is about how we go about it. (Leader 10)

The essence of my role in improving patient satisfaction! What I think really the essence is for it is a continuous quality improvement. The Plan, Do, Study, Act, work with the plan, if it does not work. Do not be so married to it that you are going to keep it forever. If it does not work towards it move on to something else. So, it is a continuously evaluating, looking at the data trying to improve, looking for best practices. So, that I think continuous quality improvement, is the essence. (Leader 16)

So that is why I think leaders are very, very important because you have to provide that as a pathway as well to eliminate the barriers whether it be a system issue or unit base issue, you are going to be the one identifying those. And as your are staff are articulating those you are going to have to coordinate your resources to eliminate the barriers, providing alternative solutions that are innovative and creative, taking the risk. If it is not working then we might as well abandon it or may be identifying other resolutions with the staff

incorporating the input of the staff. So I think it has to be redesign of processes, that will make that delivery of care more efficient, timely, that contributes to patient satisfaction. (Leader 21)

Leaders (08, 10,11, 18, 19, 20) advocated for change and view themselves as agents of change influencing their role in continuous quality improvement. Leader 08 provided her perception of the role of the nurse manager as an agent of change, and the necessity for change in the health care industry. The following insights and understanding of Leaders 08 and 20 on the dynamics and dimensions of change management underline the structures of the meaning of the experience.

First you have to make people, move people slightly into a state of discomfort. Because change does not come when people are comfortable in their state. Even if their current state is not good, it is what they know. And it is their world. So that is what the manager part isn't so fun because I need to move them and make them uncomfortable. And when the discomfort gets to a certain level then that is when people realize change has to occur. Changes occur when the discomfort outweighs the comfort of the current state. So, it is not a great job. That portion of it, is not a great job. And it is also a journey for the shift supervisors, because they are developing and those are the people that I mentor the most, because someday I want one of them to be me.

All of them in the different hospitals, but they are still stuck in "I am good, I am good, do not move me, everything is good, lets not rock the boat." But you have to rock the boat. In order to move forward you do, we have to be there as the leaders to throw out the life preserver to keep them safe as they move to

change. But they have to move, they have to move out of comfort zone. I think most of us suffer from that. I think I have changed over the years and really -The only thing that is constant is change. But I developed that over time and I am not scared of change and I find change to be a challenge and sometimes it is exciting, especially when a change works, and also getting people to understand. That it does not necessarily matter how you get to the goal. Many people start off, you get them to the point of discomfort, you get them to create their plan, their action plan, and may start implementing, and then it falls through.

But I do think that it makes the individual more, well rounded and I think it forces growth, it does. If you are not willing to move out of your comfort zone in today's work environment, you probably will not advance, you probably will not be in a higher level management position. Because you have to bend and you have to change. You have to evolve, or you will not be successful in these positions because there is too much coming from all sides. (Leader 08)

Nurse managers in this study recounted the necessity to gain process improvement skills including data collection, monitoring, implementation, and evaluation.

And then for the other things like if you are going to target some specialty things, do it is a project like, and then we will go back and really look at and then we tweak something like the whole Plan Do Check Act, because there are so many different acronyms now for what you do. But to be able to have, a starting data, pull your data at first, and see what kind of impact we get. Did we get? But we

got if, lets go back and look at it. Or if it is completely off the mark, then lets just abandon it immediately.

And the hourly rounding was a huge task, every day hours and hours and hours of data collection, out there policing it, checking it, having my unit secretary at night collecting and going through who did not sign, going back and counseling them. You did not sign how you could get into our ledger to sign the paper. Just because I did not sign the paper it does not mean I did not go in the room. Well, being able to just kind of move in the right direction, we again if we could get in the top box you know 99th percentile in the patient's sat and top box score you know what, we do not need the paper any more, unfortunately right now I am not ready to pull it, I am not ready get rid of it. (Leader 04)

Study participants described themselves as open minded, creative with ideas for improvement, and risk takers (Leaders 04, 05, 06, 07, 08, 11, 14, 19). Excerpts from Leaders 08 and 11 represent the nature and the focus of the experience.

And then, creative thinking out of the box how do we fix them. And my managers, the four that I have, are very dynamic. They really do start thinking out of the box, they will try something, and if it does not work it is not successful, they are going to try something else. They are going to continue. They just are not going to say, "Okay I failed and that is it." (Leader 11)

We got to think outside the box. There is no more, so if you are telling me you have done everything and your patients are still falling, what is that tell me about you as a manager. You need to get your hand around this. You need to solve this. So then I go around thinking of another strategy. (Leader 14)

"And being able to think out of the box, change is good, you got to be able to change every day, put something, do something a little bit different" (Leader 19)

Nurse managers in this study were able to foster change by keeping an open mind to different ideas and initiatives for improving patient satisfaction.

> If they come up with an idea, I never shoot it down, let us trial it. I am a big trial person, we will trial anything. I am open minded and I try and foster them to be open minded rather than say, okay, we have done this like this for 10 years, we are not going to do like this I trained for. Open your brains and let us do something else and we will see if it works. (Leader 08)

The nurse managers in this study described their responsibility in the quality improvement process by collecting data and transferring statistical data into meaningful information for staff.

> I am data junky! So once a month, I would go and get my own data to see where we are moving ----percentile wise. I would not wait for them (QI) to send the data to me. So I just go into Press Ganey's website and grab it. And grabbing that data, moving it over into my own spread sheets. I got my spreadsheet, because we talked about movements, so I have a baseline period and then a period where it is moving. I probably spent a few hours setting up the spreadsheet and then each month I probably spend half hour to 45 minutes, adjusting to get the data in, and to make sure that we get the data out to the staff. Where I look to move is, where I am seeing negative movements. So I am watching the movement, if something is moving in a negative direction then it is something we need to focus on. (Leader 07)

> First is communication, and I think we had to reduce as an organization our communication down to more layman's term, when I would bring these in . . . people glaze over. They do not understand percentile ranking, nor do they want to, they want the down and dirty. (Leader 08)

"And also, I think constantly reviewing the surveys that we get back, I definitely, my managers call back patients, if there is complaint. And I have to say that I have minimal complaints." (Leader 18)

Study participants (Leaders 04, 05, 07, 08, 13, 17, and 18) mentioned that they communicate with staff regularly regarding results of patient satisfaction survey results for process improvement and feedback.

> I am kind of very transparent, with the staff, I run the scores every week, if not twice a week. Unusually on Monday I try to get them run by Monday in a nice graph for, because I think that is a quick visual. I did not bring that with me, but that is supposed to be sitting on my desk that I have printed two days ago. And that is just kind of in the face, we shared that in the patient staff meeting that has come like a month and half behind but so we just shared on the hospital level December scores kind of post them up there. (Leader 04)
>
> We review our comments like every month. And they send the comments to Orex, but then we get through service excellence, we get a summary of all the comments negative or positive. So with the staff meetings we review them, this is the thing this is what happens, and it is in the open form, it is in the minutes. So it is important, we would not want something to be there that somebody was rude or something they did not respond to, something right away, so it is very open, it is

very transparent to anybody to be able to view those comments, and things like that. It highlights that when somebody went out of their way to help out, so everybody sees that, and of course they kind of want to model, "that guy got recognized or I want to be recognized." So it kind of helps them. On monthly basis, we kind of review where we are with our comments, and things like that. Or if there is something that it is upsetting the family members, or there is a theme noise level, or something like that we will try to regroup with, "This is their feedback, what can we do to make it better?" So it becomes an opportunity for them to feel like they are the part of the solution, or to continue to enhance something that is already working. (Leader 17)

Study participants (Leaders 04, 05, 08, 14, 15, 16) engaged staff in researching best practices and initiatives. Nurse managers also solicited ideas from staff even though it was time consuming because of the many benefits of staff engagement as mentioned in this theme.

So we started to drive as a group, how we can increase our communication with patients, we have daily plan of cares, we have implemented on a lot of different things based on Quint Studer's book of what some of the most successful best practices were, in trying to put those forward. Listen to what they (staff) are saying and then look at processes and see if there is a way to improve the process because most of the time it is not really people issues it is process issues. We have to have a clear vision and be able to take the time to find out what the processes actually are and how you might improve them. (Leader 04)

We tried to see what other hospitals were doing for this question and one of the things that some of the nurses brought back from, either places they work in other hospitals, or have had personal experiences with other hospitals was a medication list. It is a daily log that comes out and it has the list of medications the newest on top to the oldest ordered. A general quick blurb of what the medication is, and some side effects to look for. We are really tried to focus on getting to the root cause of what is happening, no shame in finding out what other hospitals are doing, that is working. One of things, actually my assistant nurse manager did a literature research on how we could improve communication with nurses. (Leader 05)

It is sometimes comes from research that I do. So I would get what the evidence based practices or best practices are even on the Health Stream™ web site. We have the Health Stream™, HCAHPS handbook. (Name of patient satisfaction coordinator) comes up with stuff, I hear about stuff in TCAB. We also have monthly relationship-based care, meets as a whole, then it is called Results Council, and they share their best practice. Or sometimes we will just take from other units what they are doing. So it is a combination of a lot of different things, but if something is not working and I do not have the answer, I am right away to look for best practice. (Leader 16)

Nurse managers expressed concern about lack of knowledge on any one best practice that will improve patient satisfaction, alluding to the complexity, and multifactorial context of patient satisfaction.

> Because we struggle and no matter how much we try to it has been a challenge and I know that we are not alone. There are some hospitals who are struggling there, there are hospitals that are better than we do, so we kind of adapt some of those practices. (Leader 15)

Nurse managers engaged the staff in the process of formulating new ideas for change. This theme webs into previous theme for staff engagement and empowerment. Many nurse managers mentioned the significance of team effort in many quality improvement projects and initiatives.

> "So if there was any one thing that I could change well for the day, or if there is any one thing that we can improve, what would it be?" Again the open ended question try to solicit some sort of a response because again, you are never perfect and you are always looking, because what they may be afraid to say, they may say if you propose the question like that and because somebody else may have the same issue. (Leader 04)

> And I think we forget that, we are so busy researching, we are so busy contacting and for a while I did not do that. And then we actually started polling and asking people just informally. "What do you think we can do, this is where we are, what shall we do?" And sometimes you get some answers and sometimes they work and sometimes they do not. (Leader 08)

Nurse managers in this study recollect their experience with addressing one patient satisfaction survey issue and initiative at a time, to allow for staff buy in and for creating sustainable cultural change before addressing other issues.

So we kind of looked at each domain, and subdivided it into what can we do here to make it better, what do we do here to make it better. We did not take it as a global. We broke it down into each area and that is what we do continually. What can we do on each section and look at the scores to see where we are falling and where we are doing well and kind of focus on those domains and juggle it that way. (Leader 20)

Nurse managers (Leaders 10, 17,19) engage and work with the staff to sustain any process improvement initiatives.

So a month later, I go back to those staff members that were very actively involved and say, "How is this process going, is there any suggestions, Is there any feedback? or how we could improve ways to do things better?" So I believe in that a lot too, because ultimately I want them to have that confidence in order to the steps necessary for them to do something, to do right. So I could put steps A through Z in place, but if they feel like some things are not necessary or something like that and still we were able to accomplish what we are envisioning then it is importance. So I was going back to them and trying to see, and sometimes there could be certain things that we have no control over, like certain regulations, certain things that we have to put in place, but then get them to understand that it is not coming just from me now. But this is the expectation that is expected, everywhere else, to try to buy into it a little bit better, it helps, and it is not just my unit, it is our unit, and I believe in that too. (Leader 17)

Leader 21 described the holistic role of the nurse manager in the quality improvement process. This excerpt effectively captures the essence and nature of the focus of the theme.

> The nurse manager's challenge is to be innovative and creative and engage the whole staff for that (process improvement). The nurse manager cannot be dictating, has to facilitate that process, that there is some collaboration with the interdisciplinary team to provide care that is satisfactory, efficient, and timely. But engaging the staff so that there is a buy in and then making that plan- a unit based plan, and give them (staff) the freedom to explore resolution to issues. (Leader 21)

Nurse leaders in this study attribute their success to certain models, philosophies, concepts, and processes such as Patient Centered Care Concept, Shared Governance, and Relationship Based Care, which allowed them to introduce necessary changes in their departments. Leader 05 comments on the need for such models to create staff engagement and improve patient satisfaction.

> Their (organization's) big focus is definitely on patient's satisfaction, but just a whole patient centered care. When we go to department head meetings, our CEO, we have a little blip on patient satisfaction, is not focused on the numbers as much as what we are doing in our organization to improve the quality of care to serve our community and I think that is really important. That community atmosphere is really present here. (Leader 05)

Patient centered has to be, because most probably more, what is driving the scores on the other side, because again like I said, these people care about the patients. So we are putting the patient as the center of the care absolutely. It is the patient's experience that we measure and this will be measuring, right? We are measuring how much did our staff follows that patient care. (Leader 07)

The one that is currently here is a patient centered model. I really think that that works and it is really all the parts coming together for the patient. So I would say that would be model that I think. (Leader 12)

Well patient centered care, it is key, it is important. Regardless of where we are a kind of brings you to the fact that if it was not for our patients we would not be here. And ultimately, we kind of have to adopt ourselves to lot what we do make to sure that we are meeting their needs. So things change so fast, but at the end of the day it is them, what matters and they are the ones who are here for a reason. And it is our responsibility to attend to them so with that whole saying that "they are customers." And they are regardless of how we are, we have to make sure at the end of the day they are priority at all times, there is no other way. (Leader 17)

I would say the patient centered care. Yeah. The biggest influence probably, I am not minimizing the others, but I think that the patient centered care principles because it really boils down to the patient and the patient centered care principles really when you redesigning processes you realign those processes to answer the question is this best for the patient, and would they have the positive experience. So if we change the hours of this with the impact the patient satisfaction? If we change the process of medication administration providing the centralized system

for the nurses such as your or is computerized system like Cerner, for example or anything you provide the nurses WOW so that they can still go at the bedside, or you know providing wall units and you take them away from the bedside, so it has to be the patient centered? It has to boil down to the question- "Is this best for the patient? Would we deliver care timely for the patient? Is it safe for the patient? And of course, is it safe for the practitioners." Making sure that the patient is always at the center of those discussions, so I think the patient centered care. (Leader 21)

Most nurse managers with shared governance models in their hospitals attributed success with staff engagement and empowerment. Nurse managers used unit based councils as a vehicle to implement departmental cultural change. The following excerpts from Leaders 03, and 21 is selected as they evoke a clear message, and thoughts of the role of nurse manager using shared governance models to influence change in culture.

I feel that shared governance has really helped the nurses feel good about coming to work and with the work that they do. (Name of CNO) and (name of Nursing Director) have done an excellent job with really engaging and empowering the staff nurses. So I think that, when you feel good coming to work and you feel like you make me difference. I think in small way that probably, does come across to the patients. (Leader 03)

Shared governance support that process too. So, so evolve the philosophy and principles of that patient centered care model, but shared governance is a way and a tool to really have an equal participation of all the people that are involving the care deliver process who are your caregivers. And providing them the autonomy

of that and being . . . empowering them to be able to deliberate those things and ensuring that the philosophy of nursing is lived out, where is the forum is the shared governance process. So I strongly believe that that supports that so that it is effectively delivered so that it is effectively weaving through all the processes that you are going to design, because, if you do not have shared governance it is all like from it is hierarchical, and all that.

And without empowering the real people that will influence, that I do not think that it is going to be successful. Yeah, shared governance is a wonder. Because it is a tapestry and synergy of balance and inputs that makes the whole better. Because recognizing talents basically, and empowering the staff because they are at the forefront, they could articulate better the challenges, the barriers. And they could come up with some solutions that are meaningful for them that really still my role is to always say is that in alignment to the organizational goal then they can think of other ways. But if I ask the question I provide the answer they are just like, you know, puppets it is not going to be able to achieve the outcomes that we want. There is going to be some type of. . . that is just ridiculous.

It is just ridiculous, although and there is a way also to say because sometimes. If you are part of a system or bigger system like (name of the health system) sometimes it comes from the top and how do you present that to still be a part of their idea. You present the idea and you ask them, so hopefully that in the facilitation of discussion where the communication skills is very important for the manager to have, is to effectively facilitate that process, asking the right

questions, evolving the right answers, to answer to the right plan that you already have and then it is their idea, right? So sometimes we have to do that. (Leader 21)

Leaders 14, 15, and 16 recounted their experiences with Relationship Based Care Model consisting of essential processes that allow for building relationships by first caring for self, then peers, and customers. Relationship Based Care is based on Jean Watson's Caring Theory. Executive leadership in one hospital implemented Relationship Based Care program through a consulting company.

To me I see that it is the Relationship Based Care. I mean that Magnet is good, but Magnet existed prior. I think our first Magnet was 1999. And the patient satisfaction existed before Relationship Based Care. What I see, is really building relationships with the patients is what makes a difference here. That is really what it is all about. I mean we have always given quality care. We have always done our very best. We have not always taking great care of ourselves. Talk about burned out, when everything else. So now we are really living consciously, and talking about it with each other. Care of colleagues, we no longer accept bullying, unprofessional chatter, and gossip. I mean that is just not a part of our culture here, and when we talk about relationships with the patients the focus is off like I said like probably 20 times already, off the very task oriented and onto relationship building. So I think that is what makes the difference. (Leader 16)

Leader 16 expressed that relationship building was important in improving patient satisfaction outcomes.

> I think it is the relationship building with the patients. That we find is--- to me, seems like the more significant in the overall score, and our score for likely to recommend it. I know that is the yes or no. It is always quite high too. So people want to come back here, and I think it is because that we built relationships with the women that come to our unit. Sometimes very often we will see them more than once and if they come back after their discharge because their babies are may be in the NICU or intermediate nursery. It is always with big hugs, so happy to see them, so it is really not just a relationship in the moment, but it is a relationship like for a lifetime and that is I think how we approach it. (Leader 16)

Theme 6 expounds on the role of the new nurse managers as a change agent and in continuous quality improvement. Table 12 contains coding clusters with high frequency data sources and references contributing to the trends for clustered meanings of Theme 6.

Table 12

Theme 6: Coding Clusters with Data Frequency Patterns

Theme	Free Nodes	Number of Data Sources	Number of References
Theme 6: Change Agent – Continuous Quality Improvement	Process Improvement Skills	10	18
	Oversight	13	27
	Change Agent	11	18
	Process Improvement	15	57
	Researching	9	13
	Sharing Results	5	7
	Patient Centered Care	15	34
	Shared Governance	15	23
	Relationship Based Care	6	22

Theme 7: Impact of Organizational Focus and Culture to Improve Patient Satisfaction

Nurse managers in this study expressed the importance of organizational philosophy, culture, administrative leadership focus, and support for nurse managers to improve patient satisfaction. The organizational philosophy and focus to customer service excellence provides the foundation on which nurse managers are able to drive the importance of patient satisfaction and influence front line employees. Nurse managers attributed their success to the new focus and support from administrative leadership resulting from changes in the health care environment.

> There is a culture that we want to be the best, and that is the bottom line. We want our patients to come here and say that they would never go anywhere else because we give the best care and that is only reflective what they tells us. (Leader 11)

> It is culture of excellence, so we have to be able to know that we are providing excellent care. And that is part of our scripting, part of what we say we want to make sure you receive excellent care. And then, when you are meeting you needs in the way that is satisfying to them. So that is what we strive for- like with everybody, "Have you done everything to your fullest potential, to make sure that was the best possible interaction that you could have had?" And things like that, so it is that culture of excellence and that kind of expects everybody to a high standard. (Leader 17)

Nurse managers observed the influence of administrative leaders who live the mission of the organization, model patient centered behaviors, and are authentic.

Idealized influence of top-level leaders influences the nurse managers' inner values and ideals. These leadership behaviors of top level leaders motivated managers and staff to go over and beyond to meet organizational expectations to improve patient satisfaction. The following excerpt from Leader 10 captures the essence of the influence of leadership in health care organizations.

> The whole organization, I think, through (name of hospital) we are all very focused on the mission standards. It is a culture and it starts with top with our President, he is the main messenger, and he gathers us frequently, all the departments, hospitals, nursing homes, to convey that message to us, so it is a culture here and they are very, very focused on that. It is just something is new for me, it fits me better, it makes me feel like, I have been doing the right thing and that was the reason because it really does matter. I did not feel like it always mattered at those other places to the leadership. They are trying to pay the bills I think and a lot of those are the places, and here we are trying to manage a budget, but it is really patient focused and family focused and is good and that was another reason why I am still here after, three-and-a-half years, four years almost or so. (Leader 10)

Leader 05 stated there is new focus from the organizational leadership to develop a patient centered culture and service excellence and is communicated to the nurse managers through the following:

> I think universally it is a culture of excellence and that is important. Their (administrative leadership) big focus is definitely on patient's satisfaction, but just a whole patient centered care. When we go to department head meetings, our

CEO, we have a little blip on patient satisfaction, is not focused on the numbers, as much as what we are doing in our organization to improve the quality of care to serve our community and I think that is really important. That community atmosphere is really present here. (Leader 05)

The organizational philosophy of customer service is ingrained into the thoughts and actions of the nurse managers.

Our organizational culture is really very patient focused culture and I believe that that has been that way since I have been here, I have been here a little over five years now, so I have been here long enough to know that the patient is important to everybody and that has been the culture. It is a bit of a shift as far as these "Always" questions, but not really a big shift as far as the patient satisfaction because we always scored high in this organization and we go above or beyond. We have patient reps running around here I mean just doing anything and everything to make the patients stay a good one.

I think all of the techs, the nurses, the assistant nurse managers, and nursing administration everybody understands that patient satisfaction means a successful organization. I think for the most part we have the right people in the right positions to do that. (Leader 05)

But we do it every day here, but at this time it is second nature to me what we are doing that we are constantly looking for ways to keep people happy and like when we walk through the door, you know, we start with that thought in mind until we walk out of the door at the end of the day, so that is the background for that. (Leader 10)

Organizations focused on improving patient satisfaction, infuse patient centeredness and service excellence in written documents such as Behavioral Standards to influence employees of expected standards. The following example from Leader 17 captures the essence of the nature of this experience.

> But now it is a facility wide, that if you are an employee here, you sign standards that you are going to follow. And we really hold very close to the standards with our staff. So it is our expectation throughout the unit that people are going to be doing the same things every time and it is part of their evaluation so they have to be very mindful and take it seriously.
>
> I think, setting the standards of how each employee is supposed to conduct themselves. From time of hiring point I mean, they are oriented they sign off the standards that they are going to model their standards. It is so important, because if they supported the organization support staff. It makes easier for me to reinforce that here because it is an expectation that all throughout, regardless of what the positions were in, we are all expected to behave and behave the same way. So that helps a lot. (Leader 17)

The organizational mission for customer service excellence is driven during on-boarding sessions during orientation. Nurse managers communicate vision and philosophy of customer satisfaction to new employees.

> We have even to the point where our CEO goes to orientation and talks about it and that is how important it is to the organization. Yes . . . so from orientation on . . . the expectation is placed right from the beginning. (Leader 05)

Nurse managers in this study influenced change through various initiatives and processes through the support of administrative and nursing leadership. “I think that the organization supports us. They help us with charts for your data. We have to report to different quality councils” (Leader 05).

> I guess it is just support of our leadership. They like we do, they listen, they are very well and listen to our suggestions and implement changes as much as possible. I feel comfortable going to my leader and my leader feels comfortable going to her leader with suggestions and thoughts and we, it is a good relationship, having a good relationship with the people there. (Leader 10)

Many organizations in this study channel their resources to meet external demands for improved patient satisfaction scores. Most of the nurse managers surveyed attest to the support of dedicated patient satisfaction coordinators and a team approach by involving other departments to change organizational culture.

"We have patient reps running around here I mean just doing anything and everything to make the patients stay a good one” (Leader 05).

> We have a patient experience team, We have a patient experience team that meets every other Wednesday and it is all multidiscipline, all the people do rounding and we talk about our HCAHPS scores and what we can do where we are going to gaining and where we are not gaining, so I think it is a team approach, very integrated. (Leader 19)

Some nurse managers described that organizations were channeling their resources to improve the aesthetics of the environment to enhance the patient experience.

The following verbatim excerpts represent the cluster of delineated meanings into this theme.

> You reason is the commitment to the patients I think the philosophy of like we are saying a lot, it is the commitment to do satisfaction with the family and the patient sits beyond that I guess the environment is beautiful, it is a very different experience coming here for and the lot of care than it is going in many other places. I think that hugely affects the reasons the people come in and probably the reason that they are satisfied and may be why we score high on lot of these results because this is a beautiful campus and a very nice place to work and they bear no expense in fixing it and making it nice and making it beautiful if we have a light bulb out for more than an hour, it is a tragedy, there is e-mails that there three hours that is going on, we really pay close attention to that stuff and I think makes the whole experience for the people they are here in the psychiatric hospital in the long-term care, assisted living rehab, and that makes a big difference in their satisfaction feeling like it is home more than feeling like they are an institution and (hospital) is really has invested in continuing that and making that their experience, so that is. (Leader 10)

Organizations in this study support nurse managers in promoting a healthy and learning environment necessary for adopting new practices and initiatives house wide.

> "I have a lot of autonomy. I think lot of things came out of our HCAHPS meetings that went hospital wide. I am kind of proud of that." We had a holistic nursing committee, which has come up with some really nice things. We have our Standards Committee that reviews all nursing processes and it is attended

well. We have a unit practice councils on each level again everybody owns it. Many improvements are made through the unit practice councils. (Leader 05)

And many of those committees hit onto the patient satisfaction. Whether it is really I think it just gets incorporated into everything that I think that . . . it is a culture change . . . in order to that is all you do as you live and you breathe your patient satisfaction, your HCAHPS, your core measures scores. Those that is what you live on every day and if you are doing very well that you are going to continue to do well. (Leader 11)

Nurse managers in this study recount their collective experience with increasing focus from administrative leadership to engage all members of the organization to improve patient satisfaction outcomes.

When service excellence was introduced in the facility few years ago, it kind of got everybody to think a little bit different, to shift, that we just cannot focus on the nursing piece, and our skills and our interactions and things like, that but all of that comes together. And then seeing that, the rewards, are so worth it at the end, which is the driving force, it kind of puts everybody on the same page. (Leader 17)

Now we have a program we call "Every Patient is my Patient." So if the respiratory therapist is walking down the hall and somebody is calling the call bell that respiratory therapist right there has to respond to that. And we are doing competition like monitoring by competition and recognition on any department that within the months they responded the most on call bells, except nursing for example right because nursing are there, so it is a biased competition because

nurses are always there or nursing staff are always there, other departments if you have the most number of responses, responding to call those in the months we recognize something like that. (Leader 21)

Some organizations are in various stages of the journey to build an organizational culture of service excellence, caring, and patient centered philosophy.

So that is when our CNO, she is such a brilliant, very nice, very brilliant woman, she really then incorporated this ancillary departments into the relationship-based care and now everybody is accountable to respond to these meetings and everything. So since then yes, we are more aware, not probably changed the culture, but they are more aware of the initiative in the organization. So I think that is great. (Leader 14)

Leader 10 described the leadership in his organization promoted a collaborative approach, with many disciplines and departments working together as a team to improve the safety, quality, and satisfaction of the patient. Top level leadership in these high performing organizations are striving to change the culture by engaging all resources and personnel to realize the philosophy of excellence in customer service. Nurse managers recounted their experiences with multidisciplinary and interdepartmental committees to improve patient care experiences through shared accountability, and ownership. Patient satisfaction survey's focus on the entire patient experience and some organizations in this study, focused on engaging every single employee of the organization to influence an enhanced patient experience.

It was actually a wrap up meeting for our 2012 contraband team, the things we have done to improve safety on the unit and we had staff from all areas, pastoral

care, activities, social work, nursing, our staffing coordinator was part of it so hearing everybody's thoughts is really, it does make the difference, so it is shared, an opportunity to have a say. It does really effect the patient satisfaction. If just nursing, if we left it with just nursing administration, we were very restricted and strict with who we had made decisions and suggest changes and then I think we would be very limited and we wouldn't have all the ideas where the things have improved satisfaction and with this meeting things that have improved, safety a lot on the unit in the last year or so. (Leader 10)

In almost every meeting and in every aspect, I think we look at marketing, we are looking at patient satisfaction, we are working at who our consumers are out there. Finance you want to make sure that you are not the highest, you know hospital that is charging the most money to get your appendectomy done, you know. You wanted be able to be transparent and be able to mix with the rest of it, so that is another area where there is patient satisfaction and consumer satisfaction. So I think it hits no matter where you go. Your outpatient departments, it hits there. It is not just who we see in as a patient inside the hospital. (Leader 11)

Organizations that have high patient satisfaction scores understand the need for the entire organization with every department working together to realize the goals for improving patient satisfaction. These organizations hold every department accountable and responsible to improve patient satisfaction. Nurse managers in this study related their experience with success in attaining high patient satisfaction scores, when

organizations have a multidisciplinary approach rather than shifting the accountability of improving patient satisfaction solely on the nursing department.

> Oh sure, absolutely every department is critical and that some of things we get involved in, as nurse managers. Is like I was saying earlier, families unhappy with this one and that, social work did not call me back, the doctor did not call me back, and yeah it is critical getting everybody on board and smoothing all of that over. But yet, every department has to be involved in, and vested in patient's satisfaction, even though most of them come down to nursing, there are still other areas that were scored on, but yeah they have to be involved, and have to be a part of well . . . because they deal with the patient's face-to-face as much as nurses do. Social work, pastoral care they do one-to-one therapy, patients are in groups all day long with activity staff, so they are interacting with a lot of those different departments and if those departments were invested in as much as nursing was, we could not score so high and we would not get some nice comments like we got, as social works. (Leader 10)
>
> Oh sure, we talk to every department, we have the hall of leaders in multiple departments are all invested in it from housekeeping to facilities to food services everybody wants patients to be satisfied, they are going to do their best. (Leader 10)
>
> Yeah that is right, when we had a few years back with patient satisfaction we had like a work group. We included secretaries from the main reception, to lead CNAs of nursing assistants, and people from different aspects, because the main reception is the key. They come in, they greet the families, I know if they know

there is somebody upset they walk-in, they quickly call me to say there is a family member here there might need a little attention, making sure that they knew that- if it is important to me, I expect for them to know that it is important for anybody, at any point to take that time, and address that. So you now we try to incorporate, many different people to make it to know the roles seeing the same thing for the same place. So even other disciplines like activities, social work, everybody else kind of put a little input into that. (Leader 17)

Well, we do patient rounds, and I know you talked to (name of Perioperative Director). And we do rounds, so we know, that it absolutely affects patient satisfaction. It is a team approach; it is for the whole hospital. It is administration, it is housekeeping, and it is transport. If you room is dirty, I mean (name of Perioperative Director) and I make rounds. We go in and the boards are not up-to-date, and they have got last week's information on, and I am seeing there is a patient, "They even did not do the boards, what kind of care I might going to get, the room is dirty; it is not clean, who would be in this room, I do not know what these are, the furniture does not match." They have nothing better to do but look at what is going on so every piece of the team is influential in the patient satisfaction, every piece of it. From the person that walks in, with the dietary tray, that does not say anything, but plops it down and walks out. To the transporter that goes from room to room without washing their hands, everything, is absolutely. It is such a good idea for people to be patients, and to sit and just watch what goes on. (Leader 19)

Leader 18 noted changes in the organization because of a team-based approach by organizational executive leadership to resolve system, and process issues to deliver excellence in customer service.

> So I have seen them work better together again, developing the process, versus than this is an OR problem, I do not want that, that is your problem. So that is challenging to me as a director, as an administrator, and my managers because, my managers are split in the departments they manage, so there is bias. But I think you it is realized that we are just one department. It is not about OR, PACU. It is not about same day. It is about the patient. You have to work hands-in-hand with all the disciplines, with the department of surgery, anesthesia, nursing, because it is important that in order to run smooth, we are in the same page. (Leader 18)

> Same thing with discharging the patient. The doctors, everybody is a team. If the nurse is busy, the doctor will discharge the patient. It is not one person's job. It is every one's job. The same thing- with getting the bed ready for the next patient. If the nurse is not busy, then the other nurse does it, they would not wait for the multi tech to do it. It was a team approach. They see I will do it. It is not one person's job. Every body is part of the team in order to get the patients moving. So I think those were probably some of the biggest initiatives that we put in place, and probably the most important was getting that patient back to the ED, for the doctor to see, eliminating all those barriers. (Leader 19)

Nurse managers observed the new enhanced focus by physician leadership to fulfill organizational mission, improve the overall patient experience, and patient satisfaction scores.

> So we have a very good Medical Director who listens to us as well, we can go ahead and tell him anything than we frequently do, he reads the patient's satisfaction scores, which frequently say my doctor didn't spend any time with me or my doctor was great, so he sees it too and yeah that definitely helps doctors are, I think, more part of the culture. We have like treatment team rounds, three times a week, but it is interdisciplinary and we do have family meetings that are very interdisciplinary too, social worker, doctor everybody kind of integrating and coming together with the families to kind of make sure that we are addressing their needs. So there is a very good communication, open communication at all times. Our doctors are very accessible, that you call them, you have a concern, or a family has a question or something you could meet with the doctors. They are very available to respond to the families, to talk them on the phone even at that moment when they might need something. So we try to facilitate that all the time, and I really truly believe that the other departments do support that mission. (Leader 10)

Employee centered organizations attract nurse managers who believe in the value of human resources and capacity.

> Well, I think this organization is pretty employee friendly. So I mean that would equate to nursing staff as well as other employees. I mean they try and do things for nurses week, they do employee recognition things . . . they, you know, have

employee lunches, and barbecues, and holiday things as I am sure as other organizations do. (Leader 06)

Nurse managers in this study perceive positive reinforcement of patient centered behavior essential to maintain success in a cultural change. Nurse managers in this study expressed positive feelings when organizations reinforce customer service excellence through structured awards and recognition programs.

You know we do a lot of positive recognition as well which I did not mention. We have a (name of hospital) Star Program in the computer. Any hospital member can actually go in (to the computer) and put first name of the employee or department where they work and you could send them a little note and you accumulate points. Every Christmas I wind up with about 80-100 dollars in gift cards, it is a nice program we do a lot of staff recognition. (Leader 05)

Well they do recognition for Press Ganey™ scores; they still do Press Ganey™ scores, but they only do them quarterly. So they reward units that are in the 90th percentile with baskets, and you get pictures taken. I think you have noticed the pictures on the wall. Yeah, this has a whole wall of them. So that is something that because they always tease over there that we won we won 90th percentile basket, and I say we are going to get it one day. So you need a quarter of that so that is another thing I mean they do reward and recognition for high scores throughout the organization.

Yeah. They do get (name of hospital) stars. If they get a particularly nice comment about a particular nurse or tech or you know employee they will make them a (name of hospital) star and then, they get the picture taken, and it gets

posted in the hospital . . . and it goes up to the department head and discussed. So that is a motivator too. (Leader 06)

And then the rewards that we get, if any of my employees can mention their survey by name or CEO automatically get a thank you card and they get mailed to their home and then I get a copy myself that goes in their files. So that recognition something that positive, it only indicates, that it is important to us, if it is important to our CEO to take the time to write every time the family member mentioned an individual by name, it is a lot, we have a lot of employees in this facility and he does it all the time. (Leader 17)

Some nurse managers in this study observe that some executive hospital leaders are accessible, approachable, and transparent with front line staff. Transformational executive level leaders inspire nurse managers to emulate similar transformational behaviors. According to study participants, leader visibility, and accessibility opens the door for communication, sharing of information, staff satisfaction and creating a healthy working environment.

Administration does do, is they will come and round weekly on the staff. They do not go and see the patients, but they want to know what is going on with the staff, "How are things going? Do need anything?" What are issues that they are having now? And they are really good at getting results because you know they are the senior VPs. So you know that was one thing. When it is done, the staff appreciate it, and do see results from it. (Leader 03)

And I think in some ways . . . staff perceives senior leadership to be more approachable. And I think that they are more, one of the most important words-

Adjectives I would use is realistic in their vision, because again, I think a vision, a transformation leader is lovely, but that vision needs, to be one that we can hope reach. So in theory, it can be beautiful. But I can tell you our CEO who has been here about four years now. He is a transformational leader and he is very charismatic and I would take the KOOL AID for him. Because he makes me understand, why we need to do, what we do. And again, it inspires me to want to do what he is asking us to do, because it makes sense to me. On any given day, you find him out walking through units in his $800 suit and find him sitting next to the unit secretary on the floor just yacking away, chatting, chatting, chatting. Where he will be grabbing a towel because he was going down the hall and our nursing assistant, did not know its him and yelled up, "Somebody please get me a towel." And so before the nurse or anybody else can grab it, this man will go to the clean cupboard and will get it down. "I hope this is a towel." And people will like it first "but just like I am sorry (name of CEO) . . . I did not realize it is you Mr. (name of CEO)."

That inspires me, so I think over the time, that we have blurred the line between the C-suite, which I think is wonderful. You can be in C-suite, but there should be no glass ceiling between them and us. There needs to be an open door, and I think we are getting better at that. People are now in the C suite, more often. That was a forbidden zone, you went there when you are getting fired. It is not a forbidden zone any more. I am up there a lot. I see CFO, I talk to the COO, I was just with him a little while ago doing rounds on the units. So I was with the CNO and COO, and then a couple directors and that is how we do business here.

So that example inspires me. When the staff see that I am on the floor, overtime, its getting better that they will approach and they will talk and they will ask questions. So I think that is in integral piece to get in to buy-in staff. So we are doing better in that area. (Leader 08)

Oh! It (organization culture) plays a big role. It has to filter both ways. It has to be an example at the top. There has to be people that set those expectations and set the goals and set the marks. And they have to be able to perform in that way in order for anybody else to be the same way. So, you have to lead by example, and if you do not lead by example they are never going to pick it up, they are never going to understand. They are going to say you are telling us do this, but we are doing something totally different, so it has to be all-together. Everybody has to be together in it.

I think administrative support has always been. I think that influences the way the staff do things. They are very supportive of the CEO. They absolutely love him. And when he has his town hall meetings they attend, because they want to hear what he has to say. Anytime he speaks they want to hear him, so they are very supportive of him and I think that he does influence how people feel. I know in my level he influences how I do things and how I feel because I believe he is a great leader. I believe that he does, he has his vision of what is going to happen and how things are going and this hospital would not been here today, if it was not for his visions, so I really do believe that he has a big influence. (Leader 11)

I encourage my nursing managers, I also by example in terms of that standard of leadership I would like my managers to emulate that is basically. And I do it in

different forms in terms of my actions as well as I have one to one with them. And I always put the time, where we talk about my observations, and what are the things that the person can do or the manager can do, to professionally develop as well as, you know, growth and all that. So it is a lot of forums I touched that in terms of modeling and then I expect them to go out and do the same thing and I would say that has been very satisfactory on my end, because I see that they are responding, and they are really very eager to be mentored, so I am enjoying that. So that is I think that is a very critical role of the manager is through that process. (Leader 21)

Nurse managers feel supported when top level administrative and nursing leadership offer emotional support, mentorship, and practice an open door policy.

They are sometimes, I am kind of stuck in the middle between the staff and upper management, so I need a sounding board. I have a wonderful director, who you know like she will help me work though something. And sometimes, I do not need to do work through, I just need to blast about it and then I am okay fine and then you will put my head back on my shoulders and just go back to work, but I am need an area to vent. Our CNO was wonderful. She is a nurse's nurse, which I really appreciate, I mean she is for nursing and she is 100% nurse, which is very helpful to the nurse managers that work for her. (Leader 09)

I would say (name of CNO) she is a visionary. She definitely has the capability of running a huge organization like this and she has done an amazing job. The two-and-a-half years that I have been here I have seen changes that have happened in the organization. I mean you could have couple of people here and

they are totally supporting that, not because we like her as a person, because her visions are very high quality and people who really want that quality gets really, it is like a magnet, you attach to that. And as a leader as a (CNO) would, she acknowledges that different people have different way of getting it and she is very flexible in making that happen, which I appreciate as well. (Leader 14)

I have to say (name of CNO) coming on board, was you know as you go through different VP's, different management techniques and skills. I have to say she is down here a lot and I was always visible that is how I achieve success in New York and all that and she is visible. So she is in the building and that is important and she could speak. She knows her employees, that is important, she knows, and a lot of the information you have to share with. We have one to one every month, and or more so if we needed, so I have to say that is good. It will be nice, if more people actively took a step. We need that. (Leader 18)

Theme 7 emerged from the analysis of coding clusters and the higher frequency of free node descriptions presented in Table 13.

Table 13

Theme 7 Coding Clusters with Data Frequency Patterns

Theme	Free Nodes	Number of Data Sources	Number of References
Theme 7: Impact of Organization Focus and Culture	Patient Satisfaction Philosophy	15	53
	Team Approach	12	24
	Patient Satisfaction Committees	14	26
	Learning Organization	6	8
	Organizational Strategies	10	42
	Rewards and Recognition	9	14
	Educate Staff	11	23
	Administrative Influence	19	45
	Mission/Vision	14	17
	Nursing Leadership Support	21	45
	Physician	13	19

Theme 8: Challenges Facing Nurse Managers in Their Journey to Influence High Patient Satisfaction Outcomes

Nurse managers in their journey to improve patient satisfaction encounter multiple challenges. Theme 8 highlights the two most referenced issues namely sustainability of many of the patient satisfaction initiatives and lack of multidisciplinary approach and accountability to improve patient satisfaction outcomes. The main theme is divided into two sub themes as two distinct but essential challenges experienced by the nurse managers.

Theme 8a: Sustainability of initiatives. Participants in their journey to improve patient satisfaction experienced variability in the success of various initiatives and best

practices. Some nurse managers have experienced a lack of sustainability on many of the initiatives as they learn, experience, and develop patient caring cultures. Some of the participants experience these challenges, alluding to the complexity of the new role and experience with improving patient satisfaction. The challenges lie in the multifactorial and multidimensional context of patient satisfaction that eludes the health care organization attempting to meet customer expectations. Participants with high scores still experience variability in initiatives due to the many other factors affecting the nurse manager role. The following graph in Figure 13 is a matrix coding query in NVIVO 10.0 software representing the number of participants who described their lived experiences and challenges for sustaining initiatives to improve patient satisfaction.

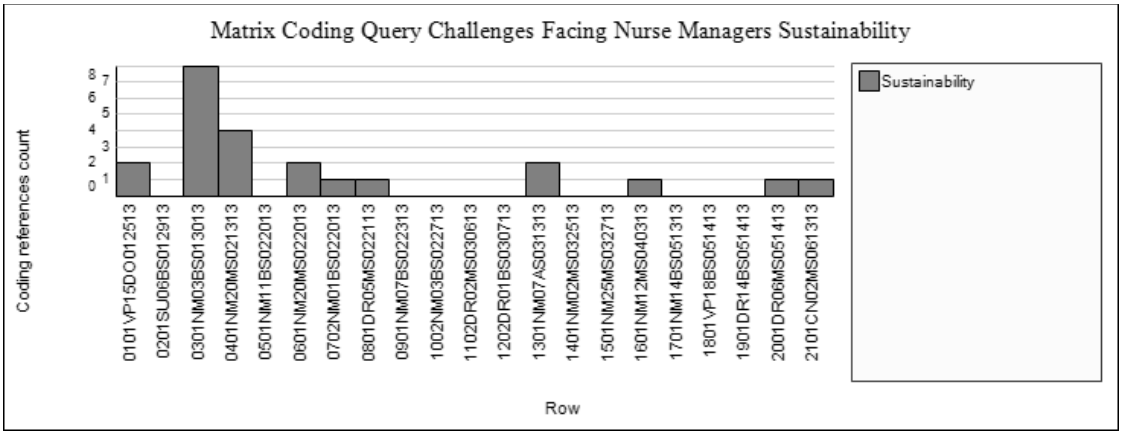

Figure 13. Matrix coding query: Theme 8a: Challenges facing nurse managers-sustainability.

The following participants provided their account of the lived experiences with challenges for sustainability of initiatives.

We tend to have seesaw type tracing you know, in everything. We do not sustain anything. We could peak at 90% and then the next core you look at it and you are

down to 70%. There do not seem to be any rhyme or reason to why we plummet like that. (Leader 01)

Well I think we have had ups and downs, each quarter things changing and that is a part of our frustration is to be able to control and come up with an action plan timely enough- to be able to correct the next quarter, so we do struggle with that. (Leader 08)

I think everything, all the initiatives have benefited. I think I have challenges sometimes maintaining. The call back sometimes becomes very challenging depending on volume. If there is downtime that is when the nurses have a better time to follow through and be more compliant with it. We are very busy. I feel like I am always challenged to make sure that it is getting down let say. Well this is strictly patient satisfaction driven, I think everything we put in place it is benefited; it has not been a negative. (Leader 20)

Participants in this study perceived issues with sustainability of initiatives and programs. Study participants recount their experiences with inability to sustain patient satisfaction practices due to lack of top level leadership focus.

When administration comes in and does round and does do the rounds, even though it is not on a consistent basis you do see the support. But other times it (Administrative support) is just not there and it is not any one persons fault, it is just that is the way it just happens, so there is no consistency or sustainability from them either. (Leader 03)

Nurse managers in this study assign issues of sustainability of initiatives to a lack of buy in from some staff members who are resistive to change. "Some people are just resistant in every step of the way and that is a challenge too" (Leader 04).

> Sometimes it is easier just even with nurses on floor sometimes I would rather have a brand new nurse that you can shape, and develop and grow, versus hiring a 15 year veteran who is set in their ways. So it can be a struggle, to get people to change. They say you cannot change, or teach an old dog new tricks sometimes you can, but I think the odds are stacked against. (Leader 08)

"I think this institution and I am part of it. The institution has a lot of long-term employees in it. And that is very hard to change" (Leader 20).

Nurse managers verbalized frustrations to improve and sustain patient satisfaction initiatives because of multiple demands and overwhelming responsibilities that challenge the necessary focus and energy needed for change management.

> Another challenge that I have had is getting to see every patient. It is very time consuming and if it is a day of meetings it is almost impossible. I would say that that is a struggle. You wind up putting out fires instead of being proactive and you know that is obviously not any manager's goal. Resources, probably just constant monitoring of the new processes, you put it in place. That it is challenging. Making sure, being present, when there is a lots of meetings. We live in a world of meetings. You have a meeting for the meeting . . . a lot of meetings. So, maybe we have less meetings you will be more available on your floor. (Leader 05)

But yeah my demands are very, very split up and I constantly feel I want to spend more time with the patients. But the reason if I really tears me up the more time I spend with the patients better I feel when I leave at the end of the day and then I come back the next day I am much further behind in my work, so it is really hard to find that balance. (Leader 07)

But the practical part of that I do not know that it is going to change too much, because I think that we are asking managers to do so much right know, that I do not know that there is much you could ask them to be involved in. Truly, I cannot think of another area that, I feel that I do not have piece of. (Leader 08)

It is difficult, you know and you have to kind of go by the triage of the day. And you know you can come out with the intention of saying this is going to get done, this is going to get done, you know where I may have to, so I have to get the staff information in a timely manner. I have to get their schedules out, I have to get the patient's rounded on. I think again it is just we have to be. You cannot be in this role and be very- Type A, you cannot do it. (Leader 13)

I do have challenges you know like you know time management is always my struggle you know specially at the end of the day you want to do more than you are already tried and then you keep on you know and that something that I had always been working on. Because of the volume of the work that you do and sometimes I end up to be honest with you end up bringing my work at home- to give me a little extra edge. (Leader 15)

I guess, as probably having many different jobs, and trying to manage all of them and still be able to keep your focus. I would probably say, not time management,

but what is on your plate. Getting it done you get it done, but it is managing all of the expectations in today's health care. And that is probably why most people are getting out of it is you know it is very demanding, very stressful. So I think probably that is probably the part of juggling all of the balls in the air. (Leader 19)

Leader 19 provided a glimpse of an organizational culture that hold nurse managers responsible and accountable for improving patient satisfaction instead of a collective organizational responsibility for change. The excerpt is an example nurse managers' account of the lack of ownership and responsibility from other departments and leadership within the organization to enhance the patient experience.

And as a nurse, you know, it all runs downhill. "Who gets it? nursing! If it can't be done, nursing does it. Right." And I guess that is sometimes difficult. And the time, you spent a lot of your days here, lot of work, to homework, it is trying to get everything done in a short period of time and be there for everything. The fiscal requirements, and demands, forces start shrinking. I can say I have ICU, I have ED, and I have the psych unit. Some days I do not know which way to go first. So I would say yes.

I feel like sometimes the nurse managers they gofer for everybody. You know, "Go do this, go do that, and go distribute this, go give out that." There are more of the gofer than the manager. Nursing always seems to be the one that gets the job. Because someone else does not want it and I think lot of nurse managers spend a lot of time doing other peoples jobs, because someone else does not want to do it. And I guess that is a part of accountability whether that is right or wrong.

> Stop asking me to do everything, tell me what you want that is the most important for me to do and I will get it done. But everybody dumps everything on you, and expect you to get it done when they do not want to do it, so they give it you to do it? Right. And that is why I think people are getting out of management because it is too stressful. (Leader 19)

Nurse managers in their interviews recounted their experiences with financial challenges facing organizations to provide an enhanced patient experience namely adequate nurse staffing. According to Leaders 03, 05, 09, and 15 adequate nursing staffing is often a taboo subject in hospitals, but nurse managers attribute dips in patient satisfaction scores because of inadequate staffing. The following selected passages evoke a clear image of the struggles by the nurse manager to improve patient satisfaction.

> So I think that you know also for me the expectation of leadership that I will be able to change those scores without changing staffing ratios and things like that is very stressful, but it is reality that that is what the expectation is. Improve staffing ratios for the nurses so that they are able to do their job better and then I am not putting up fires. They all want to a good job. (Leader 05)

> Sometimes it is staffing, that is it. The not everyone wants to hear that is of course, but it has a very different impact. If you do not have enough people you don't perform the same and you are not able to do all the things that you are supposed to do when you have more patients than less. (Leader 06)

> The issues are . . . staffing, which of course no body wants to go near that issue. You can have all these things in place, if you do not have adequate staff to take care of the patients, none of this matters and that is challenge sometimes,

especially during a surg. It (patient satisfaction initiatives) falls apart. We did not expect the surge and is very difficult to predict in November we started, out of nowhere, Okay and all of at sudden had high volumes and I am budgeting for 24 patients and I will on 33 it is a full capacity for me. So of course I needed two extra nurses and I did not have them, so my nurses are troopers they stuff them to the plate they will do and took 8 to 10 patients a piece, and was awful.

Manager and the nurse manager running around to do what we could, it was truly exhaustive, but we do hire per diems with that agency nurses and here the problem was; it takes a while, so they are for like a little while, it was a little crazy and that was reflected in the scores. You can see the scores comedown during the month of December because there was not enough staff on the units to take care of all the patients and the patients felt it. We tried not to have the patient feel that, but it is evident when the nurse said I will be back in five minutes and half an hour later she comes back. (Leader 09)

So you talk about again not having enough manpower is one of the challenges that we will face with regards to trying to please our customers, because we do not have the body to provide the services. People do not want to hear that, that you do not have enough staff. But the reality is that the needs of the patients are so much higher now. (Leader 15)

Nurse managers contend with harsh realities of staffing and look to be innovative in resource management and in improving patient's perceptions and experience. Leaders 04, 15, and 16 provide diverse perspectives on adequate staffing and patient satisfaction.

When I speak to patients, and they said to me, “I know you very short staffed." I said, “Is there anything I could do for you before I can leave?" “Yes hire more staff." You know, I say to myself, "Interesting! You know, I still have wonderful staff, plethora of staff, I staff my unit to the matrix if not over. They come in the morning and occasionally our staff are pulled, I have no control over that." But how it upsets me about that perception. Like even if we are short staffed, that should never be their perception, because it is not their problem. (Leader 04)

You know, because everybody has to understand, we do not have perfect staffing. It is not just in (name of hospital) nowhere, and I have worked many health care nowhere, you think (name of other hospital) whoever has the best staffing, they do not, they really do not. If you go inside any department, they all are struggling, so do not think that grass is greener on the other side. If you think so, please do, please leave, because and you will realize later this was a better place. (Leader 15)

We have to learn how to work harder with less, it is just the way the industry is. We are not being punished. It is not because they do not want to give us staff, and they want to see us work little fingers to the bone; it is just because this is the new health care, so we have to work smarter, we have to be more creative, and we have to get over it, cannot sit here an whine “Oh if I only have one more nurse.” No! I know it is not going to happen so lets move on. And figure it out. And that is really what I try to tell the staff too. So I do a lot of things with that. Right now, two of my nurses are going to start IRB research project on time motion study of a nurse. Try to identify are we doing things that we could delegate to

other people like really where is our time spent, so we can spend the time at the bedside. So staffing is staffing it is not going to change, we have to work smarter. (Leader 16)

Nurse managers in this study suggested that issues of sustainability were related to implementation of multiple initiatives and not enough time to hardwire the new behavior or change. According to nurse managers, hospital leaders adopt new patient satisfaction initiatives, without consistent monitoring and oversight for sustained behavioral change.

I am saying the sustainability of the initiative that gets rolled out. I mean if you only knew of the number of things they tried to, or they did try here, and they tried them for a week or a couple of months and then they just whistled out. One of the things that I guess they had tried, may be year-and-a-half ago, was the patient advocate day: where the nurse manager of a particular unit would go down and sit with the heads of the other different departments, and you would discuss what was going on and what you needed from each department or what they could help you do to improve. They did for that two-and-a-half may be three times three months in a row and that was it and now just recently they are talking it back up again and you know they never sustained it the first time. What made you think you are going to do it this time. I mean they felt that it really worked, and we did get very quick resolutions to some of the issues that we were having on the unit. But it was not sustained, so I think the sustainability of things. (Leader 03)

Nurse managers in this study offer the following suggestions to address issues with sustainability. Nurse managers suggested carefully choosing and prioritizing initiatives and a focus on developing and educating staff to sustain initiatives.

> So those take with tedious, busy work, time consuming things, we need to get rid of and focus on the round and doing boards, staff engagement, getting continuous education and in-services with that, I think will help. (Leader 03)

Leader 01 suggested enculturation of patient satisfaction philosophy to hardwire service excellence among all employees of the organization.

> Well, I think everyone has to be. I don't know if there is one model, but everyone has to be on board with it, everyone has to know where we were going and what we were doing. It has to be a common shared goal, we all have to speak in one voice, we all have to know, we just cannot be doing all things, all this has to be programmed, it sounds terrible, but I mean it is scripted, programmed until becomes hardwired right into our psyches and into our practice. So we do not need to think about it. And if somebody asks later on, "Did you do?" "Sure I did." You just do things and you react and that is what patient satisfaction has to be- as something you react to, do just like a code. You have to react to which you have to work towards it. It does not come easy, but you know when you get there, you will know it. (Leader 01)

Study participants suggested engaging and empowering staff to implement and sustain initiatives to improve patient satisfaction. "What the staff would do is they would develop these initiatives to help improve care and they ran with it I mean they just did a phenomenal job and we are sustaining it" (Leader 09).

According to Leader 01 ongoing monitoring and consistent oversight ensures hardwiring of new behavior.

> I think whatever gets done is got to be done consistently, otherwise just do not do it all. If you got to do follow up phone calls, do you follow up phone calls every single day or just do not bother. (Leader 01)

Leader 13 thought that nurse manager visibility and presence helped with sustainability of any initiative. Visibility helped nurse managers address issues in real time, take corrective action, encourage staff caring behaviors, model patient centered behavior.

> To sustain, you know again I think it is being present. I think you now being there "just in time." We had a change from me, where I had an office that was on the unit. And it was when I tell you a quarter of this room and I could not have two people, three people sitting there at the same time. I had files, but what I loved about it was that I was at that main door. I could hear patients coming in and out; I could hear what the nurses were saying to the patients. I could hear them at the nurses station when I got really quiet I knew things was not good. Like when your kids are quiet at home, but most like I could hear what they are saying in the desk. I could hear rumors; I could hear talking about so and so, schedule issues, but I could not be there any longer with med-surg unit and you know all this things I needed to do, so I had to move my office off the unit. I think it is so important that you be present "just in time". You know, if I have doctors having a hard time with order entry . . . . If I have nurses having a hard

time getting what she needs to get for the patient to be there be able to intervene is so important. (Leader 13)

Theme 8a Challenges- Sustainability emerged from the analysis of coding clusters and the higher frequency of free node descriptions presented in Table 14.

Table 14

Theme 8a: Coding Clusters with Data Frequency Patterns

Theme	Free Nodes	Number of Data Sources	Number of References
Theme 8a: Challenges: Sustainability of Initiatives	Sustainability	14	30
	Staffing	15	29
	Lack of Staff Buy-in	9	19
	Change Current Habits	8	9
	Multiple Demands	10	22
	Multiple Initiatives	9	12
	Address Challenges	12	28
	Resources	11	24

Theme 8b: Lack of interdepartmental and interdisciplinary teamwork.

Some nurse managers verbalized frustrations with the lack of interdisciplinary and interdepartmental cooperation, collaboration, accountability, and ownership to realize the philosophy of improving patient satisfaction. Organizations with overall high patient satisfaction scores enacted a multifaceted team, to fulfill their mission as mentioned in Theme 4. Figure 14 contains a matrix coding query in the NVIVO 10 software of the participants who recounted their lived experiences with lack of interdepartmental and interdisciplinary collaboration.

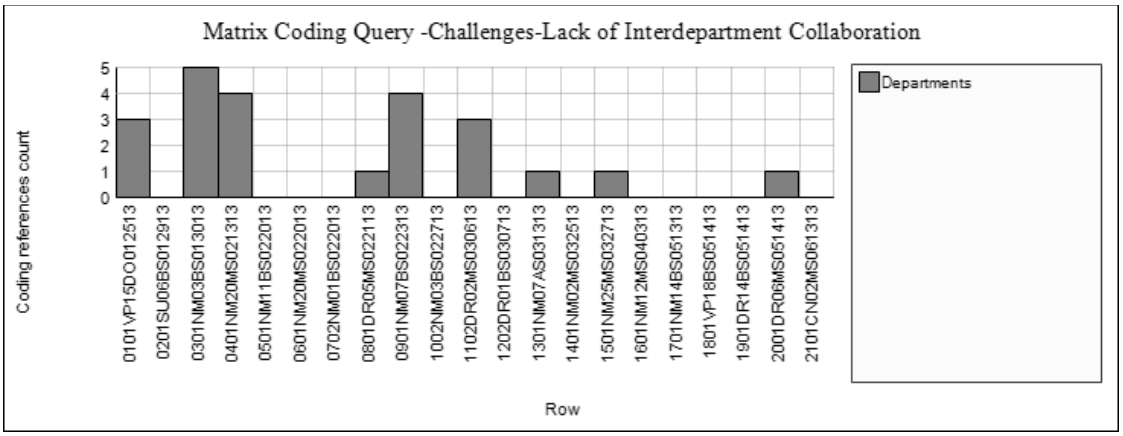

Figure 14. Matrix coding query: Challenges facing nurse managers: Lack of interdepartmental and interdisciplinary teamwork.

Leader 01 stated that nurse managers are responsible to coordinate the different departments and disciplines to enhance the patient experience and health outcomes. However, some participants expressed frustrations with a lack of responsiveness and cooperation from different departments and disciplines to improve service excellence.

> They certainly can influence it, but they get frustrated, so if the nurse consistently complains that the garbage is not being taken out, if the floors have not been not cleaned, or the beds are not being turned over. Everybody's role is very important here and here and you know, she could complain about it, but if she does not actually document it somewhere, there is no paper trail, so people, she does not remember, I am calling all the time, but what that does mean in numbers. So they are very busy, they have got a lot of balls in the air. It is very difficult for them to do an incident report every time. They need the garbage taken out. Something else may come up. So, I understand that on the one hand, but on the other hand I am thinking you know we guys got all be accountable and make each other

accountable and if we do not then we are going nowhere fast. So, I definitely think the nurse managers have a huge influence over things. (Leader 01)

Leader 04 stated lack of buy-in from leadership of ancillary departments for improving patient satisfaction. Leader 04 stated hospital leaders hold nurse managers responsible for the patient satisfaction scores on the inpatient unit and coordination of multiple service lines to improve patient outcomes. Leader 04 experiences difficulties due to a lack of ownership from other departments. Some study participants express discontent over new expectations of the nurse manager without ensuring a collective organizational ownership to improve patient satisfaction.

> You know a responsive hospital staff. And again you know the patient tells me. Soon as they lie in the bed and they look up at the ceiling, and that they are laying there, they are looking up when I look up at me standing there. "I can see the dust like this, on the vents like this," I don't know about it, but as soon as they tell me, I have to address it. So today I called the Director of environmental and then I get a song and dance, "Well that is maintenance,", and maintenance will say, "that is not us that is this." This is what you go through. So it is a kind of like this, so again the culture needs to be held accountable. So, I will give a message to you and if it not your department, like help me coordinate the right department, because he is going to tell me it is your department. So kill each other and work it out. I am a clinical person. But you do not actually see that, and I think that what is makes you or break you. And I think all those pieces are not necessarily all in place. (Leader 04)

Leaders 04, and 09 verbalized the importance of teamwork and interdepartmental collaboration to enhance patient experience. Leader 04 reinforced the role of nurse manager to coordinate all disciplines and resources, however the burden of that responsibility is not shared among all departments. Some nurse managers in their journey to improve patient satisfaction experienced a lack of accountability from leadership of other ancillary departments.

> You know, so, it is nurses will constantly pick up those pieces to have a better end result to make the patient happy, but again, where does the other accountability from other departments going to fall into place. However, if we work like a team, we never miss anything, again social worker is so crucial to the team. But again, how it is still, that it is tolerable. So it is being able to have where your ancillaries in place them having them have through the same standard.
>
> That I think we carry so much of burden and so much of responsibility that it becomes huge; to a point, where you could get frustrated. You feel like you are like a one-man show sometimes, but again very rewarding too, because you do see good outcomes. So you could out that brings you back the next day. You know, I do not know what else to say. (Leader 04)

> I think as a manager there are things I can control and there are things I have no control over, okay and the part that I have no control over, it is a frustrating part because I can control the nurses, I can assist them and guide them and lead them to all the nurse sensitive indicators. I cannot control how much time you spend in x-ray, how much time you spend waiting for transport, I cannot control whether or not the tech in a vascular lab explained your procedure to you. So I think that

in view of the fact that the nurse and the floor is the one that is getting the results, in fact every single department that touches the patients, should also be accountable.

I find it frustrating as a manager, and even when they do put things into place, it not followed through. So I think they (other departments) should be held as accountable to the highest standards that a nurse manager, so should everybody else that make a leveled playing fields because the nurse managers take a lot of abuse for the scores and I am sure that is like in all institutions. (Leader 09)

Study participants employed in organizations that expect the nurse manager to coordinate care and enhance patient experience without providing the necessary support or process for collective accountability among all areas of their organization, experience a considerable amount of frustration to improve their overall scores. Nurse managers expressed frustrations in organizations where the administrative leadership fails to institute an organizational wide change, ownership, and accountability for customer service excellence.

I do not see any improvement in the physician issues without much improvement at all. The food issues we suffer with still. The environment, we suffer with. I think what I find frustrating is that they will have an excuse and it is acceptable, but there is no excuse with Nurse Manager and we are told that. You know no excuses, but yet an excuse for housekeeping not emptying the trash and they are building garbage all over the floor, the expectation is my nurses are picking it up. And they would do that anyway. Okay that we do that anyway, but I think that everyone should be accountable for their own departments. Okay. If there is a

> supervisor here on the weekend from housekeeping then his job should be go and check every single room and make sure that they are tidy because I am here today, doing manager rounding, to make sure that all the staff is happy. I am not the supervisor today. I am just a manager. Make sure everybody is happy. I have been to every single unit in this hospital, walked every floor round and round, talked to all the nurses, the PCTs, said hello, how are you to doctors, patients in the hallway. Okay, if I can do, it once a quarter and I think that these guys would be able to walk around, and at least make sure rooms are tidy. And not have my nurses picking garbage up off the floor and their excuse is they have two sick calls or they had this or somebody quit, not acceptable because I cannot use that, so it has to be accountability process of work. (Leader 09)
>
> But again, unless you have that support and that interdisciplinary, inter-collegial, once you have those things, we can get the nurses communicate. We cannot do that. We can get you shared governance as I can get unit counsel together. But if I missing that piece that involve the other departments, then it is not going to work. (Leader 13)

Leader 13 discussed issues with sustainability of patient satisfaction projects because not all departments were working together. According to participants, each department worked in silos, unable to empathize with each other's responsibility and difficulty. Leader 13 felt that nurse managers should have the maturity as a leader to recognize their vulnerability and reach out for assistance and work together as a team.

> I think we struggle. I think we struggle. I think that there is an interest. I think where we struggle with, is that, you know I would say like you know . . . being

closer to the trunk, closer to patient. That further out you get and the further away from those process the issues of may be supplies or admission, wait times. And you start to get into those things. You see . . . here . . . you know that there is still a silo, that there is a protection of among your departments. And we will kind of joked that with service excellence. We had a huge push a few years ago- Service Excellence. We are going to have these teams and cultures of excellence. And we are going to have a physician team, we are going to have this team, we are going to have that. It is awesome, awesome, but as we started to . . . the middle managers okay if we were in charge of these teams, we have co-chairs, we have you know, great work involved the staff, we have got physicians, and we have got. But what where you would find is that, you know what? We cannot make this change without involving this person and we cannot make this change without doing or we call it a "Just Do It Culture." (Leader 13)

Leader 13 attributed failures of many best practices to improve patient satisfaction to the silo mentality among the different department. The bureaucratic nature of the organization creates barriers to institute, and sustain patient satisfaction projects.

But the overall day-to-day, the nurse has no garbage cans to throw her stuff in. You know these transports team . . . we also have those struggles that the communication does not go out, transports being bombarded with you know stat tests and they cannot transport the patient, you know there is a 45 minute lag to PCT, "Could your PCT bring the patient down to x-ray?" Put it on a blurb, put it on an e-mail, give a call to you know, instant message like, whatever it is going to be.

> We do not have a "Just Do It Culture" and when you have to go into this committee and that committee and call AVP, then you are three months out from the initial problem. We have moved on to another issue. And that you reeve up and you drop it and there is not that consistency to do this on just nurse communication. (Leader 13)

The new expectation of nurse managers to improve patient satisfaction scores without a supporting organization culture caused frustrations as expressed by Leader 13.

> So I think that is where we struggling, I think that is where a lot of other places struggle is that, "Are you vulnerable? How do you open up to what your struggles are individually, so that you can work on it together?" And you know my hope . . . we all joke as a middle managers that we are going to do some thing on our own. But not tell the leadership like upper and they probably will not notice for about six months. But this is what needs to be done. Because as soon as you get up here, how do we know, unless we try? And I think that is the vulnerability, that I have learned something over the last may be four or five months, you have to be vulnerable to say, "I am in over my head, I made a mistake! I need help." And you know people still want to be vulnerable and I do not think it is a culture, health care in general is not a culture that supports that. They need all; I need answers all the time . . . I want to action plans, tell me three months, you are going to do it, going to do it, going to do it. Wait a minute I can't get urinals for my patient. How can I be responsive to his potty needs if I do not have a urinal here, but that is a process issue right? (Leader 13)

Leader 13 experiencing issues with coordination and collaboration, attribute issues with improving patient satisfaction to the bureaucratic structure and silo mentality of the organization.

> So I do not think that support is missing, but I do see where you know there are still a silo among top leadership you know whether it is nursing agenda or finance agenda and there is HR agenda there is you know and how do we get them to agree and have "A just do it." Right! because we know to just do it, if we could just do this, but now well that effects each other. This affects HR and no this affects this one, and that affects that one and that is where you get those road blocks. And I think that it has gotten better, but I think we have long way to go. (Leader 13)

Leader 09 felt that other ancillary personnel in the hospital were not trained or did have the experience, with patient related interactions thus affecting patient satisfaction scores.

> Fear. I think the people that are not used to taking care of patients are fearful, when they enter the room that they will be asked to do something that they cannot do, or do not want to do, or they are afraid even to go in there. We have some germophobes, so I do not think that is why I do not work on the floors. I think that was big factor. They really bombed.
>
> It is a bigger effort. I think that also it needs to be a collaborative hospital, so if they were going to educate, I would like to seek education for the entire facility, and how you can work together. I cannot control that transport has had mass exodus of people and the patients have to wait an hour downstairs to get

transport from their X ray back up to their room because that comes back on my score. I cannot impact that. I do not work the transport department. (Leader 09)

Leader 13 from her experiences suggested a collective responsibility and team-based approach to improving patient satisfaction as mentioned in Theme 5.

I think support from leadership not because if they knew about the issue that would not support you, but I think that knowing some of the obstacles like if they think something is being done, but it is not being done and then having to communicate this is not here for me and this is what I need at the bedside. So it is one of the things I would like to incorporate into the other units as rounding with the department leaders of distribution, rounding with an environmental service. And I do not mean walking around the hallway, I mean going into the patient room looking at the environment, looking at the garbage can, hearing what the staff has to say about may be what they did not have. So that it is not I got you, its oh my goodness we can do it as a little bit better and may be have it, may be I do not know if this is possible but I think that can be an obstacle. The information does not get up to where it needs to be sometimes. (Leader 13)

Theme 8b Challenges- Interdepartmental Collaboration emerged from the analysis of coding clusters and the higher frequency of free node descriptions presented in Table 15.

Table 15

Theme 8b: Coding Clusters with Data Frequency Patterns

Theme	Free Nodes	Number of Data Sources	Number of References
Theme 8b: Challenge: Lack of Interdepartmental Teamwork	Lack of Buying in from Different Department	12	33
	Barriers—Department Culture	12	31
		10	18
	Bringing all Disciplines Together	12	24

A schematic representation of the essential themes and the major findings from the exploration of the lived experiences of the nurse managers that constitute the themes is presented in Appendix V.

Connecting Themes to Research Questions and Supplemental Findings

The central research question of the study guided the data collection process and sought to explore the comprehensive, and holistic lived experiences and perceptions of the changing nature of the projected contemporary nurse manager's role, skills, cross functional practices, and dimensions, that align with the newer dimensions, and expectations of increased patient satisfaction among selected nurse managers in seven acute care hospitals in New Jersey.

In this study, the researcher explored the structures of the human life world of the nurse managers as experienced in everyday situations to improve patient satisfaction. The findings from the study confirmed the general problem and specific problems, the rationale to conduct the study because of the new expectations and dimensions to improve quality health care. The new changes in health care and the driving forces

behind health care reform echo through the participant's responses of their lived experiences. Data collection and analysis provided the essential information on the new and changing role of the nurse manager aligned with the expectations of improving patient satisfaction. Participants are nurse managers, directors, supervisors, and chief nursing officers selected by their respective hospital due to their experience and success in improving patient satisfaction scores. Data collection from the study participants provided insight into the new role, functions, practices, and dimensions of a nurse manager to meet the demands and expectations to improve patient satisfaction outcomes.

The lived experiences and structure of meaning of themes from lived experiences of the participants provided consistent indicators for the research question. Participants in this study discussed the new changing and dynamic role, functions, leadership styles, behaviors, skills and competencies from personal experiences and perceptions of his or her lived journey. The following excerpt from Leader 17 presents the focus of the experience.

> It is kind of tying in the expectations from the leaders, the expectations of our staff, the expectations of our family and everybody else. I am in a role where I have to absorb a little bit of everything. And then from there, trying to simulate what is important to everybody and, kind of, make sure that everybody are aligning with meeting everybody's needs. For leader or management from the top, feels this is a priority, then I have to kind of see, where we could blend then everybody else's vision too. So it is kind of connecting my staff's satisfaction, my patient's satisfaction or leader satisfaction so kind of blending down and then out. (Leader 17)

Leader 19, and 21 offered the following powerful insight into the essence of the new nurse manager role.

> Well I think, visibility to your own staff, because if your staff is not happy they are not going to make the patients happy. Listening to what your staff and your patients are saying. Being open to suggestions. I guess, you are part of the team as they are part of the team, so you have to be a team player, so that they can be a team player. Like I said that is the part of being the role model I guess. Treating them the way you expect to be treated, and then they will do what they are saying. And I think that is really your key to your patient satisfaction, is your staff have to be happy to be able to make patients happy and you have to look at what patients want, and how your staff buy into that also. (Leader 19)
>
> Overall, I would say that it is very important for the nurse manager to be able to engage the whole staff in this endeavor for patient satisfaction. The nurse manager has to be able to align, again the mission in the vision of the organization in context to patient satisfaction, the nurse per se to articulate that vision. And part of that the vision is really to deliver care and provide care that is satisfactory. And service excellence is the focus.
>
> So, it is to execute the organizational goals and mission, but be able to inspire and facilitate that process engaging the full staff, providing an environment where the ideas and the opinions and input of the staff are valuable, working towards the goals of our metrics in terms of patient satisfaction, celebrating the wins and recognition of staff and putting it and bringing it to the next level. So, it is a journey, where the manager is there facilitating and guiding

from point A to point B, but when you reach the point B you have to push harder to get better and better. (Leader 21)

Five sub-questions aligned with the broad research question and further narrowed the boundaries to allow for meaningful expression. Carefully constructed interview questions categorized under five sub-questions resulted in the extraction of 8 major themes presented in the above sections. The sub-questions categorize perceptions and lived experiences of the holistic role of a contemporary nurse manager to improve patient satisfaction. The following sections contain discussions on the significant findings for the respective five sub questions and related interview questions.

Sub RQ1. What are the current practices, dimensions, indicators, and expectations for the nurse managers to monitor, measure, or influence patient satisfaction on their units?

Research Sub Question 1 focused on expectations and the new role of the nurse manager to monitor, measure, and improve patient satisfaction. The interview questions under this sub question led to several key insights on the experiences of nurse managers to improve patient satisfaction. Theme 6: Role of a Nurse Manager as a Change Agent – Continuous Quality Improvement emerged as direct result of the interview questions. The participants recounted their experiences in implementing many initiatives and practices over the years to achieve success in improved HCAHPS survey scores. Related supplemental findings not included in the above themes are the nurse manager influence on the HCAHPS survey question domains. All 21 participants agreed that they influenced the "Communication with Nurse" domains on the HCAHPS survey question in their leadership role. "Everything about the nurse, everything about the nurse I can

influence. Courtesy and respect of nurses, nurses listening carefully to patients, clear communication of nurses to patients, discharge instructions, clear discharge instructions" (Leader 14).

> Easy, first of all nursing communication. That is the number one thing that I think that we can manage for patients. Is being able to go out there, and talk to our patients, in a language that they understand. And be able to give them enough information that they can make their decisions . . . the right decisions. (Leader 11)

Most of the participants however cited that they could not influence the *Physician Communication* component of the HCAHPS survey.

> I cannot influence outsiders, I cannot influence physicians. Environment is challenging because I can have nurses maintain cleanliness and tidiness and stuff like that, but we cannot also be expected to do all patient's care if something really is not fixed or something. (Leader 20)

Other HCAHPS domain questions that many nurse managers are finding hard to influence is the *Quietness at Night*. The excerpt from Leader 05 effectively captures the struggles in achieving high scores.

> The noise is very difficult. We have tried everything. We cannot influence it (noise control) I do not know why. I really think that this question I have given a lot of effort to, and I have made absolutely no improvement on. (Leader 05)

Leader 16 verbalized nurse manager influence on all questions in the HCAHPS survey, indicating a significant and pivotal role of the nurse manager to coordinate and enhance the patient experience.

> I think that it really is my responsibility for all of it, number #1. Because it is ultimately the buck stops here. So what I can say, I think that the most that I can control, which is within my scope of practice here, in the unit is the nurses. So it is call bells, it is pain, its explanation of medications, courtesy and respect, listening, communication. What I do with an overall. I just try to take an interdisciplinary approach for the stuff that really I am not 100% sure is within my control as much as the nursing piece. (Leader 16)

The interview questions also solicited information on the many initiatives by nurse managers to improve patient satisfaction. The participants recounted the various successful initiatives. The participants also recounted the lived experiences with many new and ongoing initiatives implemented with staff to improve patient satisfaction scores. The exploration of the experiences with implementing best practices and initiatives under this research sub question linked to the Theme 8. Theme 8 contains the participant's perceptions and lived experiences with consistency and sustainability of various initiatives. The largest variance includes the bedside rounding initiative as participants experienced variable success, and at times staff resistance to change. Table 16 contains the study participants' experience with sustained and non-sustained best practices to improve patient satisfaction.

Table 16

Comparison of Sustained and Non-Sustained Initiatives to Improve Patient Satisfaction

	Sustained Practices		Non-Sustained Practices	
Node Description	Sources	References	Sources	References
Hourly Rounding	9	15	10	16
Beside Reporting	7	14	0	0
Discharge Phone Calls	5	11	0	0
TCAB Initiatives	6	11	0	0
Discharge RN	2	6	0	0
White Boards	4	5	0	0
Patient Education	4	4	1	1
Scripting	3	4	1	1
Service Recovery	3	3	0	0
Self-Scheduling	2	3	0	0

Sub RQ2. What were some of the essential themes from past nurse manager experiences that should be maintained with the new nurse manager role, practices, attributes, functions, strategies, or performance improvement initiatives that may continue to influence improved patient satisfaction in current and future times?

Research Sub Question 2 provided the bulk of the information on the new nurse manager functions, practices, leadership styles, behaviors, skills and competencies to improve patient satisfaction, The above research sub question and pertinent interview questions provided in-depth responses that horizoned the meaning of the experience. Theme 2: Building a new culture and Theme 3: Leader rounding were the main themes derived from the above research sub question. The leadership styles, skills, practices, and behaviors intertwined through the sections of Theme 2, Theme 3, Theme 4, and Theme 5.

Participants in this study were able to provide insight into their leadership styles. Most participants in the study identified themselves to be participative and democratic in their leadership styles (Leaders 01, 03, 06, 08, 09, 10, 11, 14, 15, 18, 19, 20, and 21).

> So that it is again going back to that style of the ability and your ability to manage groups, your ability for interdisciplinary collaboration and your style of participative leadership. Because they (Staff) will respond better to you if you are not dictating an authority, that is just my experience. (Leader 21)

Leaders 14, and 21 clearly identified themselves as being transformational. The following excerpt by Leader 14 provides insight into the essence of transformational leadership style.

> We need a leader who really can influence staff in a very positive way. I think I learned how to influence my staff, which was not easy. You definitely need to have a person who is transformational, who really engages the staff, makes them feel valued, makes them feel respected, makes their ideas heard, if you cannot do that forget it. There is no change going to happen. I think they look at me like, "Oh! My God I am on." Sometimes how much our words and actions are influencing the staff and from those comments, I learn. I should take it and go with their very positive energy because if that can influence, let it influence and go with the positive energy to the staff. (Leader 14)

The nurse manager's reflective thoughts and experiences invoked retrospective insights characteristic of transformational leadership capabilities and behaviors. The majority of the nurse managers and nurse leaders in this study provided examples of inherent attributes of transformational leader such as idealized influence, inspirational

motivation, intellectual stimulation, and individualized consideration. The direct supervisors also identified transformational leadership capabilities essential to changing the culture and meeting organizational goals for improved patient satisfaction outcomes. The following Figure 15 is a matrix-coding query in the qualitative NVIVO 10 software representing participants with transformational leadership capabilities.

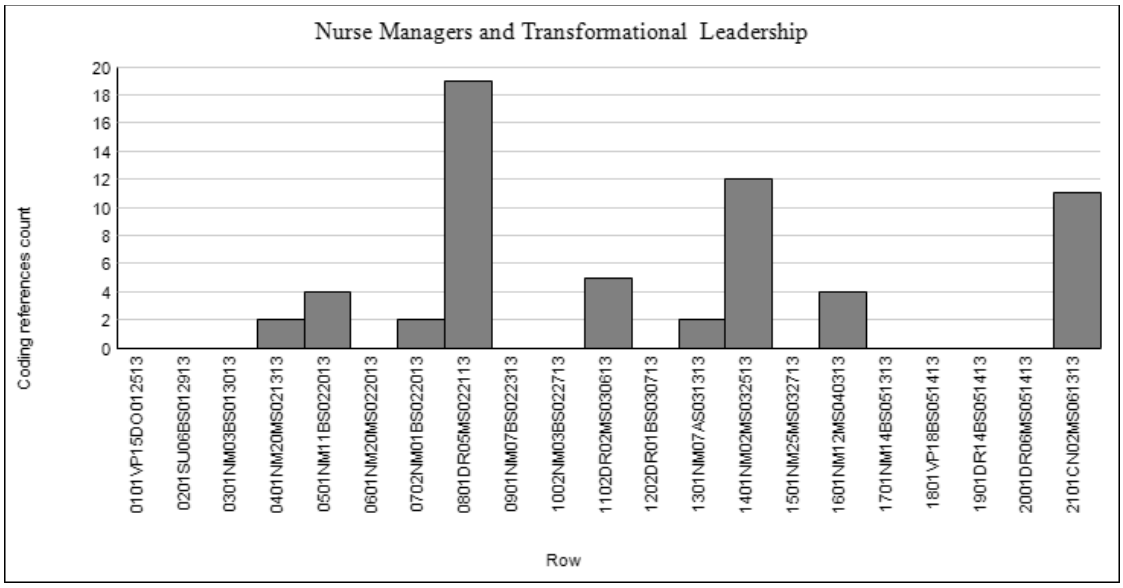

Figure 15. Matrix coding query: Transformation leadership style.

Nurse managers in this study appealed to the follower's innate values, motives, and ideals to fulfill the visions of caring culture displaying idealized influence (Leaders 04, 05, 08, 06, 14, 10, 11, 12, 13, 14, 15, 16, 17, 19, and 21).

> That is part of the reason I am still at (name of the organization) because I really uphold the mission and the values of this organization because to serve the poor and the underserved and really it takes a great heart to do that, and to be part of an organization, who does not? I couldn't be in a better place. I really value that in life. So that how my model with the families. So it could be a loved one, it could

be somebody else, and I want to make sure that we focus on that as much as I would like to be, if it was me, in their shoes. I want somebody to be able to provide me with that attention, or that support, or that understanding of where I am coming from. So often times it is kind of reversing your role. This is what I think, it is right, or this is what I think I should be doing, but try to taking a step back, and say "What is it that they need, and if I were them, what would I need?" And try to see it from that perspective. (Leader 14)

All study participants in this study articulated the need to motivate followers to engage, empower, and realize organizational vision. Nurse managers articulated their vision clearly, compelling followers to align with organizational vision. As change agents, nurse managers intellectually stimulate and challenge followers to think and be innovative in their many ideas to improve patient satisfaction (Leaders 04, 05, 08, 09, 10, 11, 14, 18, 19, 20, and 21).

I do not mind change as you could see. I implemented lot of changes in seven years and try to keep up with the times. We have gone in nursing of the future, and the future of nursing and healthcare and with everything going on. But we survive. It is a matter of survival and you have to be able to change because if you are stuck in, I never did it like this, you will be stuck outside the door, not in. (Leader 18)

Coaching, mentoring, and support are essential characteristics of transformational leaders mentioned in Theme 4: Creating a Healthy Working Environment.

Coaching our staff to improve, by coaching for success, not so much coaching you in the negative way. If we could coach them to success, to improve in a better way then that is why we are here, to kind of educate them or to mentor

them. And trust me, their feedback is important to us too, so that they that we put certain things in place to achieve something. You coach them to do their best. (Leader 17)

Leaders also commented on how they were able to provide individualized consideration by caring for and addressing staff and patient needs, as mentioned in Theme 4: Creating a Healthy Working Environment. "I wanted the staff to be happy and I think the majority of the team knows that I am behind them no matter what" (Leader 13).

I have gone that extra mile that everyone in the staff knows, every one. If they needed something or they did not need something, whatever it was they know that I am there for them. It is visible, I tell them all the time, I mean, I think that is really been the only way for me anyway. It has been my experience to reach out with that lending hand and go above and beyond for my nurses and my staff. So it is really investment in relationships, an investment in the staff. And it takes time, takes money, right? And it takes like emotional diligence and that is just a commitment, just a personal commitment I have to each one of the staff members. (Leader 16)

Other nurse managers in this study identified themselves as being a servant leader (Leaders 16 and 17), and authentic (Leaders 08, 12, 14, and 15). The following table contains the data sources and frequencies by the aggregate coding of tree nodes of leadership styles to present a trend in the data.

Table 17

Nurse Manager Leadership Styles

Leadership Styles	Sources	References
Transformational	12	67
Democratic/Participative	13	33
Change Agent	11	19
Authentic	5	13
Situational	5	13
Servant	2	7

The following table contains clusters of free nodes coded under descriptions of nurse manager behavior and attributes for assessment to develop Theme 2: Build a new culture, Theme 3: Leader Rounding, Theme 4: Create a Healthy Working Environment, and Theme 5: Staff Engagement and Empowerment. Low frequencies attributes are not mentioned in the above themes but presented in the following table.

Table 18

Nurse Manager Behaviors and Attributes

Leadership Attributes	Sources	References
Caring Patient Centered Philosophy	21	79
Goal Oriented	13	26
Diligence	11	26
Empathy	12	25
Motivate	11	19
Consistency	10	17
Open Door Policy	11	13
Risk Taking	10	12
Learner	6	12
Drive for Excellence	9	12
Flexible	7	11
Respect	6	11
Reflective and Reflexive	7	10
Trust	6	10
Transparency	5	9

Table 18 (*continued*)

Non-Punitive	7	9
Professionalism	6	8
Honesty	6	6
Overcoming Challenges	5	5
Passionate	4	5

The following table displays the various descriptions of nurse manager functions to improve patient satisfaction from interviews Theme 3: Leader Rounding, Theme 4: Creating a Healthy Working Environment, and Theme 5: Change Agent- Continuous Quality Improvement contain clusters and high frequencies of horizoned experiences of the study participants.

Table 19

Nurse Manager Functions to Improve Patient Satisfaction

Node Descriptions	Sources	References
Process Improvement	18	104
Leader Rounding	21	99
Holding Staff Accountable	19	83
Feedback and Reinforcement	18	64
Communicating and Coordinating	18	55
Staying Clinical	12	23
Facilitating Resources for Staff	10	20
Recruitment	6	10

Leaders in the study provided information on specific skills and competencies required for nurse managers to improve patient satisfaction presented in Table 20. High frequencies of clustered descriptions provide the underlying structures in the development for Theme 5: Staff Engagement and Empowerment, and Theme 5: Change Agent- Continuous Quality Improvement.

Table 20

Nurse Manager Skills and Competencies for Patient Satisfaction

Skills	Sources	Frequencies
Communication	15	46
Listening Skills	10	15
Process Improvement Skill	10	18
Analytical Skills	5	8
Detail Oriented	1	1
Emotional Intelligence	9	12
Building Relationships	6	10
Clinical Expertise	8	13
Business Skills	4	4
Efficiency	2	4
Patience	3	3
Time Management	2	2
Maturity	2	2

Sub RQ 3: What is the essence of the new complex and transformative changes in the projected nurse manager leadership roles and trends for best practices in the context of new regulatory requirements to improve patient satisfaction in highly competitive health care environments?

The interview questions under this research sub questions led to the exploration of the study participants' understanding of the global context of the nurse manager role in a changing health care environment. The inquiry led to participants' perceptions and experiences with the new pivotal role of the nurse managers with new expectations to enhance patient quality outcomes through nurse manager influence. The in-depth descriptions under Research Sub Question 3 led to formulating Theme 1: New expectations of the nurse manager to improve patient satisfaction. The following excerpts from Leader 01 and Leader 14 provide value to the essence of the meaning of the theme.

> I have been a nurse for 40 years and I learn something new everyday, it is amazing, it's changing, how it (Health care) is changing and has always been evolving. I think that sometimes it is hard to keep up because I am, but I like the way it is evolving. (Leader 01)

Leader 14 verbalized dismay on the lack of ownership and responsibility of the health care system to address issues without external forces mandating these changes through financial cuts.

> It is unfortunate that CMS had to or regulatory agencies have to force that on health care. As a health care organization especially in this country with all these incentives, all the initiatives that we have in, all the financial the things that we have, we still did not come up. I cannot believe that we had not taken a way first, to figure out. The money had to be taken away from our hand, for us, to figure out, how to keep it. It is unfortunate! But it is all right. Me and you will be a patient one day, at the other end, we definitely want quality care, so I am glad this initiatives are coming in from the organizations that we are supposed to provide the best quality care and these numbers says that. If we cannot, we might not be here. Yes, it should have been their priority before and I guess not just in this organization, I guess the entire healthcare was talking a good talk and never an action, hence this initiatives that came above from CMS. (Leader 14)

One of the significant observation from nurse managers, not mentioned in the themes but contribute to the essence of the nurse manager role is the training and professional development needs of nurse managers to meet the expectations for improving patient satisfaction including Value Based Purchasing. This supplemental

information as experienced by the Leaders 03, 06, 12, and 13 echoes the problem of this study. The following is an excerpt by Leader 03 and 12 on gaps in essential nurse manager training and education.

> I know that we could definitely use some more training with patient satisfaction. And may be how to resolve some of the issues that we have here, with the patients are dissatisfied, what could we do to sort of nip it in the bud. Or what can they do to make sure that it does not get to a level of that we cannot manage. (Leader 03)
>
> When I came on no, I was not prepared. No, I really do not think that, you know the reality is, when you come out of school, I came out of a Bachelor's program. I think from the management perspective I do not think they really spend enough time, and truthfully even if they did spent time in the bachelors program, there is no way that you could even get on these concepts. Or just it would be I think it is kind of foreign from the clinical side. Even though you need the clinical side to make some of the decisions on the management side. I do not think we are really prepared. (Leader 12)

Leader 01, 03, 04, 06, 08, 10, 11, 12, 14, 15, and 21 impressed the need for leadership training and understanding the context of patient satisfaction. High performing organizations in this study recognize the need to bridge this gap and to build the nurse manager's capabilities and capacity to influence change.

> To have to have continuing development, training, leadership, development institute. Providing them a venue where they can continue to grow. Incorporating some aspects of the health care management reform education and providing the venue for them to fully understand what is going on. So we realize

to knowing the process to formalizing that Leadership Development Institute that will incorporate those key competencies for new managers and then for experienced managers with different identified educational offerings as well health care management, health care reform. All the basics do, like managing teams, conflict management all of the other competencies. But we felt that for patient satisfaction per se it is totally different curriculum as well. We have empathy training that we develop, that is for the staff, but there is different thing for the managers. And it is a full Leadership Development Institute for patient satisfaction. So that we can continue on to have the right leadership for better aspect for patient satisfaction. (Leader 21)

Research Sub Question 3 also led to the information concerning the role of the organizational culture in the new regulatory changes to improve patient satisfaction that led to Theme 7: Impact of Organizational focus and Culture.

Sub RQ4: What is the overall value or benefit of the newer nurse manager position and opportunities in meeting requirements for improving patient satisfaction?

Several study participants in response to the interview questions articulated the essence of the nurse manager's holistic and comprehensive role in the new transforming health care environment to meet customer service needs. Study participants provided unique perceptions and lived experiences of the essence of the new evolving role to improve patient quality. According to the nurse managers, the new role is changing dramatically with the shifting focus to greater accountability for patient outcomes and providing value as mentioned in Theme 1: New Expectations of the nurse manager to improve patient satisfaction. The nurse manager role is shifting with greater emphasis on

patient outcomes by addressing the structures and processes in the health care system to deliver high quality and satisfied care. Leader 03 and 06 viewed their new role shifting with a focus and accountability to enhance quality outcomes. The following excerpt from Leader 03 captures the focus of this research sub question.

> Well before I used to feel very much that I worked much more for the staff that I did for the patients. And now it is sort of reverse, have to work more for the patients that I do for the staff, so that is different. Where I always thought of myself as advocating for the staff on their behalf of for the things they need and the things they want. And now I have to be out there with patients more, and advocate more for the patients, or working with the nurses and the physicians, and staff and case management. We really need to work together to improve. (Leader 03)

The following nurse managers provided a comprehensive and holistic view of the new nurse manager role and what it means to them, in relation to the staff, customers, organization and health care system. Leader 08 discussed evolution of the new nurse manager role in response to the transformative changes in health care while reflecting on the essence of the lived experience with the phenomenon.

> I think it is helping to grow it is moving me out of my comfort zone, learning to work smarter, learning to delegate, and in turn it has helped to develop the others behind me. So, I think they have done exactly what I tried to do, is to force someone out of the comfort zone. And that is the way the world is going. And we are all, no matter what industry you are in; we are all doing more with less. So, is it the best practice? We can debate that for very long time. I do not know

if it is? But I do think that it makes the individual more well rounded and I think it forces growth, it does. If you are not willing to move out of your comfort zone in today's work environment, you probably will not advance, you probably will not be in a higher level management position. Because you have to bend and you have to change. You have to evolve, or you will not be successful in these positions because there is too much coming from all sides. (Leader 08)

Leaders 05 and 16 articulated the new role of the nurse manager in continuous quality improvement as mentioned in Theme 6: Change Agent- Continuous Quality Improvement.

The essence of my role in improving patient satisfaction! What I think really the essence is for it is a continuous quality improvement. The Plan Do Study Act, work with the plan, if it does not work, you know do not be so married to it that you know you are going to keep it forever. If it does not work towards it move on to something else, so it is a continuously evaluating looking at the data trying to improve, looking for best practices, so that I think continuous quality improvement, is the essence. (Leader 16)

Other nurse managers in the study mentioned coaching and mentorship as mentioned in Theme 4: Creating a Healthy Working Environment**.**

The essence is constant coaching and mentorship . . . building your staff, growing your staff to be more autonomous along with your assistant nurse managers. I think that there is high expectation and we should be ready to meet it and I think that there is constant change and we have to be on our toes and ready and willing to change . . . obviously to not be afraid to try things. (Leader 05)

Leader 05 described the dual and equal responsibility of the nurse manager to attend both to the needs of the employees as well as the customers and creating a synergistic and partnering relationship.

> I think that your people and your patient satisfaction and I think they are really do go together because you want to maintain the competencies of yours nurses to make sure that they are giving the best care to the patient, so when in return that the patient is feeling that they are satisfied with the care that they are receiving, so I think a kind of all hand and hand goes together. How are we going to work with them, how are we going to co-exist, and we are a team . . . patient and health care. We have to be a team somehow, and that is why I say both. (Leader 05)

Leaders 14 and 21 reflected on the essence of the nurse manager role, focusing on the leadership capabilities to influence lasting change in a patient caring culture.

> You definitely need to have a person who is transformational, who really engages the staff, makes them feel valued, makes them feel respected, makes their ideas heard, if you cannot do that forget it. There is no change going to happen. Those kind of things takes patience, practice, and an efficient manager, you know, to do that. So for that process to really show in number it might take up to three months to six months to a year. And at that same time you are challenged with all these other things in the organization, you need to be able to handle it. You need to able to handle these situations and still focus on a patient's satisfaction goal. (Leader 14)

> I would say you know, I strongly believe that it comes down to the style of leadership participated democratic leadership or management of teams and their

behaviors. The characteristics of that leader in terms of being participative, engaging the staff, valuing their input, and engaging the whole team. I would say that, leaders that have the awareness of their abilities their aesthetic self. They value the meaning of what they do, so I am saying there is a connection of what they do to their work and are committed to that. I would say that those are the types of nurse managers that have better results.

I would say that the essence would be that he or she is a valuable role in terms of patient satisfaction. The role has an influence to achieving better results in line to the behaviors and leadership style. So I think the essence, the value is very critical to an organization, this nurse manager role. Because without a nurse manager in a unit I do not think that you can have that coordination and collaboration. (Leader 21)

Table 21 contains the clusters of the descriptive emergent aggregate tree and respective child nodes that provide a structure for the themes in the quest to understand the unknown phenomenon.

Table 21

Nurse Manager Role to Improve Patient Satisfaction

Node Descriptions	Sources	References
Create Patient Satisfaction Culture Engagement	21	248
Develop Mentor and Coach Staff	21	115
Empower Staff	21	105
Modeling	19	85
Healthy Work Environment	16	49
Visibility	19	39
Staff Satisfaction	18	37
Team Building	12	32
Constant Oversight	13	33
Building Relationships	9	27
Support Staff	10	19
Follow Through	7	17
Accessibility to Staff and Patients	6	12
		10

Other supplemental and significant findings in response to sub RQ 4 is the nurse managers perception of the amount of time and energy spent on improving patient satisfaction compared to other nurse manager role and responsibilities. Most of the leaders verbalized the new role is all encompassing, threading through their other functions and role as a nurse manager. Table 22 provides an overview of the time spent by each study participant in the role to improve patient satisfaction.

Table 22

Time Spent on Patient Satisfaction

Leader	Time Spent
01	50%
02	50%
03	60%
04	100%
05	40%
06	90%
07	2 hours a day
08	1 hour a day
09	60%
10	100%
11	75%
12	Almost 100%
13	#1 Priority
14	60%
15	Rate #1
16	75%
17	70%
18	NA
19	NA
20	30%
21	40%

Sub RQ5: What are the influences and or overall obstacles barriers, or complexities that may challenge the nurse manager within the organizational culture to meet requirements for improving patient satisfaction?

Theme 8 provides the clusters of high frequencies and sources for the various challenges experienced by nurse managers in their journey to improve patient satisfaction. Theme 8 contains the nurse managers' insightful reflective and reflexive responses to mitigate such challenges. Table 23 contains supplemental information that is significant to understanding the various obstacles, barriers and complexities in the new role to improve patient satisfaction.

Table 23

Nurse Manager Role to Improve Patient Satisfaction

Node Descriptions	Sources	References
Sustainability	14	30
Lack of Buy-In from Other Departments	12	33
Staffing	15	29
Customers	12	25
Resources	11	24
Multiple Demands	10	22
Lack of Physician Alignment for Patient Satisfaction	11	20
Organizational Culture	10	18
Lack of Staff Buy-in	9	19
Time	6	13
Multiple Initiatives	9	12
Resistance to Change	8	9
Electronic Medical Records	8	9
Lack of Leadership Support	2	9
Reliability of Survey	7	9
Communication	4	7
Task Oriented Staff	4	6
Economy	3	6
Generational Differences	3	4
Environment	4	4
Lack of Training	3	5
Staff Burnout	3	4

The following table represents the supplemental and significant findings from the exploration of the research question and sub research questions to understand the meaning of the essence of the new manager role with expectations for improving patient satisfaction (see Table 24)

Table 24

Supplemental Findings From Research Questions and Research Sub Questions

Sub Research Questions	Findings
Sub RQ1	• HCAHPS question domains the nurse manager is able to influence • HCAHPS question domains the nurse manager is not able to influence • Sustained and non-sustained patient satisfaction initiatives
Sub RQ2	• Nurse manager leadership styles to improve patient satisfaction • Nurse manager attributes and behaviors to improve patient satisfaction • Nurse managers functions to improve patient satisfaction • Nurse manager skills and competencies to improve patient satisfaction
Sub RQ3	• Training and education of nurse managers: Leadership training
Sub RQ4	• Essence of the new nurse manager role • Time spent for patient satisfaction
Sub RQ5	• Other challenges faced by nurse managers

Summary

The purpose of the transcendental phenomenological study using a modified van Kaam approach was to explore the lived experiences and perceptions of nurse managers and immediate supervisors on the new holistic role of the nurse managers aligned with expectations to improve patient satisfaction in seven acute care hospitals in the northeast segment of the United States. The central research question and five associated sub questions guided the face-to-face semi structured open-ended interview questions. Twenty-one participants explored the comprehensive and holistic role of the projected contemporary nurse manager role, skills, practices, and dimensions that align with the

new expectations for improving patient satisfaction. Data collection and analysis included transcribing audio recording of the interview and importing transcribed data into the NVIVO 10 qualitative software. Data analysis continued with using the modified van Kaam approach by horizoning the experience and clustering meaningful textural descriptions of the data.

The composite textural and structural description provided the synthesis of the experience of the holistic new nurse manager role with improving patient satisfaction. The synthesis of structural and textural data was organized into themes to understand the universal essence of the explored phenomenon. Eight major themes emerged from the data analysis include the following: (a) new expectations, (b) building a patient caring culture, (c) leader rounding, (d) healthy working environment, (e) staff engagement and empowerment, (f) change agent for continuous quality improvement, (g) impact of organization focus and culture, and (h) challenges: sustainability; lack of interdepartmental and interdisciplinary teamwork. Chapter 4 also included connections of the themes to the central research question and sub question findings and significant supplemental information that added value to understanding the phenomenon.

Chapter 5 will extend the interpretation and conclusions of the study findings in its entirety. Discussions include impressions derived from the emergent themes in the study finding and connections to literature review. Chapter 5 contains the social meaning and significance of the data findings to society, profession and leadership studies. The discussion entails limitations of the study, recommendations for future research and reflections of the research process.

Chapter 5

Conclusions and Recommendations

The United State health care system is besieged with poor quality outcomes, and high costs of delivering inefficient care. The current payment system rewards providers for quantity rather than quality outcome of care. Stakeholders in healthcare system are transforming the system with new focus on outcomes of care. At the heart of this transformation is a shift from a provider-centered to patient centered models of care, considering the customer's perception and expectations of quality care. Health care leaders are crucial in transforming organizational cultures to align with customer expectations of high quality and satisfied care. Transformative changes in the health care environment suggest health care leaders adopt new leadership capabilities and capacities to lead and manage change.

The purpose of the qualitative phenomenological study was to explore the lived experiences and perceptions of the comprehensive and holistic nature of the projected contemporary nurse manager roles, skills, practices, and dimensions that align with the newer dimensions and expectations for improving patient satisfaction among expert nurse managers of seven acute care hospitals in the northeast segment of the United States. The exploration of the lived experiences and perceptions among 21 study participants led to formulate eight major themes that explain the nature and essence of the experience with the phenomenon.

Chapter 4 elucidated the research findings with composite structural and textural descriptions to formulate eight essential themes (Moustakas, 1994). The main research question and five related sub research questions through open-ended semi structured,

face-to-face interviews led to the exploration of the lived experiences and perceptions of the comprehensive role of a nurse manager in improving patient satisfaction. The analysis of textural and structural data led to understanding of the meaning of the essence of the new nurse manager role, functions, practices, and leadership styles to meet organizational goals for improved patient satisfaction. The study findings also include related contexts and dimensions affecting the nurse manager role to meet the new expectations for patient satisfaction. Findings of the study substantiated the new expectations for change and the importance of the nurse manager leadership role to influence change and meet quality outcomes.

Chapter 5 includes interpretation and conclusion of research investigation by comparing and distinguishing study findings to theoretical and conceptual frameworks as well as related body of knowledge. The objective of Chapter 5 is to present a synopsis of the experience of the new nurse manager role and the relevance to health care organizations, and study of leadership. The final chapter also contains limitations of the study design and methodology, future research recommendations, disseminations of the study findings, and concludes with a discussion on the experiences of the researcher with the research process.

Summary of the Research Findings

Gaps in current literature and regulatory practice (Cummings et al., 2008; Fairman & Okoye, 2011; Hay Group, 2006; IOM, 2010), indicate a need to understand the new holistic role of the nurse manager in response to new transformative changes in health care with demands for high quality care. The following research question guided the qualitative phenomenological study, What is the comprehensive, holistic, and

changing nature of the projected contemporary nurse manager's role, skills, cross functional practices, and dimensions, that align with the newer dimensions, and expectations of increased patient satisfaction among selected nurse managers in seven acute care hospitals in New Jersey? The five related sub research questions narrowed the context of the central research questions and focused on the purpose of the study. Related open-ended, semi-structured interviews with selective nurse managers and nursing leaders with experience and expertise in improving patient satisfaction among their respective organizations, led to exploring the relatively unknown phenomenon.

Data analysis consisted of using a modified van Kaam approach using the process of epoche' phenomenological reduction, imaginative variation, and synthesis of data. NVIVO 10 qualitative data analysis software assisted in coding and organizing high frequency word patterns into corresponding and emerging tree and child nodes. The queries and analysis of clustered data in NVIVO 10 contributed to constructing individual and composite textural and structural descriptions and synthesis into eight essential meaning and essences of the experience (Moustakas, 1994).

The eight emergent essential themes that encompass the context of the new contemporary and holistic role of the nurse manager to improve patient satisfaction include the following: (a) new expectations, (b) building a patient caring culture, (c) leader rounding, (d) healthy working environment, (e) staff engagement and empowerment, (f) change agent for continuous quality improvement, (g) impact of organization focus and culture (h) challenges: sustainability; lack of interdepartmental and interdisciplinary teamwork. Data analysis through review of research sub-questions led to essential supplemental findings that add to understanding the meaning of the

essence of the experience. The various research sub questions integrate the various themes and include the educational and training needs for nurse managers, various initiatives and projects to help improve patient satisfaction, and the percentage of time spent dedicating to improving patient satisfaction.

Previous literature suggested patient satisfaction is a multidimensional and multifactorial construct and hard to define (Cole, 2008; Davino, 2007; Milutinovic et al., 2010; Wasden, 2010). Traditional scholars have addressed various leadership styles, management practices and functions among nurse managers with employee satisfaction (Sellgren et al., 2008; Utriainen & Kyngas, 2009) and patient care outcomes (Bruyneel et al., 2009; Mrayyan, 2008; Tourangeau et al., 2010; Wieck et al., 2010). Few, if any, studies explain the nature and essence of developing the human enterprise through relational and interpersonal experience between the leader and follower.

Leaders of organizations expect nurse managers to influence positive patient outcomes such as improved patient satisfaction that meet new standards and expectations. Little is known about the new role of the nurse manager to meet organizational demands and expectations to improve patient satisfaction. The current study sheds light and fills the gap in current literature on the new emerging phenomenon of the front line nurse manager holistic and comprehensive role, skills, functions, leadership styles that align with the new expectations to improve patient outcomes especially patient satisfaction.

The evidence from the study leads to the conclusion, the holistic and comprehensive leadership role of a nurse manager is pivotal in changing cultures, aligning, and engaging followers to meet organizational goals. The related dimensions of the new holistic role include leadership styles, practices, functions, skills, competencies,

and attributes in a supportive environment to meet expectations of improved patient satisfaction.

Contributions to Literature in the Field

Chapter 2 contains an extensive review of literature on the following categories: nursing management, management, leadership, patient satisfaction, and quality improvement. The following sections contain investigation of the 8 themes within the context of prior research and reports. The investigation provides rich findings that support and distinguish current literature, contributing to the body of knowledge.

Theme 1: Expectations of Nurse Manager to Improve Patient Satisfaction

Health care reform strategies through Value Based Purchasing Program and Accountable Care have resulted in lower margins for hospitals from Medicare reimbursements (Centers for Medicare & Medicaid (CMS) Services, 2010a, 2010b; Institute of Medicine, 2009). Information in Theme 1 provides confirmation of study participants' experience with the reality of changes in health care through market and regulatory forces. The analysis of texts provide rich information on how economic downturn has affected the bottom line for the organization and the need to drive patient satisfaction and loyalty, supporting the current literature (Goldstein et al., 2010).

Researchers have considered patient satisfaction as a multidimensional construct with various factors influencing the assessment of patient satisfaction with healthcare experience (Cole, 2008). The study findings do not claim to provide a comprehensive assessment of the complex patient satisfaction construct but rather attempts to understand the unknown phenomenon of the nurse manager holistic role to align with expectations of patient satisfaction. This study expands the base knowledge in the current literature on

health care by addressing the patient satisfaction construct and focusing on the nurse manager role.

Review of literature revealed the expectations for comprehensive assessment of the nurse manager leadership role on the following: achieving organizational goals of providing high quality patient care, reducing mortality, morbidity, length of stay with the diligent use of human, financial, and technological resources (Kirby, 2010; Lee & Cummings, 2008; Sherman et al., 2007; Zori & Morrison, 2009). The realities of the health care environment are resulting in the new expectations of the nurse manager to influence patient satisfaction outcomes on his or her unit of control. This new finding is significant because many studies do not address the role of nurse manager in improving patient outcomes.

Previous studies suggests an indirect influence of the nurse manager by providing leadership and guidance, creating structures, process, and managing staff for positive patient outcomes (Anthony et al., 2005; Lee & Cummings, 2008). Few quantitative or qualitative studies established direct relationships with nurse manager leadership skills and competencies with patient outcomes such as patient satisfaction. Previous research studies on nurse manager role, skills, and practices provide little information, if any, on influencing patient satisfaction.

The direct influence of the nurse manager in patient outcomes through the holistic and comprehensive role, functions, and responsibilities provides a new direction and focus in leadership studies. All study participants Leaders 01-20 verbalized the new expectations to improve patient satisfaction. Fourteen of the 21 participants articulated the new role of the manager to monitor, measure, and implement patient satisfaction

initiatives. Six study participants vocalized a healthy and positive outlook on the new holistic and comprehensive role of the nurse manager. The role and responsibility to improve patient satisfaction without supporting structures and processes was source of concern for four participants. The study findings confirm previous study results on the unrealistic expectation, and configuration of a nurse manager role and responsibilities (Shirey et al., 2010).

Theme 2: Holistic Nurse Manager Role: Building Patient Caring Culture

Numerous researchers have examined patients' satisfaction with nursing care as well as the perceptions of the quality of nursing care. A review of literature indicates that patients' perceptions of nursing skill and competence are influenced by the interpersonal nursing skills such as kindness, caring, compassion, empathy, communication, gentle touch, attentiveness (Cescutti-Butler & Galvin, 2003; Davis, 2005; Fosbmder, 1994; Johansson et al., 2002; Kralik et al., 1997; Radwin et al., 2005; Wysong & Driver, 2009) and other interpersonal attributes such as courtesy and ability to comfort (Chilgren, 2008). Nurse leaders in this study understand the urgency of building new culture of caring that stems from understanding influence of employee interaction with patients and family members. Nurse managers in this study focused on building patient care cultures rather than just merely focusing on initiatives and projects to improve patient satisfaction survey results.

Prior review of related literature on nurse manager roles and functions emphasize the nurse manager role and responsibility for coordination of patient care, hiring, retention, termination of staff, managing staff schedules, payroll, and performance reviews, financial management, quality, risk management, collective bargaining,

interdepartmental communication, and relationships with staff as well as other managers, and executives (Lee & Cummings, 2008; Zori & Morrison, 2009). Prior studies lacked sufficient information on the new, holistic, and comprehensive role of the nurse manager in light of the contextual phenomenon of improving patient satisfaction. Theme 2: Build New Cultures contains rich information to address the gap in literature. Participants in this study stressed the need to build new foundations and building sub-organizational or unit cultures for improving patient satisfaction. Unit cultures within the larger organizational cultures are highly significant in affecting patient outcomes. The unit cultures are essential building blocks to the organizational culture with greatest impact on the overall patient experience.

Theme 2 provides rich information on how to nurse managers built new patient caring cultures. Sixteen of the 21 participants provided rich account of their experiences with building new unit culture, through attributes of ownership, authentic leadership, and drive for patient satisfaction. Nurse managers in this study influenced, motivated, and stimulated followers for change, through transformational leadership styles.

Prior to the current study, little was known about the direct relationship between transformational leadership among nurse managers and improving patient satisfaction in current contextual challenges in the health care environment. The current study portrays new understanding on transformational leadership styles along nurse managers in influencing followers by appealing to follower's inner values to perform beyond high expectations for a caring culture. Six of the 21 participants recounted their experiences in clearly articulating a vision for service excellence and align followers to exceed expectations. The study findings provide rich information of the modeling behaviors of

19 expert nurse managers to improve patient satisfaction. Creating patient caring cultures enables the delivery of high quality care that is compassionate, safe, and centered on the patient's values, and needs.

Researchers advocated combining transformational and transactional leadership model for manager effectiveness (Bass, 1985; Judge & Piccolo, 2004). Recent empirical nursing research supports the contingent reward component of transactional leadership to motivate employees for positive outcomes (Adadevoh, 2003; Judge & Piccolo, 2004). The current study findings also portrayed the nurse manager's lived experience and emphasis on real time feedback, rewards, and recognition to reinforce positive patient caring behaviors among followers, supporting current literature findings.

Theme 3: Nurse Manager Functions to Improve Patient Satisfaction: Leader Rounding

Studies indicate that differences exist in the staff nurses' perceptions of patients' satisfaction and patients' perceptions of satisfaction (Ekman et al., 2007; Young et al., 1996). Staff nurses, managers, and patients value their care differently (Young et al., 1996). Researchers found gaps between patients, nurse managers, and staff nurses regarding perceptions on patient satisfaction and quality of care (Price et al., 2007), and the value of patient-centered care (Young et al., 1996). Prior studies lend themselves to seeking and meeting patient's expectations of satisfied care.

Differences in perceptions of quality of care occur when patient needs or expectations are not met. Health care organizations have started new processes called Leader Rounding and expect nurse managers to round on their patients. Leader rounding

mentioned by all 21 participants provides an opportunity to seek patient's perceptions and expectations for enhanced patient experience.

Prior to the study extensive review of literature on nursing management and patient satisfaction, revealed a lack of sufficient information about the direct influence of nurse manager in improving patient satisfaction. A study by Shirey and Fisher (2008) indicates the role of the nurse manager is shifting from the nursing responsibility for budget, staffing, and unit compliance to a broader accountability toward patient service across a continuum. The current study findings indicate nurse managers play a pivotal role and direct influence in improving patient satisfaction namely: (a) creating patient caring cultures through the following, strong patient caring philosophy (21 participants), (b) rounding on patients to solicit patient expectations (21 participants) and feedback, (c) service recovery (nine participants), (d) being visible (18 participants) and accessible to patients (six participants), (e) building relationships with patients, (nine participants), and (f) ownership of patient satisfaction (13 participants).

Prior managerial responsibilities have taken a back seat to the expectations that nurse managers rounds on their patients, model service excellence, seek patients perceptions and expectations of experiences, and coordinate resources to address any patient satisfaction issues and concerns in real time. Executive leaders of some organizations recognize the added responsibility and assist the nurse managers in this role by hiring assistant nurse managers and supervisors who also help oversee clinical quality. The study findings fill the gap in understanding the specifics on how nurse manager role can affect performance variables within the health care organization.

Theme 4: Holistic Nurse Manager Role: Creating a Healthy Working Environment

According to the Press Ganey™ 2009 survey, from 3,047,705 patients at 2,162 facilities nationwide, nursing questions correlate highly with likelihood to recommend and overall rating of the hospital. Previous nursing leadership research on nursing manager leadership style and behaviors focused on outcomes such as nursing staff job satisfaction, productivity, and organizational commitment (Bruyneel et al., 2009; McNeese-Smith, 1995, 1997; Mrayyan, 2008; Sellgren et al., 2008; Utriainen & Kyngas, 2009) through building high trust leader-follower relationship (Andrews & Dziegielewski, 2005) and promoting nursing autonomy (Erenstein & McCaffrey, 2007; Wilson, 2005). Other leadership studies point to the influence of nurse manager on staff satisfaction through visibility, being approachable, consistent, coaching, mentoring, working side-by-side, practicing organizational values, engaging in supportive communication (Andrews & Dziegielewski, 2005; Brown, 2010; Kouzes & Posner, 2005). Prior review of literature highlights that high quality and safe nursing care by qualified, competent, and satisfied employees lead to improved patient satisfaction (Ten Haaf, 2008).

The results of the current study supported and augmented prior literature on the influence of the nurse manager leadership role with the followers. Eighteen participants articulated their role to improve staff satisfaction. Nine of the participants were emphatic on staff satisfaction affecting patient satisfaction, hence the importance of the nurse manager role to improve staff satisfaction. Discussions with 16 participants led to developing important constructs in Theme 4 that reveal nurse manager influence in

creating a healthy working environment for staff development, engagement and empowerment.

The current study expands the current understanding of nurse manager influence in healthy work environment with new expectation of improving patient satisfaction. The American Association of Critical Care Nurses (AACN) in 2005 established standards for creating and sustaining healthy work environments. AACN's six essential components for Healthy Work Environment include (a) skilled communication, (b) true collaboration, (c) effective decision making, (d) appropriate staffing, (e) meaningful recognition, and (f) authentic leadership. Evidence in nursing literature provides information on positive outcomes of healthy work environment on improved staff outcomes (Schmalenberg & Kramer, 2009; Shirey, 2006; Shirey & Fisher, 2008) and patient outcomes (Aiken, Clarke et al., 2008).

In Theme 4, the holistic role of the nurse manager, the study participants concentrated on addressing staff satisfaction with attributes of valuing staff, courtesy and respect. Nurse managers supported (10 participants), developed, educated (18 participants), mentored (21 participants), and coached staff for a healthy and vibrant work environment. Nurse managers in this study identified, mentored, and developed staff champions for leading and influencing other members of the team and build new, vibrant, healthy, work and patient centered culture.

Prior studies on leadership indicate that management support, transformational leadership style, participatory management, accessibility, and visibility in nursing contribute to positive staff outcomes such as satisfaction, retention, and recruitment (Manojlovich & Laschinger, 2007; Wong & Cummings, 2007). Nurse managers in this

study were cognizant of the leader-follower role and the influence of the nurse manager to affect staff outcomes. Twelve study participants provided information on how transformational leadership capabilities influenced, motivated, and developed staff to excel in their role.

A review of literature indicates that patients' perceptions of nursing skill and competence are mostly influenced by the interpersonal nursing skills such as kindness, caring, compassion, empathy, communication, gentle touch, attentiveness (Cescutti-Butler & Galvin, 2003; Davis, 2005; Fosbmder, 1994; Johansson et al., 2002; Kralik et al., 1997; Radwin et al., 2005; Wysong & Driver, 2009) and other interpersonal attributes such as courtesy and ability to comfort (Chilgren, 2008). Nurse managers in this current study understand the value of focusing on the staff by exhibiting attributes of care and respect, so the followers can show caring and respectful behaviors towards patients.

Theme 5: Holistic Nurse Manager Role: Staff Engagement and Empowerment

Empowerment studies in nursing have shown positive relationship on job satisfaction and work performance (Casey et al., 2010; Laschinger et al., 2002; Sarmiento et al., 2004), improving the safety, and quality of patient care (Armstrong & Laschinger, 2006; Laschinger et al., 2003). Theme 5 contains constructs on the role of the nurse manager to engage and empower staff for greater participation. The study findings are important in light of current literature supporting engagement and empowerment for improvement in quality patient care. The nurse manager transformational leadership capability (12 Participants) was essential to influence, engage, and empower staff to perform beyond expectations.

Nurse managers can create organizational structures that empower staff nurses to have control over work in a positive work environment leading to greater work engagement (Albrecht, 2010). Unit practice councils (12 participants), committee meetings, shared governance (15 participants), TCAB (six participants) are structured vehicles through which nurses actively participate to improve processes for patient care and staff outcomes.

Review of current nurse manager competency models indicates broad and comprehensive categories to improve quality but fails to provide specifics in how nurse managers may improve patient outcomes. The current study provides rich information on the need to build and add to the current competency frameworks for improving patient outcomes. The skills and competencies for the nurse manager to improve patient satisfaction, identified in the current study, include mastery of communicating skills with patients and families, staff, disciplines, and leadership to enhance the patient experience. Listening skills were very important to involve staff and to accept input for change. The holistic role involved other competencies for performance improvement in changing and building new processes to improve patient satisfaction.

Theme 6: Role of a Nurse Manager as a Change Agent: Continuous Quality Improvement

Nurse managers are responsible to monitor, track, plan, implement, and evaluate quality improvement programs based on quality indicators on individual units. According to literature nurse managers are responsible for continuous quality improvement by instituting evidence based practice besides overseeing daily operations, human resource management (McLarty & McCartney, 2009). Quality improvement not

just the purview of a selected few but its success is dependent on collective engagement of all employees for effective change. The role of the nurse manager in health care organizations is expanding with responsibility to implement Continuous Quality Improvement (CQI) processes for improving patient outcomes. Nurse managers in this study use unit based councils, patient satisfaction committees, and patient satisfaction coordinators to affect positive change.

Fifteen participants in this study stressed the role of the nurse manager in performance improvement (PI) or CQI to improve patient satisfaction outcomes. Ten participants stressed the need to have essential performance improvement skills including data collection, measurement, analysis, and presentation. Improving patient satisfaction through a quality improvement process includes analyzing the data, making sense of the data, and then explaining it to the staff. Nurse managers in this study transfer statistical patient satisfaction survey data into meaningful information for staff for buy-in and engagement. Transparency and sharing of data is essential to keep front line staff engaged in the process (five participants).

Theme 7: Impact of Organizational Focus and Culture to Improve Patient Satisfaction

A systematic review of literature on nurse manager leadership and satisfaction provides evidence that reducing span of control, improving empowerment, and organizational support of frontline managers reduces adverse patient events, mortality, improves patient satisfaction and staff outcomes (Lee & Cummings, 2008; Wong & Cummings, 2007). The new findings are significant to the body of literature, regarding impact of organizational culture and top-level leadership focus on the nurse manager role

to improve patient satisfaction. Few studies provide information on how to shape health care organization cultures through core values and behaviors of caring, patient and employee centeredness.

The systems perspective takes into account the complete organizational focus to address issues at a systems level rather than a unit or a micro-level. Nurse managers in this study provide information on organizational leadership support and focus to improving patient satisfaction (19 participants). Organizations with high patient satisfaction and a patient centered philosophy approach the phenomenon of improving patient satisfaction as a cultural initiative. Executive leadership that lives and breathes the culture of patient satisfaction is able to influence other members of the organization (15 participants). Executive leaders of acute care hospitals in this study have put formal rewards and recognition programs in place for positive reinforcement. Findings presented under Theme 7 address gaps in body of literature on the influence of nursing, administrative leadership, and focus of the nurse manager holistic role aligning with new expectations to improve patient satisfaction.

Theme 8a: Challenges Facing Nurse Manager in Their Journey to Influence Patient Satisfaction: Sustainability of Initiatives

Prior studies on patient satisfaction address the subjectivity of the patient experience. Researchers contend that larger socioeconomic factors may explain for the differences in patient satisfaction indicators (Bleich et al., 2009). Other studies find contradictory evidence that information given to the patient does not significantly improve patient satisfaction supporting the theory that patient satisfaction is a multidimensional concept with subjective evaluation (Cole, 2008; McGilton et al., 2006;

Walker, 2007). Nurse managers struggle sustainability of initiatives due to multiple reasons. Participants express resistance to change from some of the more experienced staff that is less motivated and influenced to change current practice and culture.

The literature review also addresses the expanding role of a nurse manager with increasing demands for new knowledge and skills in a decentralized governance structure (Swansburg & Swansburg, 2002). Study findings indicate nurse managers in the current study have larger span of control, multiple responsibilities, in organizations with flat governance structures allowing for more staff engagement to meet organizational goals. Top level leadership in healthcare organizations face scarce human and financial resources to support nurse managers to manage the business of complex patient care operations, budget management, human resources management, and multi-level communications (McLarty & McCartney, 2009).

A systematic review of literature by H. Lee and Cummings (2008) on nurse manager satisfaction provides evidence that reducing span of control, improving empowerment, and organizational support of front-line managers provide positive patient and staff outcomes. The current study findings echo the multiple complex contexts impacting the new comprehensive nurse manager role that align with the expectations for improving patient satisfaction outcomes. The study will bridge the gap between perceived holistic and comprehensive nurse manager role, skills, functions, and dimensions to improve patient satisfaction in current and future contexts.

Another challenge for the nurse manager affecting sustainability of initiatives is staffing. According to current literature, the scarcity of nursing staff is mainly due to an increasing demand, increased turnover due to stress, burnout issues, and fewer nurses

entering the workforce (Medland et al., 2004). Nurse managers in the current study discussed their experience poor staffing on decrease in patient satisfaction scores however some managers expressed the need for caring individuals with good communication skills to mitigate patient satisfaction issues in the presence of less than adequate staffing.

Staff dissatisfaction has shown to result in poor patient outcomes such as patient safety (Blegen et al., 1998; Gardner et al., 2007; O'Brien-Pallas et al., 2010) increasing length of stay, poor collaboration between professionals, late detection of complication, and failure to rescue (Aiken et al., 2002; Curtin, 2003; Pronovost et al., 2001). The current study finding support current literature on different constructs that affect the nurse manager role in improving patient satisfaction such as staff satisfaction, adequate staffing, availability of resources in creating healthy work environments necessary for improving patient satisfaction.

According to literature most nurse managers are promoted from the ranks of clinical nursing staff without ensuring adequate management training (Grindel, 2003; Kleinman, 2003; McLarty & McCartney, 2009; Wilson, 2005). Swearingen (2009) recommended a formal leadership education and training program for different leadership levels by expert members and leaders of the organization. Developmental needs identified for nurse managers include building communication skills, conflict resolution, role transitioning, scheduling, budgetary, payroll management, performance evaluation, and staff counseling (Sullivan et al., 2003). The current study findings provide new findings from the experiences and perceptions of nurse leaders for the need for nurse manager leadership development and training to maximize effectiveness in a changing

health care environment. The information is crucial for health care organization looking to recruit, and develop nurse managers to maximize in their role.

A recent study on stressors of nurse manager reveals staffing, understanding finances, workload, patient satisfaction scores, patient safety, and operational effectiveness as major source of stress (Shirey et al., 2010). A review of the composite textural descriptions of nurse leaders reveals frustration, stress and sense of urgency to improve patient satisfaction scores. Current study findings support previous studies on subjectivity of the patient satisfaction surveys (Bleich et al., 2009; Cole, 2008; McGilton et al., 2006; Walker, 2007). The study participants acknowledged the influence of variables such as societal influences, prior experiences, demographics, and unrealistic expectations on the patient experience and patient satisfaction survey scores.

Theme 8b: Challenges Facing Nurse Manager in Their Journey to Influence Patient Satisfaction: Lack of Interdepartmental and Interdisciplinary Teamwork.

Chapter 2 contains little information on lack of interdisciplinary collaboration affecting the role of the manager to improve patient satisfaction. Thematic findings contribute to the body of leadership studies regarding lack of interdisciplinary buy-in (12 Participants), and interdepartmental cultural variation (12 participant) as barriers to the nurse manager role to improve patient satisfaction. Findings in this study may relate to systems approach to analyze and understand interrelationships with different disciplines to acquire an in-depth understanding the nurse manager role to improve patient satisfaction. The concepts of interrelatedness and interdependence are developed in organizations that value shared governance and multidisciplinary teamwork approach to patient care (Huber, 2006).

Broader Interpretation of Research Questions

The central question and five sub-questions provided a framework for interview questions that probe into the unknown phenomenon of the nurse a holistic role aligned with expectations for improving patient satisfaction. Interview participants provided insight into the essence of the meaning of lived experiences with the unknown phenomenon. The thematic expressions provide meaningful essences and the nature of the human lived experiences of expert nurse manager and leaders in their new role aligned with expectations for improving patient satisfaction outcomes.

The sub-questions narrow the boundary of the central research question and provide the necessary framework for open-ended interview questions. The following sections present discussions that link the emergent themes to respective research sub questions (RQs).

Research Sub Question 1

Sub RQ1. What are the current practices, dimensions, indicators, and expectations for the nurse managers to monitor, measure, or influence patient satisfaction on their units?

Explored under Research Sub Question 1 are the expectations of the nurse manager role for improving patient satisfaction. Theme I provided the answers to the primary question. The new role of the nurse manager is expanding from managing and leading followers to influencing patient quality outcomes. This is a new focus and direction of the role of the nurse manager. The influence of the nurse manager can be seen both as a direct influence through modeling of patient centered behavior and leader

rounding or an indirect influence by developing, engaging, and empowering followers for a enhanced patient experience.

Sub RQ1 also provided meaningful expressions to develop essential themes under category Theme 6: Role of nurse manager as a change agent: continuous quality improvement. Nurse managers described their unique experiences to monitor, measure and improve patient satisfaction through various patient satisfaction initiatives. The collective textural descriptions of the experiences of improving patient satisfaction were grouped under Theme 6. Nurse managers articulated a change in responsibility for quality improvement with functions for data collection, researching best practice, planning, implementing, evaluating outcomes, and communicating results staff. The essence of the new role of the nurse manager is a change agent in a journey for excellence with innovation, creativity, resourcefulness, and risk taking as hallmarks for success.

Research Sub Question 2

Sub RQ2: What were some of the essential themes from past nurse experiences that should be maintained with the new nurse manager role, practices, attributes, functions, strategies, or performance improvement initiatives that may continue to influence improved patient satisfaction in current and future times?

Sub RQ2 resulted in elaborate and extensive information interspersed through Themes 2, 3, 4 and 5. The interview question sought specifics on leadership capabilities and the different initiatives and practices influencing patient satisfaction. The different leadership styles appear in the different themes. Authentic leadership styles (five participants) were considered important to building a new culture. Authentic leaders with

strong moral and ethical values have a genuine desire to serve other through their leadership. The authentic leader builds meaningful relationship with followers and influences others through their strong sense of self.

Transformational leadership style is necessary to fulfill the holistic nurse manager role for staff engagement and empowerment mentioned in Theme 5. Transformational leaders in study encouraged participation, shared power, and information to transform followers and cultures to achieve patient satisfaction. Servant Leadership addressed in Theme 3: Leader rounding, exemplifies attributes of listening, empathy for patients and staff, communicate, strong inner self to serve others.

Participative leadership by study participants is discussed throughout the themes and necessary for staff engagement and empowerment. The major leadership styles namely transformational leadership, authentic, servant, and participative leadership styles are practices by study participants to align with the expectation for improving patient satisfaction. The nurse manager attributes of a patient centered philosophy, diligence, empathy, learning, and drive for excellence are hallmarks of successful leaders for effective change.

The current health care system is in a constant state of turmoil. Health care organization facing the effects of external regulatory and market forces and dangers of internal stagnancy will need cultural transformation to survive. The study findings shed light on the urgency to develop nurse managers with leadership capacities, and capabilities to transform unit culture for sustainable and meaningful change. Current models and initiatives for provision of patient centered care are ineffective unless accompanied by meaningful cultural change.

Change leaders, not satisfied with the status quo, are flexible, visionary, patient, diligent, and adapt to the changes confronting them. Fluid cultures promote teamwork, take risks for innovative practices, empower, develop, and are committed to their most valuable resource- the human enterprise. Front-line expert managers realize the need to change the foundation and culture of an organization by concentrating on the people being served (patients) and the persons serving them (employees).

An important study finding is leader rounding on patients and staff for outcomes. Study participants described the benefits of rounding to glean patient's perspectives, expectations for an enhanced patient experience. Expert nurse leader are visible, accessible to staff and patients, display their passion, and ownership for customer and employee service. Expert leaders *walk the talk*, and mirror their vision of patient caring through role modeling patient centered behavior.

Research Sub Question 3

Sub RQ3: What is the essence of the new complex and transformative changes in the projected nurse manager leadership roles and trends for best practices in the context of new regulatory requirements to improve patient satisfaction in highly competitive health care environment.

The composite textural descriptions resulting from exploring this research question provided the structure for formulating Theme 1: The new role of the nurse manager and expectations to improve patient outcomes. The current health care system is shifting towards a market-based economy governed by many forces that affect the survival of the organization. At the center of the change is the emphasis on providing

value in exchange for provision of service. Both consumers and third party providers are focusing on the value of services and not the quantity of service.

Focus on patient quality outcomes includes both clinical indicators and the subjective experience of satisfaction of care. Health care leaders are scrambling to address these changes and improve quality outcomes by expecting front line managers and leaders to affect necessary change. Effective leadership is essential for health care organizations to compete in a market-based economy. The current study findings highlight the nurse managers lived experiences and understanding of the importance of customer driven market economy in healthcare. The study findings provide insight on how expert nurse managers aligned the expectations of improving patient satisfaction by developing their leadership roles, skills, role, style, and functions in this new era.

Research Sub Question 4

Sub RQ 4: What is the overall value or benefit of the newer nurse manager position and opportunities in meeting requirements for improving patient satisfaction?

The current study findings through exploration of RQ 3 provide significant information on essential and supplemental nurse manager functions to improve patient satisfaction. This research question gets to the heart of the study to probe nurse managers perception and understanding of the essence of their lived experiences. The rich insightful perspectives offer a holistic and comprehensive understanding of what it means to be a manager and leader in the current and the future health care environment.

The study findings through exploration of this particular research question provide the foundations for understanding Themes 1-7. Nurse leaders in this study clearly understand the priority to create a more caring, compassionate, and effective

cultures. Visionary nurse managers and leaders understand that creating change is a multistage process and require the collective energies and focus of followers, disciplines, and customers for effective patient outcomes. Nurse managers infusing values, of caring, compassion, empathy, and patient centeredness align followers to this vision.

Nurse managers in this study achieved effective cultural change by building relationships with followers, and embedding shared values, purpose, and beliefs in a culture of follower engagement and empowerment. Study findings are significant to understanding to develop caring cultures for sustainable quality outcomes. The current study provides a foundational understanding of nurse manager skills and competencies that align with the new expectations for improving patient satisfaction outcomes. The study findings through the exploration of research questions provide rich information of how the nurse manager is able to create a caring, mission oriented, thriving, cohesive, learning, and empowered culture that can drive changes for positive patient outcomes.

Research Sub Question 5

RQ5: What are the influences and or overall obstacles barriers, or complexities that may challenge the Nurse Manager within the organizational culture to meet requirements for improving patient satisfaction?

The exploration of the last research question and data analysis of high frequency references led to formulating essence in Theme 8: Challenges facing nurse managers to improve patient satisfaction. The two major issues are lack of interdepartmental and interdisciplinary teamwork, and sustainability of initiatives by various study participants. The nurse leaders in their journey for improving patient experience encounter several

issues. Interviews from a large spectrum of nurse leaders at different stages of their development provide insights on how to mitigate such issues.

The challenges and insights offer rich and meaningful information for other health care organizations undergoing similar issues. Nurse leaders emphasize a holistic organizational approach rather than a nurse manager driven stand-alone initiative that often needs constant monitoring, direction, follower reinforcement through ineffective leadership behaviors. Leaders of organizations need to engage all departments, disciplines, and levels of the organization to focus on and enhance the patient experience.

Nurse leaders emphasize the need to cultivate empathy and caring behaviors of caregivers by first demonstrating care and empathy towards them. Organizations developing the human capacity and capabilities may produce effective results. The exploration of the research question led to nurse manager role in educating, coaching, mentoring, supporting, engaging, empowering, rewarding, and recognizing followers through role modeling of caring behaviors. Follower engagement, empowerment, and partnership with patients will help in identifying, addressing and resolving structure and process issues for an enhanced patient and staff experience.

Contributions to Theoretical Frameworks for Current Study

Several leadership and management theories discussed in Chapters 1 and 2 provided the framework in understanding the management and leadership nurse manager role. Both management and leadership role is a human relations role, essential and interchangeable for the contemporary nurse manager. Management is differentiated from leadership as a process of coordinating and allocating resources to achieve organizational

goals while leadership is influencing and empowering followers to goal achievement (Yukl, 1999).

Management Theories

Several management theories discussed in Chapters 1 and 2 include great man theory, Theory X and Y, and Maslow's hierarchy of needs theory. The textural descriptions of the participants in the current study indicate potential dangers and ineffectiveness of bureaucratic management to build new caring cultures and healthy work environments. The act of controlling, and top down management style ran contrary to the management practices of the nurse leaders in this study. The study findings in Theme 2 and Theme 4 indicate the role of the nurse manager in setting clear expectations for excellence in patient satisfaction and addressing poor behaviors for customer service. The construct of employee accountability and addressing poor behaviors may not necessarily fall under the confines of bureaucratic management responsibilities of the nurse manager but was significant findings in the study.

Theory Y by Douglas McGregor proposes managers use positive reinforcement, feedback, rewards and recognition as incentives to perform (McGregor, 1960). In Theme 4: Creating a healthy work environment, nurse managers practiced real time feedback, rewards, and public recognition of excellence in customer service. Study participants considered rewards, recognition, and feedback as necessary functions for reinforcing positive behaviors, and staff satisfaction. The study findings validate the practice of Theory Y and in creating a healthy work environment for positive patient outcomes.

System theory in management looks at internal factors, external factors and subsystems as an integrated whole for innovation or change management (Johnson, Kast,

& Rosenzweig, 1964). Study findings in Theme 8: Lack of Interdepartmental collaboration and accountability for improving patient satisfaction discusses challenges for nurse manager's role to enhance the patient experience in the heath care organizations. Nurse leaders in the study verbalize lack of interdepartmental collaboration, buy-in, and shared accountability as major challenges in their journey to improve patient satisfaction. Study findings in Theme 7: Organizational Focus and Culture provide information on alignment of all employees in the organization, shared accountability, collaboration, and team approach to enhance the patient experience. As the HCAHPS survey seeks perceptions on the entire patient experience, health care leaders must focus on taking a systems approach to improving patient outcomes.

Maslow's hierarchy of needs theory is essential in understanding employee motivation and personal development. The five stages of inner motivating needs, begins with basic biologic needs, safety needs, need for belonging, self esteem needs and the highest need for self actualization or self- fulfillment. Nurse leaders in this study alluded to attending to staff basic needs by facilitating and coordinating resources for staff to perform effectively. The study findings described in Theme 4: Building Healthy work environment indicate the important role of the nurse manager in staff satisfaction through attributes of respect, caring, listening, and building relationships. As described in Theme 5: Staff engagement and empowerment, nurse managers meet follower's self-actualization goals by identifying, and developing staff to fulfill personal and professional goals.

Leadership theories discussed in Chapter 1 and 2 relevant to the study findings include transformational leadership, servant Leadership, structural empowerment theory,

and authentic leaders. Transformational leaders influence, inspire, and stimulate followers to achieve extraordinary outcomes (Bass & Avolio, 1994). A transformational leader may have one or more of the following components; idealized influence, idealized motivation, idealized stimulation, and idealized consideration. Analysis of the individual and composite textural descriptions in interview transcripts reveals transformational leadership characteristics among many nurse manager participants.

In Theme 2: Build a new culture, the constructs include being visionary, having a internal drive, and ownership for high patient satisfaction, aligning organizational vision with followers, and role modeling, are representative of idealized influence. Immediate supervisors of nurse managers stressed the need for transformational nurse leaders to transform cultures into patient caring cultures for positive outcomes. Top-level transformational leaders inspire nurse managers to go over and beyond. The study findings in Theme 7: Impact of organizational focus discuss how top level transformational leaders inspire and motivate nurse managers to fulfill shared vision for excellence in customer service.

Transformational leaders in this study intellectually motivate and stimulate followers through engagement and empowerment and working towards innovative solutions and initiatives to improve patient satisfaction. Theme 5: Staff engagement and empowerment provides evidence of the transformational leadership characteristics. Study participants stressed the need for first building healthy working environment by concentrating on their staff through respect, act of caring, courtesy, valuing, coaching, and mentoring to achieve mutually shared goals. Institute of Medicine (IOM), Joint Commission, Magnet Recognition Program®, and American Organizations of Nurse

Executives (AONE) require transformational leadership as essential building blocks for providing safe and high quality patient care. The study findings support the presence of transformational leadership characteristics among nurse managers to create, manage and effect meaningful change for high patient satisfaction.

Servant leadership proposed by Robert Greenleaf (1977) proposes that the leader is the servant first, focusing on the growth and well being of others by sharing power. Nurse leaders in the study articulate the philosophy of caring that guides their professional practice. The caring philosophy is extended to followers with attributes of genuine respect, support, develop, and going over and beyond for staff.

Current studies lack sufficient evidence of influence of servant leadership on positive patient outcomes. Theme 2: Building new caring culture, nurse managers in this study model service excellence in their interactions with patients. Study findings are indicative of servant leadership qualities in first line nurse managers not just with employees, but also with patients. Servant leaders believe that demonstration of courteous, respectful, and caring behaviors to the staff is important to create a more patient caring culture. Current study highlights the importance of servant leadership behaviors among nurse managers to model patient caring behaviors to followers.

Kanter's (1997) structural empowerment theory posits organizations that support, and provide employees with access to resources, information, and structures for formal and informal power have greater organizational commitment. Structural Empowerment studies indicated positive relationships with employee performance (Casey et al., 2010; Laschinger et al., 2002; Sarmiento et al., 2004), improving the safety, and quality of patient care (Armstrong & Laschinger, 2006; Laschinger et al., 2003). The composite

textural descriptions of the holistic nurse manager role consist of democratic and participative leadership attributes. The current study findings indicate the presence of participative leadership attributes among expert nurse managers contributing to employee engagement and empowerment.

Verbatim excerpts from the interviews indicate that nurse managers see themselves as participative and democratic to engage and empower followers. Theme 3: Leader rounding, Theme 5: Engagement and Empowerment, and Theme 6: Change Agent- Continuous Quality Improvement address nurse managers' role in developing teamwork, engaging staff, and shared decision making for aligning followers to work toward improving patient outcomes. The findings of the study support the needs for participative leadership attributes for follower contribution. The current study findings highlighted the importance of follower participation, engagement, and empowerment in creating healthy work environments and ultimately positive patient outcomes. The current study also highlighted the value of providing formal structures and processes of the shared governance model for follower participation, engagement, and empowerment in creating healthy work environments and ultimately positive patient outcomes.

Authentic leaders have a strong moral and ethical foundation to develop and engage the human capital for positive outcomes (Wong & Cummings, 2009). Studies on authentic leadership among nurse managers indicate high frequency of patient safety (Wong & Giallonardo, 2013). The findings from the current study provide information on the presence of authentic leadership attributes among nurse managers as they are mission driven, advocate for patients, focus on results, support, develop, and mentor staff in their experience to improve patient satisfaction outcomes.

Study finding are significant to understanding the complex nature of the holistic and comprehensive nurse manager leadership role in aligning with expectations to improve patient satisfaction. The findings of the current study show high frequencies of participative leadership, transformational leadership, servant leadership, and authentic leadership among study participants. Only few leaders were able to define themselves as embodying one particular leadership style. The rest of the study participants exemplify a combination of attributes and leadership styles in their journey to improve patient outcomes.

Contributions to Conceptual Frameworks for Current Study

Chapter 1 and Chapter 2 contain multiple conceptual models in nursing management, nursing leadership, and patient satisfaction to explain the frameworks surrounding the phenomenon. The conceptual models in nursing management and leadership significant to the study findings include (a) shared governance, (b) Magnet designations, (c) healthy working environment, (d) emotional intelligence, and (e) professional practice.

Shared governance model is management strategy in health care organizations for staff nurse empowerment, cooperation, shared accountability, shared power, and investment for patient and practice outcomes (Huber, 2006; Kramer et al., 2009). Magnet designation requires hospitals to have formal structures and processes in place for shared decision making. Nurse leaders working in Magnet designated hospitals use formal structures called unit based practice councils as vehicles for nursing engagement integrating the shared governance concept.

Participating hospitals without Magnet status use the concepts of shared governance in staff meetings and multidisciplinary committees for improving patient satisfaction. A majority of nurse managers in this study find that shared governance is an effective process in promoting nursing engagement and empowerment. Analysis of the data indicates that supportive processes such as shared decision making are essential to the holistic nurse manager role to develop, engage, and empower staff to effect meaningful cultural change for positive patient outcomes.

Magnet Recognition Program® by the American Nurses Credentialing Center (ANCC) is a prestigious designation for hospitals that meet metrics for quality patient care, nursing excellence, and innovation in nursing practice (ANCC, 2013). Hospitals with Magnet designation promote achievement of high nursing quality standards. The intent of Chapter 2 was to discuss in detail the 14 characteristics for Magnet recognition. Scores of studies in Magnet and the forces of magnetism indicate positive staff outcomes, nursing sensitive indicators (Aiken, Buchan et al., 2008; Choi et al., 2004; Schmalenberg & Kramer, 2009), and nursing leadership (Aiken, Clarke et al., 2008; Friese, 2005; Stone et al., 2009; Stone & Gershan, 2009). Submission of patient satisfaction survey scores is essential for magnet designation and re-designation, however few studies findings indicate direct influence of Magnet recognition to improvement in patient satisfaction scores (Aiken et al., 2009; Armstrong & Laschinger, 2006; Bacon & Mark, 2009).

Four of the seven hospitals in the study were Magnet designated hospitals. According to participants in this study, patient centered care, shared governance, and relationship based care was more effective to improve patient satisfaction than Magnet designation. The results of the studies did not indicate the direct influence of Magnet

Recognition Program® with patient satisfaction, however indirect influences were recognized on the holistic and dynamic role and dimensions of the nurse manager to influence patient satisfaction. Leaders 01, 03, and 09 reported Magnet hospitals focused on clinical quality, however the models for shared governance provide the foundation for the nurse manager to affect meaningful change for improved patient satisfaction.

Building healthy work environment was an important study finding, supporting the conceptual model discussed in Chapter 1 and Chapter 2. Literature review indicates lack of information of how nurse managers affect healthy work environment to align with expectations for patient satisfaction. Finding of this study provides valuable information on healthy work environments in health care organizations undergoing change.

Theme 4 contains elaborate discussion of the holistic role of the nurse manager to value, develop, support, educate, coach, and mentor staff by demonstrating attributes of courtesy and respect. The holistic role of the manager to build new healthy work environment include recruiting staff with patient centered behaviors, providing real time feedback, rewards, and recognition for positive behaviors. Nurse managers also build healthy work environment by setting clear expectations and addressing any negative behaviors. The current study findings expand the comprehensive understanding of the healthy working environment of current concepts and elements and its implications to improve patient satisfaction outcomes.

Emotional intelligence (EI) is the ability to use emotions effectively through attributes of self-awareness, self-management, social awareness, and relationship management (Goleman, 2006). A manager with high EI is self-aware, self regulates, motivates, is empathetic, and has proficiency in social skills. Twelve data sources

provided high frequency references for empathy as a necessary attribute for the holistic nurse manager to improve staff and patient satisfaction. One data source indicated the importance of developing, educating, and changing staff culture based solely on the model of emotional intelligence. The study findings support empathy as an essential attribute not just for managers but also for staff interaction with patients to build a patient caring culture.

Patient centered care is perhaps the most discussed concept in health care today in the drive to improve patient outcomes. According to Institute of Medicine (IOM, 2001a), the core concepts of the patient and family centered model is dignity and respect; information sharing; participation, and collaboration. The first two concepts in patient centered care closely mirror the HCAHPS survey question domains on communication with nurses and physicians. Extensive studies on patient centered care indicate benefits with patient satisfaction are documented in Chapter 2. The gap in literature exists on how to translate patient centered model to the nurse manager role.

Data analysis on the composite textural descriptions of study participant indicate that all participants verbalized the essential attributes of a patient caring or patient centered philosophy to build new caring cultures and meet expectations for improving patient satisfaction. Aspects of patient centeredness such as information sharing, seeking patient's perspectives, building relationships, seeking, clarifying, and addressing patient expectations are important findings of the study. Participants verbalized patient centered care as being the most effective model for improving patient satisfaction. The current study findings address the need for building patient caring cultures within sub organizational units to improve patient satisfaction.

Limitations of the Study

The study contained several limitations that the researcher could not have controlled and might have affected the trustworthiness of the study. The first limitation was determining the eligibility of the study participants for the phenomenological study. Sample selection was dependent on organizations providing the names of the potential eligible study participants. To delimit issues with participant selection, organizational leadership received clear participant selection criteria. Participant selection criteria included nurse managers with high 2011-2012 HCAHPS survey or vendor specific survey results and experience or expertise with improving patient satisfaction. Only two organizations shared department specific HCAHPS survey data with the researcher for mutual decision making in participant selection.

A limitation of the study may be researcher bias and inexperience in conducting phenomenological studies. A working familiarity, knowledge, and experience with the new nurse manager role in improving patient satisfaction outcomes, may be a potential source of bias in data collection and interpretation. Inexperience in conducting phenomenological interviews and lack of expert knowledge with the NVIVO 10 software compared to an experience researcher may be subject to differing opinions of the data. An experienced phenomenological researcher may have been more cognizant in the process of bracketing, extraction and interpretation of themes from the textural description of the participants to minimize bias. Gaining experience through four pilot tests prior to the actual interviews assisted in improving the credibility of the research.

The transcendental phenomenological study used open-ended yet semi-structured interview guide to narrow the boundaries for exploration pertinent to the research

question. Limitations on time allotted for the interviews, prevented an exhaustive exploration of structure of meanings of the experience. Some interviews extended to two hours permitting the participant to engage in the reflection and recollection of their lived experiences with the phenomenon.

All the participants in the study were employees of a not-for-profit health care organization. The intent of the study was to get participation from various different organizational types. The absence of for-profit hospitals participating in the study, may decrease the confirmability of the study. The possibility exists that the different organizational type such as for-profit and not-for-profit may alter the study finding, but the other unique differences of each participating hospital is present which did not alter key findings of the study.

Significance of the Study to Leadership

The study is significant to the study of leadership as it investigates the experiences of nurse managers beyond a confined set of pre-existing theories, or concepts, or constructs. By turning away from established concepts and constructs and to return to things themselves, one can begin to unravel complexity of the holistic nurse manager role (Moustakas, 1994). The qualitative phenomenological study of holistic nurse manager leadership role aligning with expectations of improved patient satisfaction yielded major themes and meanings of the essence of the phenomenon. The collective description of the lived experiences and thoughts of the participants resulted in the development of eight major emergent themes. The analysis of the research sub-questions provided supportive and supplemental information surrounding the themes.

The study findings shed new light into the complex world of a nurse manager in today's health care environment to lead and manage people to meet customer expectations. In light of new demands, the contemporary role of the nurse manager is expanding from managerial and functional responsibilities to a more dynamic leadership role by building meaningful relationships not just with employees but also with customers to meet mutually aligned goals. This study is significant to the study of leadership as findings indicate a new focus and direction in outcomes based nurse manager leadership roles, functions, practices, skills, and competencies. New emergent themes and the focus on outcomes may influence the pedagogy of leadership and management. The information is also useful in developing nursing leadership education and training, seminars, mentoring and continuing education programs in organizations seeking to improve patient satisfaction outcomes.

The relational and interpersonal connections between leader and follower are not as simple as envisioned and many factors affect the effectiveness of the relationship. Themes in the study allude to the presence of supporting processes, organizational culture, sub-unit culture, follower personalities, values, inner motivating factors, as important constructs affecting the effectiveness of the holistic nurse manager leadership role. The descriptions in the study on the meaning of the nurse manager leadership styles augment current leadership studies and suggest the importance in a changing and turbulent health care environment. The emergent themes may provide relevance to understanding the influence of various constructs with practical applications to nurse managers, health care leaders, leaders in other disciplines, and nursing and health care leadership studies.

Significance of the Study to Nursing Education

According to Meyers (2000), nursing, nursing education, and qualitative research share the same objectives, valuing the subjective lived experiences, holistic nature, and perceptions to create and understand the meaning of the nature of the phenomenon. The qualitative research on the lived experiences and perceptions of nurse managers on the holistic and comprehensive role to improve patient satisfaction provides valuable insight into the need for nurse manager education, ongoing training, and professional development to optimize the complex role of nurse leaders and managers. The study findings are significant to the education and training programs of nurse managers with emphasis on leadership styles, strategic planning, change management, business skills, human relations, process improvement, and emotional intelligence. The study findings confirm current perceptions of nurse managers' need for education in specific areas such as new and upcoming changes in the health care industry, health care reform, regulatory requirements, stakeholder expectations, and new patient care delivery models. Nurses interested in nursing management and leadership may need formalized training programs in nursing administration to develop necessary leadership styles, skills, and competencies for transformation, innovation, and organizational excellence.

The study findings are also significant to selection and training of potential nursing students in nursing schools with emphasis on developing emotional intelligence, caring behaviors, human relations, engagement, ongoing professional development, performance improvement, regulatory requirements, new health care delivery models, and change management. The study findings indicate that in addition to developing clinical knowledge and skills in nursing students, holistic caring skills are necessary for a

patient and family centered culture. The study findings are significant to health care organizations with emphasis on investing in ongoing formal leadership development and training of current nurse managers to optimize the nurse manager role to meet quality outcomes. Organizations that expect nurse managers to lead a transformed, healthy, and empowered work force must focus on developing nurse manager leadership skills, competencies, and capabilities through formal education and training.

A Proposed Model of Nurse Manager Role in Transformation

The constructs in the themes were necessary elements in the development of a conceptual model of the holistic nurse manager role to improve patient satisfaction outcomes. The important feature of the proposed nurse manager model for transformation is the holistic and comprehensive approach to seek positive patient outcomes. The model is a comprehensive and holistic approach to transform the current environment, with supportive organizational structures and processes necessary to impact envisioned outcomes.

The themes elucidate the meaning of the essence of the experience with the new phenomenon. A new innovative model of health care delivery is essential in the acute inpatient setting to help address growing concerns among consumers, regulatory agencies, stakeholders, and third party providers on poor health care quality outcomes in the current system. The current health care system is shifting from a fee for service reimbursement system to value based purchasing system with significant financial penalties for poor clinical and patient satisfaction outcomes. The general context of the model as mentioned in Theme 1: Expectations of the new nurse manager, is the new organizational, consumer, and regulatory expectation and demands to improve health care

delivery processes and structures for high quality outcomes including patient satisfaction. Health care organizations should consider customer expectations and demands to succeed in a volatile consumer driven market.

The new model is a comprehensive and holistic approach and provides new information and guidance for health care leaders grappling with issues in improving patient satisfaction outcomes in a changing health care environment. The new model provides new information for health care organizations with the nurse manager playing a pivotal role in building new patient caring cultures and healthy work environments aligning with new expectations for improved patient satisfaction outcomes.

The model also offers a new framework for new front line nurse managers seeking to meet organizational, regulatory, and consumer demands for improved patient satisfaction in the acute care inpatient setting. The model also expands the current knowledge and information on front line nurse manager competency models with emphasis on the new role to improve patient satisfaction. Incorporating essential organizational elements reinforces the need to support the new nurse manager role and provides an organizational framework for health care leaders, policy makers, and leadership educators seeking to meet consumer expectations for improving quality of health care delivery. In implementing a new model, health care leaders may use research findings to seek innovative strategies and use customized approaches or techniques to meet new challenges in a transforming health care system.

The model provides a holistic and comprehensive new look by incorporating previously known nurse manager roles with new expectations for the contemporary nurse manager leadership attributes, behaviors, styles, roles, functions, skills, and

competencies. Integrating innovative conceptual models with research-verified constructs in a supportive organizational culture along with structures and processes may lead to increased positive patient satisfaction outcomes with best practices and benchmarks for critical care hospitals. The model may be tested for its value in real life inpatient acute care settings and among different types of hospitals in different regions.

Figure 16 contains a graphical representation of the model, which depicts the essential framework with constructs for an alignment with new expectations, and demands of patient satisfaction outcomes. The interrelated constructs are depicted as processes to build new patient caring cultures and healthy work environment. The model is shaped as a house with foundations and pillars supporting the structure to produce positive patient satisfaction outcomes. The pillars signify the major constructs that support the house and consist of nurse manager and leadership roles, styles, competencies, and functions. The central pillar is the nurse manager new role, with surrounding pillars interrelated and connected for positive patient outcomes. The roof is the ultimate goal of meeting expectations for improving patient satisfaction. The essential elements and constructs gleaned from study findings and depicted in the model, provide necessary information to meet organizational goals.

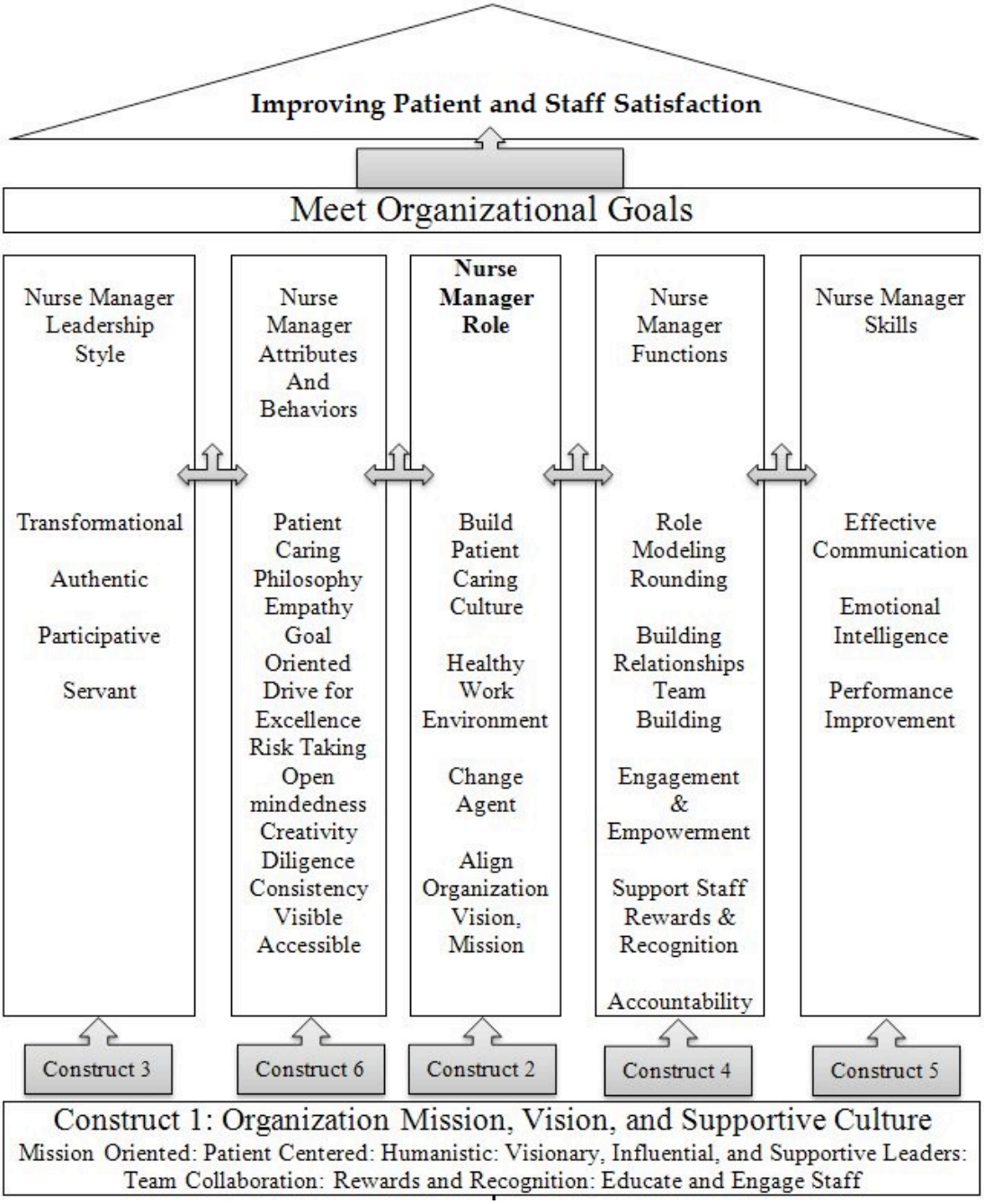

Figure 16. Nurse manager role in transformation.

The following sections contain a detailed discussion on the each of the constructs and interrelationships of constructs within the model.

Construct 1: Organization Mission, Vision, and Supportive Culture

A health care organization, mission, vision, culture, with supportive structures and processes provide the foundations for the middle and front line manager to succeed in their quest for improving patient outcomes. Visionary nurse managers align organizational mission and vision with intrinsic goals and influence followers to meet organizational goals. A mission oriented, patient centered, and employee friendly organization provides the foundational framework for the front line nurse manager to meet organizational goals for high patient satisfaction in a Value Based Purchasing environment. Executive leaders provide the vision and direction for the organization. Executive level visionary and authentic leaders role model mission oriented and humanistic values to influence and motivate managers and employees. Organizational cultures that put people first and value interpersonal relationships, and self-actualization of employees, support nurse managers in their quest for creating and sustaining healthy working environments for improving patient and staff satisfaction.

Organizational leaders emphasize the importance of service excellence through behavioral standards, and focus efforts to change organizational culture. Executive leaders focus on creating new patient caring and patient centered cultures by emphasizing employee education, collective accountability, team approach, and interdepartmental and interdisciplinary collaboration. Organizations with patient focused and humanistic values, focus resources, contain necessary structures and processes to realize mission and vision. Leaders in patient centered organizations realize the need for a collective responsibility to improve patient satisfaction and provide financial and human resources such as

amenities, adequate staffing, assistant nurse managers, patient satisfaction coordinators, and patient satisfaction committees to support the nurse manager.

An effective nurse manager requires administrative and nursing leadership support to build new patient caring cultures and healthy work environments. Learning organizations are not bureaucratic and health care leaders encourage staff innovation, creativity, engagement, and empowerment to foster new buy in and collective responsibility to meet organizational goals. Magnet designated hospitals consist of formal structures for shared governance models and leaders encourage staff participation in decision making for clinical practice and patient satisfaction initiatives (Havens & Aiken, 1999; Kerfoot & Talbot, 1992). Organizational leaders looking for sustainability of patient satisfaction behaviors hardwire one initiative at a time for continued success. Formal rewards and recognition programs provide extrinsic motivation and validation for service excellence.

Construct 2: Nurse Manager Role

The central pillar of the house is the new nurse manager role in a transformative health care environment with expectations and demands to improve patient outcomes. Health care leaders seek creative solution and innovative ideas to transform the current health care system from expert individuals within the organizations. The new role of the nurse manager is shifting from managing clinical practice to a more holistic, comprehensive, collaborative, coordinating role for positive patient, staff, and organizational outcomes. The contemporary nurse manager role is changing with greater emphasis on patient advocacy and outcomes driven focus. Nurse manager role is a comprehensive, dynamic, and holistic role consisting of many different roles and

responsibilities depicted in the model. The construct of the nurse manager new role consist of five major contemporary roles: (a) building new patient caring culture, (b) align organizational mission and vision (c) change agent, (d) create healthy work environment, (e) coaching, mentoring, and developing staff.

Build new patient caring culture. The new role of the nurse manager is multidimensional and interdependent with other essential constructs mentioned in the model in a multistage process to build new patient caring cultures. The multifaceted role is complex and dependent on the presence of nurse manager leadership styles, functions, behaviors, skills, and competencies that influence the success of the role. Despite knowledge rich and technical advances in health care, the foundational nurse patient relationship is that of caring. Nurses combine the rational and emotional component in the art and science of nursing for positive patient outcomes. Nurse managers build new patient caring cultures reverting to foundational caring component for improving patient satisfaction. A supportive organizational culture, leadership, and resources are foundational to success of building new patient caring cultures. Cultural change necessary for positive patient outcomes does not occur overnight but requires a combined effort and focus of multiple forces, factors, and conditions to facilitate a more patient oriented, and caring culture.

Building new patient caring culture requires shifting the focus from provider-centered model to a more patient centered model of care with attention to individual values, knowledge, needs, and experiences within a social and personal context (IOM, 2001a). The nurse manager meets patient expectations of satisfaction through effective communication during nurse manager rounding with patients and staff. Nurse managers

with servant leadership style, and patient oriented philosophy set an example by modeling caring behaviors. In a new culture, respect, caring and compassion are core values modeled by every member in the organization for positive staff and patient outcomes.

Align organizational mission and vision. The new role of the front line nurse manager is to align organization goals and mission with follower inner values and ideals for service excellence. The followers are front line staff, responsible for delivery direct patient care and have a direct impact and influence in affecting patient satisfaction outcomes. Followers look to nurse managers to lead them through turbulent changes affecting the health care organizations through effective nurse manager leadership styles, strategies, behaviors, approach, and functions. Nurse managers will need to inspire, motivate and influence front line staff through effective leadership styles mentioned in construct three.

Change agent. The nurse manager of the 21st century will need to embrace change for positive growth dynamics within health care organization for competitive advantage. As change agents, the contemporary nurse manager will need to understand change theory, educate staff, anticipate resistance, and manage change in a journey for continuous quality improvement. As a change agent, the visionary nurse manager influences, motivates, and leads engaged and empowered followers to create innovative ideas and processes for positive patient outcomes. A goal oriented nurse manager will need to articulate the goals for service excellence and focus efforts on creating teams for performance improvement. Organizational cultures and nurse manager's leadership styles build effective teams with shared vision to encourage innovation. Learning organizations

mentioned in construct one provides a supportive environment that encourages and supports change for positive patient outcomes.

Create healthy working environment. The new pivotal role of the nurse manager is to create and sustain healthy work environment for positive staff and patient outcomes. Healthy work environment are respectful of the rights, needs, expectations, and responsibilities of patients and staff. A healthy work environment fosters shared decision making, staff engagement, participation, and empowerment as nurse managers value and recognize the human capital (AACN, 2005). Authentic and servant leadership styles mentioned in construct three is essential in creating and sustaining healthy working environment. Nurse managers with high emotional intelligence and effective communication skills (construct 5), build meaningful relationships (construct), and collaborate with interdisciplinary and interdepartmental teams (construct) to effect positive patient and staff outcomes in a healthy working environment. The role of the nurse manager is to coach, mentor, and develop staff for effective patient staff interaction in a patient caring culture. Nurse managers develop champions and authentic leaders from among nursing staff to lead patient satisfaction initiatives for buy in, hardwiring, and sustainability of patient satisfaction practices (Avolio & Gardner, 2005).

Construct 3: Nurse Manager Leadership Style

The new role of the nurse manager is shifting from focusing on just managing and staff to leading, managing and coordinating teams for positive patient outcomes through effective leadership styles. The study findings highlight the four main leadership styles necessary to meet demands and expectations for improving patient satisfaction and include transformational, participative, authentic, and servant leadership. The essential

themes from study findings depict that not one particular leadership style is comprehensive and conclusive in attaining goals for patient satisfaction outcomes. Many different leadership styles mentioned in the construct two provide the necessary focus and direction in the multifaceted role and function of the nurse manager.

Transformational leadership. The current metamorphic nature of the current health care system requires nurse managers at the sub unit level to transform current cultures to meet the changing demands and expectation of stakeholders. A transformational and visionary leader grounded in moral and ethical values of self-service, influence others with a sense of purpose by appealing to their sense of beneficence and higher ideals. A visionary nurse manager understands external and internal forces driving the necessity for change and lead high performance teams to meet organizational goals (Bass, 1985). Visionary nurse managers have a clear direction and focus for patient and staff satisfaction outcomes and articulate the philosophy, mission, and values through effective communication skills and walking the walk. A visionary nurse manager takes the time and effort to educate, develop, and mentor staff to be authentic and innovative in achieving the visions and goals. Visionary leaders build a shared vision for service excellence.

Nurse managers with transformational leadership style are able to inspire motivate, and influence staff to build new healthy, vibrant, and high performing cultures. Transformational nurse managers motivate, and stimulate followers for high performance in a non-punitive and healthy environment through individualized stimulation. A transformational nurse manager and leader is able gain the trust of the followers through supporting and developing staff through individualized consideration.

Authentic leadership. Significant study finding indicate the influence of authentic leadership among study participants. The model includes authentic leadership as a significant construct of nurse manager leadership style aligning with new expectations for improving patient satisfaction. Authentic nurse managers are true to self, core values, ideals, ethics, and morals and lead with conviction (Avolio & Gardner, 2005). Nurse managers with high standards of moral and ethical values are able to inspire and appealing to follower's values for caring, empathy, and compassion. Authentic leaders influence followers because of their ability to lead with sincerity, humbleness, transparency, self-discipline, and purpose. Authentic leaders build meaningful relationships with followers for staff satisfaction affecting motivation for job performance and meeting organizational goals.

Participative leadership. Participative leadership is essential in creating staff engagement and empowerment for healthy work environments. According to study participants the autocratic and top driven approaches do provide sustainable change or improvement in patient satisfaction initiatives. Participative nurse managers use shared governance models, unit practice councils, staff meetings, patient satisfaction committees, informal interactions, and Transforming Care at the Bedside (TCAB) as vehicles to engage staff in process improvement for patient satisfaction initiatives. Nurse managers educate staff health care current climate, patient satisfaction, and share patient satisfaction survey results in a manner that staff can understand. Participative nurse managers seek staff input and participation on patient satisfaction and performance improvement initiatives to improve patient quality outcomes. Through buy-in, engaged and valued employees contribute to the collective team effort for research, planning,

implementing, and evaluating compliance with patient satisfaction initiatives. Nurse managers that focus on performance improvement also facilitate resources for the shared responsibility and accountability. Participative nurse manager provide real time feedback, recognition, encouragement, and support for staff driven initiatives to improve patient satisfaction. Various factors such as group dynamics, employee maturity and performance levels, organizational, and departmental culture can affect the nurse manager's ability to seek staff engagement and participation.

Servant leadership. The act of caring and service is synonymous with contemporary nursing profession and vocation. Nurse managers attempting to build patient caring cultures will need to demonstrate caring behaviors to staff and patients. The new role of the nurse manager as a leader is to influence followers by modeling caring servant leadership style. Nurse managers are in a unique position to care and serve those who care for others, providing a trustful, healthy, and nurturing work environment. Construct 5 consists of supportive nurse manager attributes that exemplify servant leadership behavior. Servant leaders are visible, accessible, non judgmental, non punitive, altruistic, and listen to staff and patients (Greenleaf, 1977; Greenleaf & Spears, 1998). The servant leadership mirrors transformational leadership behaviors by attracting followers motivated for self-actualization, and caring service to patients suffering from ill health.

Construct 4: Nurse Manager Functions

The third pillar or construct of the proposed model is the new nurse manager functions required to align stakeholder demands and expectation of improved patient satisfaction. The major nurse manager functions include the following; (a) set

expectations, (b) role modeling, (c) nurse manager rounding, (d) building relationships, (e) team building, (f) engagement and empowerment, (g) support staff, (h) feedback, reward and recognition, and (i) accountability

Set expectations. Nurse managers set mutual team derived goals that are achievable, time limited, and measurable. Nurse managers articulate and communicate goals for patient satisfaction, service excellence, and set clear expectations during recruitment, onboarding, and in formal and informal staff interactions. Clearly articulated goals, expectations, and performance standards provide a pathway for staff engagement and high performance. Nurse managers set clear expectations for followers to meet realistic patient satisfaction improvement goals. Nurse managers will need to invest time and energy individually with each follower to coach, and mentor for high performance.

Role modeling. Nurse mangers role also communicate goals for service excellence through role modeling. Followers monitor the actions and behaviors of the leaders and emulate the behaviors. Leaders can influence followers through their behaviors, actions, and commitment to excellence. Leaders build trust through congruency and consistency of expectations of goals and modeled actions. Nurse managers will need to walk the walk by going over and beyond for their staff and patients if they expect the same from the followers. Nurse managers expecting patient caring behaviors and service excellence from followers must demonstrate caring, empathy, and compassion.

Nurse manager rounding. New expectation and demands for improving patient satisfaction is shifting the role of the nurse manager to be accessible and visible to patients, family members and staff through leader rounding. Nurse managers in the study

rounded on patients and staff for improved patient outcomes. By rounding on patients, nurse managers solicit patient expectation, model service excellence behavior, address patient questions and concerns, conduct service recovery, evaluate patient satisfaction initiatives, and provide feedback.

Nurse manager rounding on patient and staff should be consistent, meaningful, and purposeful. Nurse manager set time aside daily to meet with patients and staff and use focused scripting questions when rounding on patients. Organizations support nurse managers by reducing certain administrative functions, and responsibilities by providing supportive personnel such as assistant nurse managers, shift supervisors, and staffing coordinators to permit nurse manager rounding.

Visibility and accessibility of the nurse manager opens lines of communication, provides an opportunity to communicate, and acknowledge staff. The nurse manager through rounding functions is able to improve communication, support to staff in addressing staff concerns or issues, encourage teamwork, build trust and improve staff satisfaction for a healthy working environment. Rounding allows nurse managers to visible and accessible to staff and patients, observe interactions and behaviors between staff, patients, and family, and provide real time feedback and recognition.

Build relationships. Health care is changing from an emphasis on episodic care to health care across the continuum. The health care team needs to build meaningful relationships with patients and families to collaborate, and deliver high quality care positive patient outcomes. As an advocate for patients, the nurse manager influences the health care team to create a patient caring culture through role modeling meaningful relationship building. Nurse managers build meaningful and authentic relationships with

followers for a collaborative working environment and foster similar relationships among team members. Nurse managers with high emotional intelligence, skilled communication skills, listening, and open door policy promotes trust and harmony for a healthy working environment. Nurse managers foster healthy relationships with followers through collaboration, shared decision-making, engagement, and empowerment. Nurse manager also encourages building meaningful relationships with staff and patients through models such as Relationship Based Care to deliver patient centered care and promote caring interactions.

Team building. Healthy work cultures require a team consensus and effort for high performance culture. Nurse managers build high performance teams by recruiting the right people for the job, develop leaders from within, setting mutually agreeable goals, encourage participation and engagement, and empower for a "just do it" culture. Nurse managers also encourage collegial relationship and teamwork between departments and disciplines to provide high quality patient outcomes.

Engagement and empowerment. Nurse managers engage and empower followers to create patient caring cultures, healthy working environment, and for continuous performance improvement. Organizationally adopted nursing practice frameworks such as shared governance and Magnet provide formal structures and processes to encourage staff participation in shared decision making. Engaged and empowered teams seek to improve staff and patient outcomes through partnership, shared accountability and ownership (Kanter, 1977). Risk taking nurse managers encourage creativity among empowered teams to develop innovative ideas and solutions.

Support staff. Nurse managers support staff by providing adequate staffing, remove barriers, facilitate coordination and collaboration among various disciplines and departments, and encourage teamwork to deliver high quality patient care. Nurse managers able to facilitate adequate nurse patient ratios in their departments are able to influence positive patient staff and meaningful interactions. Study findings indicate effective nurse managers improve workflow processes for quality patient outcomes by facilitating and improving communication between various departments and disciplines. Nurse managers also encourage teamwork among followers during daily work processes and for patient satisfaction initiatives.

Feedback, rewards, and recognition. Nurse managers seeking to build and sustain healthy work environment should recognize the value of staff contribution with meaningful recognition. Real time recognition of service excellence behavior contributes to validation, improved productivity, staff satisfaction, and quality patient outcomes. According to study participants, nurse managers publically recognize and reward followers during rounding for extrinsic motivation for improving continued service excellence behaviors. Nurse managers also communicate patient satisfaction survey results and comments and publically recognize staff mentioned in surveys on an ongoing basis.

Accountability. Nurse managers know their staff and focus on high performers for continued success with positive patient outcomes instead of devoting majority of their time addressing poor performers. Nurse managers are also responsible to address staff accountability of poor patient satisfaction behaviors and use negative experience to educate, clarify, and develop positive caring behaviors.

Construct 5: Nurse Manager Skills

The fourth construct or pillar is the nurse manager skills to support the new nurse manager role to improve patient satisfaction. Essential skills consist of effective communication skills, emotional intelligence, and performance improvement skills. Nurse managers acquire and leverage leadership and management skills to meet organizational goals for high patient satisfaction.

Effective communication. Effective communication skills are important for nurse managers to articulate goals, set expectations, encourage participation in continuous quality improvement, and build high performance teams. Nurse managers listen to follower suggestions and engage in active dialogue for open and honest communication. Nurse managers are transparent with patient satisfaction data, and update staff periodically on the status of the quality improvement initiatives. Nurse managers with effective communication skills inspire, motivate, and stimulate staff by relating real life stories that is meaningful, appealing to follower ideals, values, and ethics. Excellent communication is essential for building trusting relationship among team to resolve work related issues and conflicts and work together to deliver high quality patient care. Effective communication skills are necessary for feedback and validation of positive staff patient interactions for patient satisfaction.

Emotional intelligence. Nurse managers with high emotional intelligence perceive, manage, and express emotions with patients and staff for positive outcomes. Emotional intelligent nurse managers are aware and regulate emotions to control destructive and impulsive judgments (Goleman, 1998). Nurse managers build new patient caring cultures by motivating followers with emotional intelligence behaviors of

integrity, trustworthiness, and openness to change. The nurse manager role models emotional intelligent behaviors with empathy, effective social, and communication skills to build synergistic and collaborative teams to deliver high quality care.

Performance improvement. Performance improvement skills are necessary for research, planning, implementing, and evaluating patient satisfaction initiatives for positive outcomes. Nurse managers must have knowledge and skills to understand, analyze, and translate data into meaningful information to stakeholders. Nurse managers seek staff buy in for input through active communication through formal and informal meetings. Nurse managers also educate staff for active participation in continuous quality improvement process. Study participants verbalized positive experiences with using formalized processes such as TCAB and Team STEPPS for engaging staff in the unit based quality improvement.

Construct 6: Nurse Manager Attributes and Behaviors

Nurse managers seeking high quality patient and staff outcomes demonstrate the attributes of honesty, trustworthiness, sincerity, caring, empathy, and respect. Nurse managers influence followers with attributes of patient caring behaviors, goal orientation, and a drive for excellence. Open mindedness, creativity, and risk taking are valuable for performance and continuous quality improvement. Nurse managers will need to demonstrate focus, consistency, and diligence to hard wire and sustain patient caring initiatives and behaviors.

Model Summary

The context and constructs for the proposed model designed for potential organizational implementation purposes and practitioner venues or pragmatic

applications and resolution to challenging questions from hospital leaders faced with similar issues and organizational problems. These issues center on the changing nature of the projected contemporary nurse manager's role, skills, cross functional practices, and dimensions, that align with the newer dimensions, and expectations of increased patient satisfaction among selected nurse managers in acute care hospitals. Further research in this area to examine patient and staff outcomes with implementation of the model could provide further information to bridge the gap between delivery of care in health care organizations and patient outcomes. Additional research in this area would help validate the context and credibility to this proposed model.

Recommendations for Further Study

This phenomenological study is in essence, a subjective description of the lived experience of the nurse manager to improve patient satisfaction. The study provides description of the meaning of the lived experiences of the holistic and comprehensive nurse manager role to improve patient satisfaction. The study findings described as themes or essences constitute multiple layers that contribute to understanding the phenomenon. Each theme is a phenomenon by itself and is open for further discovery.

This study does not necessarily cover the complete spectrum of the holistic and comprehensive role of the nurse manager to improve patient outcomes. Due to the subjective nature of the data collection, a repetition of the study addressing each construct of the nurse manager role might provide additional insights into the new holistic nurse manager role to improve patient satisfaction. This study investigates the alignment of the holistic nurse manager role with expectation of improved patient satisfaction, but future studies may extend to study efficacy of the constructs elucidated in the themes with

additional demands and expectations of the nurse manager such as improving patient clinical quality outcomes.

The constructs in the themes are necessary elements in the developing a conceptual model of the holistic nurse manager role to improve patient satisfaction outcomes. The important feature of the proposed nurse manager model for transformation is the holistic and comprehensive approach to seek positive patient outcomes. Additional research in this area would help validate the speculation and lend credibility to this proposed model. The model may be tested for its value in real life inpatient acute care settings and among different types of hospitals in different regions. The model is a comprehensive and holistic approach to transform the current environment, with supportive organizational structures and processes necessary to impact envisioned outcomes. Further research in this area to examine patient and staff outcomes with implementation of the model could provide further information to bridge the gap between delivery of care in health care organizations and patient outcomes.

Qualitative studies that provide framework in understanding the unknown phenomenon may lead to examining the different variables emerging within the themes and relationships to patient satisfaction outcomes through quantitative analysis. Discussions by the participants during interviews suggest potential variances in patient expectations, patient experiences, patient satisfaction scores, and cultural variations in different geographic locations of the United States.

Further research could examine how differences in patient demographics, culture, and organization type in different locations across the country will affect the role of the nurse manager to enhance patient experience. Emerging Themes 7 and 8 suggest the

influence of top-level leadership, organizational culture, interdisciplinary, and interdepartmental relationships with the nurse manager to influence patient satisfaction. Future investigations and research can address the influence of top-level executive leadership, organizational culture, presence or absence of shared accountability among various disciplines and departments to improve patient outcomes.

Recommendations for Health Care Leaders and Policy Makers

In an era of transformative changes in health care, leaders are scrambling to improve patient outcomes to avoid serious penalties through Value Based Purchasing Program by Medicare. The forces of consumerism challenge health care leaders as consumers make choices based on clinical quality and patient satisfaction outcomes. In response to regulatory and market forces, health care organizations are starting to turn their focus from quantity of care to improving quality of care. Health care leaders turn to nurse managers of inpatient hospital departments to address these challenges and meet patient satisfaction outcomes.

The qualitative phenomenological study on the holistic nurse manager role aligning to meet expectations of improved patient satisfaction led to understanding the nature and essence of the phenomenon. The composite structural description with supporting textural descriptions of the nurse managers lived experiences shed light on the enhanced nurse manager leadership capabilities, role, and functions to build new caring cultures and engage followers to affect meaningful change. The study Themes 2, 3, 4, 5, and 6 provide new knowledge for health care organizations striving to improve patient outcomes by supporting nurse manager leadership capabilities, employee engagement and empowerment, and build new patient centered cultures for meaningful change.

The study finding are significant primarily to health care organizations, health care leaders, and policy makers for creating new patient centered cultures, healthy work cultures, and aligning leaders and followers with patient expectations for quality and satisfaction. Understanding nurse manager leadership attributes, skills, and competencies relating to patient satisfaction may also affect new policies, systems, and structures to address alternative approach to recruitment, retention, leadership development, training, and evaluation of nurse leaders. The study findings may result in reengineering the contemporary nurse manager role for building new patient caring cultures, healthy working environments, and promoting effective workforce utilization to enhance the patient experience.

As more and more organizations are shifting toward greater accountability for outcomes, new nurse manager leadership capabilities, and organizational culture will be essential to align with these expectations. The results of the study is relevant to health care organization seeking to enhance patient satisfaction, improve overall patient quality care, and enhance financial performance of the organization. Organizations competing for survival may use study findings to seek, validate, improve, modify, and change current skills, roles, functions, and competencies of nurse managers for positive patient outcomes.

The new holistic and comprehensive role of the nurse manager in a turbulent health care environment is to transform current cultures for positive patient outcomes. Prior nurse manager leadership and competency development models addressed different constructs without evaluating the effectiveness of the nurse manager role. A shifting focus of nurse manager role, priorities, and functions in the new health care environment

may require a new direction in creating outcomes-based competency model for nursing leaders.

The different constructs within each theme in this study were the basis in creating the proposed nurse manager role in transformation, an outcome-based competency model essential for health care practitioners. The themes and interpretations from study findings of the lived experiences of expert nurse managers with the phenomenon assisted in the development of a conceptual model or framework that identifies constructs for the holistic and nurse manager role, functions, skills, and styles with expectations for improving patient satisfaction. The model will be essential in developing new strategies and new competency-based outcomes aligned with patient satisfaction standards.

The model may help health care organizations define newer contexts for nurse manager's roles, responsibilities, functions, leadership styles, and task-related competencies to address the new demands for improving patient satisfaction in various hospital settings. The study discoveries may serve as a road map for health care organizations and the field of nursing management and leadership seeking to optimize nurse manager leadership skills and competencies for improved patient outcomes, organizational effectiveness, workforce planning, and redesigning health care delivery systems.

The research findings and newly constructed conceptual model promoting the new contemporary nurse manager role to influence patient satisfaction outcomes may be shared at various conferences and seminars for nursing management, nursing leadership, healthcare leadership, among national and government organizations seeking to improve patient outcomes. The intent of the researcher upon approval of the dissertation is to

share relevant findings and expanded knowledge in health care leadership journals, and various nursing journals. The study findings can also be expanded to national organizations for hospitals, nursing, nursing leadership, regulatory agencies, accreditation agencies, independent patient satisfaction survey vendors, and non for profit organizations such as Leap Frog and Institute of Medicine.

Experiences with the Research Process

From the inception of the general problem a few years ago, to the culmination of the study, and what was once a potential problem is now a harsh reality for health care organizations. The research on the current and prior literature, theoretical and conceptual models surrounding the context of the phenomenon has been very enlightening. The opportunity to conduct this significant research with practical implications and significance to health care organizations and nursing leadership has been a very meaningful experience for the researcher.

Prior knowledge and experience with the phenomenon was a determining factor for potential bias during the data collection and during data analysis. The research design and methodology required bracketing of researcher knowledge and suppositions. The bracketing was very challenging especially during interviews and data analysis. The feedback and practice from four pilot tests prior to the interview assisted with conducting interviews. The interviewer had to careful with verbal and non-verbal cues, facial expressions, body language, and probing questions. The interviewer had to maintain extreme diligence to avoid grabbing on to expressions that horizoned interviewers experience and to suppress the desire to contribute to the discussion.

The interviewer was inspired and motivated by rich in-depth and meaningful description of lived experience from expert nurses managers at various health care organizations. The interviewer felt privileged to experience the participants' personal reflections and recollections, and inner thoughts, and values. The interviews broadened the interviewers perspective and allowed for personal reflection on what it means to be a manager and leader.

Chapter Summary

The qualitative phenomenological study investigated the lived experiences of 21 nurse leaders on the holistic role of the nurse manager to align with the new expectations and demands for patient satisfaction. Data analysis of high frequencies of clustered data led to eight meaningful themes synthesizing the essence of the meaning of the new nurse manager role. The intent of Chapter 5 was to provide a summary of the conclusion on the findings and themes drawn from investigations of expert nurse managers lived experiences in their journey to enhance patient experience. Rooted in the phenomenological approach, the qualitative study explicates the wholeness of the experience, with research questions that seek to an in-depth insight into the phenomenon (Moustakas, 1994).

The comprehensive structural and textural description of the holistic role of the nurse manager with demands and expectations for improving patient satisfaction, add significant portrayals to the existing knowledge. As this study explores a largely unknown phenomenon, the findings provide a deep understanding of the meanings, essences, and values of the new holistic and comprehensive nurse manager role. The

holistic nurse manager role comprises of different functions, responsibilities, practices, functions, styles, skills, and competencies to improve patient satisfaction.

The themes presented in sequential manner chronicles the story on the essences of the phenomenon starting with expectations of front line nurse manager to improve patient satisfaction, building patient caring cultures, leader rounding, creating healthy working environment, engaging and empowering staff, change agent for continuous quality improvement, impact of organizational focus and culture, and ends with challenges of sustainability of initiatives and interdepartmental and interdisciplinary teamwork affecting the nurse manager role. The chapter contained conclusion related to the research questions, and contributions to literature. While some themes such as healthy work environment, engagement and empowerment can be gleaned from prior literature, the findings in this study synthesize and present the totality of the lived experiences of the nurse manager aligned with the new expectations to improve patient satisfaction.

The qualitative phenomenological study of the new nurse manager holistic role aligned with new expectations of improving patient satisfaction resulted in a nurse manager role in transformation model. The outcomes based model incorporates essential nurse manager roles, functions, leadership styles, skills, attributes and behaviors aligned with expectations of improving patient satisfaction. The model is an explanation of the new nurse manager role in a transformative health care environment to change current unit cultures for high quality patient outcomes.

Chapter 5 contained significance of the study, and recommendations for the study. From the new findings of the study, future qualitative and quantitative studies may follow to understand the various constructs discussed in the thematic expressions of the study

findings. The chapter concludes with the reflections of the research process. To summarize, the holistic and comprehensive role of the front line nurse manager is to create new thriving, innovative, and caring cultures by leading engaged followers aligned with the vision to improve patient quality outcomes. The role of contemporary nurse manager with new holistic roles, skills, and competencies is essential to lead a vital, vibrant, and patient-centered and caring organization into the 21st century.

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Appendix A

Request Permission to Use Premises, Name, Subjects, and/or Data of Facility,

Organization, University, Institution, or Association

March 3, 2012

To,
Name
Title (CEO)
Address

Dear Mr./ Ms.

I am a student at the University of Phoenix working on a doctoral dissertation in partial fulfillment of a requirement for a doctoral degree in Health Care Administration. I am seeking your assistance in conducting a research study entitled *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations"* I am writing to request your permission to recruit participants and conduct a research study in your institution.

The purpose of the qualitative phenomenological study is to explore the comprehensive, holistic, and changing nature of the projected contemporary nurse manager roles, cross-functional practices, and skills that align with the newer dimensions and expectations of increased patient satisfaction.

The intent of my letter is to request permission to invite selective members of your organization to participate in the study, to conduct the interviews on your premises, and to review patient satisfaction scores from selected the nurse manager's department to formulate qualitative survey questions. The target population for the study includes full time expert nurse managers of inpatient nursing departments with in-depth knowledge and experience in improving patient satisfaction. The inpatient satisfaction survey and HCAHPS survey scores from 2011 will provide the basis for selecting nurse managers with highest scores. The patient satisfaction scores and HCAHPS scores from the selected nurse manager's department will help formulate survey questions to address skills, practices, and dimensions of the nurse manager roles to improve patient satisfaction. The selective sampling for the phenomenological study also includes Chief Nursing Officers or immediate supervisors (Directors, Vice Presidents) with in-depth perspectives and insights on environmental and organizational contexts affecting patient satisfaction outcomes.

The study participants meeting selection criteria and consenting to participate in the study will be interviewed for approximately 60 minutes. The results of the individual surveys will remain strictly confidential and only pooled data will be published. No cost will be incurred by you or the employees of your institution.

Once I receive official approval from my university and your organization I will be mailing out a letter of invitation to selected nurse managers, immediate supervisors, and CNOs. If you are not the person in charge of approving this request, I would

appreciate if you would forward me the name and contact information of the person I should communicate with.

Your approval to conduct this survey is greatly appreciated. I will follow up with telephone call next week and will be happy to answer any questions and provide any further information you may require to make your decision. You may also contact me at [redacted] or [redacted] or my professor, Dr. Patricia Traynor at [redacted]. If you agree, kindly sign the attached form in the enclosed self-addressed envelope acknowledging your consent and permission for me to conduct this study at your institution.

Sincerely,

_____
Neena Philip, RN, MA
Doctoral Candidate,
University Of Phoenix

cc: Dr. Patricia S.Traynor, Ph.D.
University of Phoenix
School of Advanced Studies

Appendix B

Request NJHA and CNO's Permission to Use Premises, Name, Subjects, and/or Data of Facility, Organization, University, Institution, or Association

March 24, 2012

To,
Aline M. Holmes, MSN, RN
Senior VP, Clinical Affairs
Director, NJHA Institute for Quality and Patient Safety
760 Alexander Road, PO Box1
Princeton, NJ 08543-0001

Dear Ms. Holmes

I am a student at the University of Phoenix working on a doctoral dissertation in partial fulfillment of a requirement for a doctoral degree in Health Care Administration. I am seeking your assistance in conducting a research study entitled *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations"* I am writing to request your permission to recruit participants and conduct a research study in NJHA network.

The purpose of the qualitative phenomenological study is to explore the comprehensive, holistic, and changing nature of the projected contemporary nurse manager roles, cross-functional practices, and skills that align with the newer dimensions and expectations of increased patient satisfaction.

The intent of my letter is to request permission to invite selective members of your member organization to participate in the study, to conduct the interviews on premises, and to review patient satisfaction scores from selected the nurse manager's department to formulate qualitative survey questions. The target population for the study includes full time expert nurse managers of inpatient nursing departments with in-depth knowledge and experience in improving patient satisfaction. The inpatient satisfaction survey and HCAHPS survey scores from 2011 will provide the basis for selecting nurse managers with highest scores. The patient satisfaction scores and HCAHPS scores from the selected nurse manager's department will help formulate survey questions to address skills, practices, and dimensions of the nurse manager roles to improve patient satisfaction. The selective sampling for the phenomenological study also includes Chief Nursing Officers or immediate supervisors (Directors, Vice Presidents) with in-depth perspectives and insights on environmental and organizational contexts affecting patient satisfaction outcomes.

The study participants meeting selection criteria and consenting to participate in the study will be interviewed for approximately 60 minutes. The results of the individual

surveys will remain strictly confidential and only pooled data will be published. For this study you or the members of the NJHA will not incur any cost.

Once I receive official approval from my university and your members of your organization I will be mailing out a letter of invitation to selected nurse managers, immediate supervisors, and CNOs. If you are not the person in charge of approving this request, I would appreciate if you would forward me the name and contact information of the person I should communicate with.

I will follow up with telephone call next week and will be happy to answer any questions and provide any further information you may require to make your decision. You may also contact me at [redacted] or [redacted] or my professor, Dr. Patricia Traynor [redacted]. If you agree, kindly send the attached forms addressed to CNO's of NJHA network requesting permission to conduct this study at individual institutions.

Sincerely,

Neena Philip, RN, MA (sd)
Doctoral Candidate,
University Of Phoenix

cc: Dr. Patricia S.Traynor, Ph.D.
University of Phoenix.
School of Advanced Studies

March 24, 2012

To,
Chief Nursing Officer
Address

Dear Ms.

I am a student at the University of Phoenix working on a doctoral dissertation in partial fulfillment of a requirement for a doctoral degree in Health Care Administration. I am seeking your assistance in conducting a research study entitled *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations"*I am writing to request your permission to recruit participants and conduct a research study in your institution.

The purpose of the qualitative phenomenological study is to explore the comprehensive, holistic, and changing nature of the projected contemporary nurse manager roles, cross-functional practices, and skills that align with the newer dimensions and expectations of increased patient satisfaction.

The intent of my letter is to request permission to invite selective members of your organization to participate in the study, to conduct the interviews on your premises, and to review patient satisfaction scores from selected the nurse manager's department to formulate qualitative survey questions. The target population for the study includes full time expert nurse managers of inpatient nursing departments with in-depth knowledge and experience in improving patient satisfaction. The inpatient satisfaction survey and HCAHPS survey scores from 2011 will provide the basis for selecting nurse managers with highest scores. The patient satisfaction scores and HCAHPS scores from the selected nurse manager's department will help formulate survey questions to address skills, practices, and dimensions of the nurse manager roles to improve patient satisfaction. The selective sampling for the phenomenological study also includes Chief Nursing Officers or immediate supervisors (Directors, Vice Presidents) with in-depth perspectives and insights on environmental and organizational contexts affecting patient satisfaction outcomes.

The study participants meeting selection criteria and consenting to participate in the study will be interviewed for approximately 60 minutes. The results of the individual surveys will remain strictly confidential and only pooled data will be published. For this study you or the employees of your institution will not incur any cost.

Once I receive official approval from my university and your organization I will be mailing out a letter of invitation to selected nurse managers, immediate supervisors, and CNOs. If you are not the person in charge of approving this request, I would appreciate if you would forward me the name and contact information of the person I should communicate with.

Your approval to conduct this survey is greatly appreciated. I will follow up with telephone call next week and will be happy to answer any questions and provide any further information you may require to make your decision. You may also contact me at [redacted] or [redacted] or my professor, Dr. Patricia Traynor [redacted]. If you agree, kindly sign the attached form in the enclosed

self-addressed envelope acknowledging your consent and permission for me to conduct this study at your institution.

Sincerely,
Neena Philip, RN, MA
Doctoral Candidate,
University Of Phoenix

cc: Dr. Patricia S.Traynor, Ph.D.
University of Phoenix
School of Advanced Studies

Permission to Use Premises, Name, and/or Subjects AND DATA

Check any that apply:

☐ I hereby authorize Neena S. Philip, student of University of Phoenix, to use the premises to conduct a study entitled *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations"*

☐ I hereby authorize Neena S. Philip, student of University of Phoenix, to recruit subjects for participation in a conduct a study entitled *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations"*

☐ I hereby authorize Neena S. Philip, student of University of Phoenix, to review 2011 and 2012 patient satisfaction survey and HCAHPS scores from selected nurse manager's department to formulate qualitative survey questions for the study entitled *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations"*

☐ I hereby authorize Neena S. Philip, student of University of Phoenix, to use the name of the facility, organization, university, institution, or association identified above when publishing results from the study entitled *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations"*

_____ __/__/__

Signature Date

_____

Name

_____

Title: _____

DATA ACCESS AND USE PERMISSION

Name of Facility, Organization, University, Institution, or Association

Please check mark any of the following statements that you approve regarding the study and data described below:

☐ I hereby authorize Neena S. Philip , a student of University of Phoenix who is conducting a research study titled or described as follows Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations insert title of research study and a brief description of research study access to, and use of, the non-identifiable archival data described as follows: The 2011 patient satisfaction scores from patient satisfaction surveys and Hospital Consumer Assessment of Health Provider System (HCAHPS) survey will provide the basis for selecting nurse managers from inpatient units with high patient satisfaction score.The 2011 HCAHPS survey scores and patient satisfaction scores from selected nurse manager's inpatient department will be used to formulate qualitative interview questions identify and describe in detail the data to be accessed and used for use in the aforementioned research study. In granting this permission, I understand the following (please check mark each of the following as applicable):

☐ The data will be maintained in a secure and confidential manner.

☐ The data may be used in the publication of results from this study.

☐ This research study must have IRB approval at the University of Phoenix before access to the data identified here is provided to Neena S. Philip provide name of student here

☐ Access to, and use of, this data will not be transferred to any other person without my/our express written consent.

☐ The source of the data may be identified in the publication of the results of this study.

☐ Relevant information associated with this data will be available to the dissertation chair, dissertation committee, school as may be needed for educational purposes.

_____	_____
Print Name	Date
_____	_____
Signature	Researcher Signature/Acknowledgement
Title	_____
Address	Date

Current version 032012

University of Phoenix®

PREMISES, RECRUITMENT AND NAME (PRN) USE PERMISSION

Name of Facility, Organization, University, Institution, or Association

Please complete the following by check marking any permissions listed here that you approve, and please provide your signature, title, date, and organizational information below. If you have any questions or concerns about this research study, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.

☐ I hereby authorize Neena S. Philip, a student of University of Phoenix, to use the premises (facility identified below) to conduct a study entitled Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations

☐ I hereby authorize Neena S. Philip, a student of University of Phoenix, to recruit subjects for participation in a study entitled Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations.

☐ I hereby authorize Neena S. Philip, a student of University of Phoenix, to use the name of the facility, organization, university, institution, or association identified above when publishing results from the study entitled Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations.

Signature Date

Name

Title

Address of Facility

Appendix C

Signed Informed Consent: Permission to Use Premises, Recruitment, and Name, Subjects, and Data Access and Use Permission Forms

UNIVERSITY OF PHOENIX

PERMISSION TO USE PREMISES, NAME, AND/OR SUBJECTS

[redacted]

Check any that apply:

☑ I hereby authorize Neena S. Philip, student of University of Phoenix, to use the premises to conduct a study entitled *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations"*

☑ I hereby authorize Neena S. Philip, student of University of Phoenix, to recruit subjects for participation in a conduct a study entitled *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations"*

☑ I hereby authorize Neena S. Philip, student of University of Phoenix, to review 2011 patient satisfaction survey and HCAHPS scores from selected nurse manager's department to formulate qualitative survey questions for the study entitled *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations"*

☑ I hereby authorize Neena S. Philip, student of University of Phoenix, to use the name of the facility, organization, university, institution, or association identified above when publishing results from the study entitled *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations"*

[redacted] [redacted]

Date

1

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PREMISES, RECRUITMENT AND NAME (PRN) USE PERMISSION

[redacted]

Name of Facility, Organization, University, Institution, or Association

Please complete the following by check marking any permissions listed here that you approve, and please provide your signature, title, date, and organizational information below. If you have any questions or concerns about this research study, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.

☑ I hereby authorize Neena S. Philip, a student of University of Phoenix, to use the premises (facility identified below) to conduct a study entitled Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations

☑ I hereby authorize Neena S. Philip, a student of University of Phoenix, to recruit subjects for participation in a study entitled Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations.

☑ I hereby authorize Neena S. Philip, a student of University of Phoenix, to use the name of the facility, organization, university, institution, or association identified above when publishing results from the study entitled Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations.

[redacted]

te 1/3/14

University of Phoenix®

DATA ACCESS AND USE PERMISSION

[redacted]

Name of Facility, Organization, University, Institution, or Association

Please check mark any of the following statements that you approve regarding the study and data described below:

☑ I hereby authorize Neena S. Philip, a student of University of Phoenix who is conducting a research study titled or described as follows Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations access to, and use of, the non-identifiable archival data described as follows The 2012 patient satisfaction scores from patient satisfaction surveys and Hospital Consumer Assessment of Health Provider System (HCAHPS) survey will provide the basis for selecting nurse managers from inpatient units with high patient satisfaction scoreThe 2012 HCAHPS survey scores and patient satisfaction scores from selected nurse manager's inpatient department will be used to formulate qualitative interview questions : The for use in the aforementioned research study. In granting this permission, I understand the following (please check mark each of the following as applicable):

☑ The data will be maintained in a secure and confidential manner.

☑ The data may be used in the publication of results from this study.

☑ This research study must have IRB approval at the University of Phoenix before access to the data identified here is provided to Neena S. Philip

☑ Access to, and use of, this data will not be transferred to any other person without my/our express written consent.

☑ The source of the data may be identified in the publication of the results of this study.

☑ Relevant information associated with this data will be available to the dissertation chair, dissertation committee, school as may be needed for educational purposes.

[redacted]

C

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University of Phoenix®

[redacted]

Name of Facility, Organization, University, Institution, or Association

Please complete the following by check marking any permissions listed here that you approve, and please provide your signature, title, date, and organizational information below. If you have any questions or concerns about this research study, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.

☒ I hereby authorize Neena S. Philip, a student of University of Phoenix, to use the premises [redacted]dy entitled "*Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations*"

☒ I hereby authorize Neena S. Philip, a student of University of Phoenix, to recruit subjects for participation in a study entitled "*Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations*"

☒ I hereby authorize Neena S. Philip, a student of University of Phoenix, to use the name of the facility, organization, university, institution, or association identified above when publishing results from the study entitled "*Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations*"

[redacted]

1

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DATA ACCESS AND USE PERMISSION

[redacted]

Name of Facility, Organization, University, Institution, or Association

Please check mark any of the following statements that you approve regarding the study and data described below:

☒ I hereby authorize Neena S. Philip, a student of University of Phoenix who is conducting a research study titled or described as follows Exploring Holistic Nurse Manager Roles with New Patient Dimensions and Expectations access to, and use of, the non-identifiable archival data described as follows: The 2011 and 2012 patient satisfaction scores from patient satisfaction surveys and Hospital Consumer Asessment of Health Provider System (HCAHPS) survey will provide the basis for sleceting nurse managers from inpatient units with high patient satisfaction scores. The 2011 and 2012 patient satisfaction survey scores from selected nurse manager's inpatient department will be used to formulate qualitative interview questions. for use in the aforementioned research study. In granting this permission, I understand the following (please check mark each of the following as applicable):

☒ The data will be maintained in a secure and confidential manner.

☒ The data may be used in the publication of results from this study.

☒ This research study must have IRB approval at the University of Phoenix before access to the data identified here is provided to Neena S. Philip

☒ Access to, and use of, this data will not be transferred to any other person without my/our express written consent.

☒ The source of the data may be identified in the publication of the results of this study.

☒ Relevant information associated with this data will be available to the dissertation chair, dissertation committee, school as may be needed for educational purpos

[redacted]

Researcher Signature/Acknowledgement

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PREMISES, RECRUITMENT AND NAME (PRN) USE PERMISSION

[redacted]

Name of Facility, Organization, University, Institution, or Association

Please complete the following by check marking any permissions listed here that you approve, and please provide your signature, title, date, and organizational information below. If you have any questions or concerns about this research study, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.

☑ I hereby authorize Neena S. Philip, a student of University of Phoenix, to use the premises (facility identified below) to conduct a study entitled Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations

☑ I hereby authorize Neena S. Philip, a student of University of Phoenix, to recruit subjects for participation in a study entitled Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations.

☑ I hereby authorize Neena S. Philip, a student of University of Phoenix, to use the name of the facility, organization, university, institution, or association identified above when publishing results from the study entitled Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations.

[redacted]

University of Phoenix®

DATA ACCESS AND USE PERMISSION

[redacted]

Name of Facility, Organization, University, Institution, or Association

Please check mark any of the following statements that you approve regarding the study and data described below:

☒ I hereby authorize Neena S. Philip, a student of University of Phoenix who is conducting a research study titled or described as follows Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations access to, and use of, the non-identifiable archival data described as follows: The 2011 patient satisfaction scores from patient satisfaction surveys and Hospital Consumer Assessment of Health Provider System (HCAHPS) survey will provide the basis for selecting nurse managers from inpatient units with high patient satisfaction score The 2011/2012 HCAHPS survey scores and patient satisfaction scores from selected nurse manager's inpatient department will be used to formulate qualitative interview questions : The for use in the aforementioned research study. In granting this permission, I understand the following (please check mark each of the following as applicable):

☒ The data will be maintained in a secure and confidential manner.

☒ The data may be used in the publication of results from this study.

☒ This research study must have IRB approval at the University of Phoenix before access to the data identified here is provided to Neena S. Philip

☒ Access to, and use of, this data will not be transferred to any other person without my/our express written consent.

☒ The source of the data may be identified in the publication of the results of this study.

☒ Relevant information associated with this data will be available to the dissertation chair, dissertation committee, school as may be needed for educational purposes.

[redacted]

Researcher Signature/Acknowledgement

1/11/2014

Date

University of Phoenix®

[redacted]

PREMISES, RECRUITMENT AND NAME (PRN) USE PERMISSION

Please complete the following by check marking any permissions listed here that you approve, and please provide your signature, title, date, and organizational information below. If you have any questions or concerns about this research study, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.

☒ I hereby authorize Neena S. Philip, a student of University of Phoenix, to use the premises to conduct a study entitled "*Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations*"

☒ I hereby authorize Neena S. Philip, a student of University of Phoenix, to recruit subjects for participation in a study entitled "*Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations*"

☒ I hereby authorize Neena S. Philip, a student of University of Phoenix, to use the "**Community Hospital in Central New Jersey**" to identify CentraState Medical Center when publishing results from the study entitled "*Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations*"

[redacted]

1

University of Phoenix®

DATA ACCESS AND USE PERMISSION

[redacted]

Please check mark any of the following statements that you approve regarding the study and data described below:

☒ I hereby authorize Neena S. Philip, a student of University of Phoenix who is conducting a research study titled or described as follows "*Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations*" access to, and use of, the non-identifiable archival data described as follows: The 2011 patient satisfaction scores from patient satisfaction surveys and the Hospital Consumer Assessment of Health Provider System (HCAHPS) Survey will provide a basis for selecting nurse managers of inpatient nursing units with high patient satisfaction scores. The 2011 HCAHPS survey scores and patient satisfaction survey scores from selected nurse manager's inpatient department will be used to formulate qualitative interview questions for use in the aforementioned research study. In granting this permission, I understand the following (please check mark each of the following as applicable):

☒ The data will be maintained in a secure and confidential manner.

☒ The aggregated data may be used in the publication of results from this study.

☐ This research study must have IRB approval at the University of Phoenix before access to the data identified here is provided to Neena S. Philip

☒ Access to, and use of, this data will not be transferred to any other person without my/our express written consent.

☒ The source of the data may be identified as "**Community Hospital in Central New Jersey**" in the publication of the results of this study.

☒ Relevant information associated with this data will be available to the dissertation chair, dissertation committee, school as may be needed for educational purposes.

[redacted]

May 11, 2012
Date

Manager Clinical Research
Title

Researcher Signature/Acknowledgement

Signature Neena S. Philip

May 11, 2012
Date

Current version 032012

University of Phoenix®

DATA ACCESS AND USE PERMISSION

[redacted]

Name of Facility, Organization, University, Institution, or Association

Please check mark any of the following statements that you approve regarding the study and data described below:

☐ I hereby authorize Neena S. Phillip, a student of University of Phoenix who is conducting a research study titled or described as follows "*Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations*" access to, and use of, the non-identifiable archival data described as follows: The 2012 patient satisfaction scores from patient satisfaction surveys and the Hospital Consumer Assessment of Health Provider System (HCAHPS) Survey will provide a basis for selecting nurse managers of inpatient nursing units with high patient satisfaction scores. The 2012 HCAHPS survey scores and patient satisfaction survey scores from selected nurse manager's inpatient department will be used to formulate qualitative interview questions for use in the aforementioned research study. In granting this permission, I understand the following (please check mark each of the following as applicable):

The data will be maintained in a secure and confidential manner.

☐ The data may be used in the publication of results from this study.

☐ This research study must have IRB approval at the University of Phoenix before access to the data identified here is provided to Neena S. Phillip.

☐ Access to, and use of, this data will not be transferred to any other person without my/our express written consent.

☐ The source of the data may be identified in the publication of the results of this study.

☐ Relevant information associated with this data will be available to the dissertation chair, dissertation committee, school as may be needed for educational purposes.

[redacted]

Current version 032012

University of Phoenix®

DATA ACCESS AND USE PERMISSION

[redacted]

Name of Facility, Organization, University, Institution, or Association

Please check mark any of the following statements that you approve regarding the study and data described below:

☐ I hereby authorize Neena S. Philip, a student of University of Phoenix who is conducting a research study titled or described as follows *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations"* access to, and use of, the non-identifiable archival data described as follows: The 2011 and 2012 patient satisfaction scores from patient satisfaction surveys and the Hospital Consumer Assessment of Health Provider System (HCAHPS) Survey will provide a basis for selecting nurse managers of inpatient nursing units with high patient satisfaction scores. The 2011/2012 HCAHPS survey scores and patient satisfaction survey scores from selected nurse manager's inpatient department will be used to formulate qualitative interview questions for use in the aforementioned research study. In granting this permission, I understand the following (please check mark each of the following as applicable):

☒ The data will be maintained in a secure and confidential manner.

☒ The data may be used in the publication of results from this study.

☒ This research study must have IRB approval at the University of Phoenix before access to the data identified here is provided to Neena S. Philip

☒ Access to, and use of, this data will not be transferred to any other person without my/our express written consent.

☒ The source of the data may be identified in the publication of the results of this study.

☒ Relevant information associated with this data will be available to the dissertation chair, dissertation committee, school as may be needed for educational purposes.

[redacted] 1-29-13

Print Name Date

[redacted] Neena S. Philip (s/d) Date: 1/25/2013

Signature Researcher Signature/Acknowledgement

Title Director, Research Operations

Address [redacted]

Current version 032012

University of Phoenix®

[redacted]

PREMISES, RECRUITMENT AND NAME (PRN) USE PERMISSION

Name of Facility, Organization, University, Institution, or Association

Please complete the following by check marking any permissions listed here that you approve, and please provide your signature, title, date, and organizational information below. If you have any questions or concerns about this research study, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.

☒ I hereby authorize Neena S. Philip, a student of University of Phoenix, to use the premises of [redacted] conduct a study entitled "*Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations*"

☒ I hereby authorize Neena S. Philip, a student of University of Phoenix, to recruit subjects for participation in a study entitled "*Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations*"

☒ I hereby authorize Neena S. Philip, a student of University of Phoenix, to use the name of the facility, organization, university, institution, or association identified above when publishing results from the study entitled "*Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations*"

[redacted] [redacted]

Signature Date

[redacted]

Name

Director, Research Operations

Title

Address of Facility

[redacted]4

1

Appendix D

Informed Consent: Participants 18 years of Age and Older

Informed Consent: Participants 18 years of age and older

Date:

To

_____

Dear ,

My name is Neena S. Philip and I am a student at the University of Phoenix working on a doctoral dissertation in partial fulfillment of a requirement for a doctoral degree in Health Care Administration. I am seeking your assistance in conducting a research study entitled *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations"*. The purpose of the qualitative phenomenological study is to explore the comprehensive, holistic, and changing nature of the projected contemporary nurse manager roles, cross-functional practices, and skills that align with the newer dimensions and expectations of increased patient satisfaction.

Your name was provided to me by leadership at _____for participation in the study because of your highly valuable expertise and experience in improving patient satisfaction scores. Please see attached document that verifies your organization's permission to conduct study and to access patient satisfaction data for participant selection and develop qualitative interview questions. The study participants include 15 nurse managers and five CNO, or immediate supervisors with experience and understanding of dimensions and expectations for improving satisfaction. Your background, knowledge and experience in this area make you an ideal candidate for participation in the research study. If you are able to assist me, your participation will involve an informal, approximately 60 minute (audio recorded) face-to-face interview covering the new emerging phenomenon of roles, practices, skills, and dimensions of front-line nurse managers that align with the new expectations of improving patient satisfaction. You may be asked to participate in a brief follow up interview to confirm my understanding of your responses.

Your insights and experiences are valuable to the study, and I will be grateful for your participation. If you agree to participate, I will contact you to schedule a convenient time and place for an interview. Kindly sign the attached Informed Consent letter and mail to [redacted] or fax at [redacted].

Thank you for your kind participation. I will be following this email with a telephone call later this week. If you have any questions concerning the research study, please call me at [redacted] or [redacted]. For questions about your rights

as a study participant, or any concerns or complaints, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.

Sincerely,
Neena S. Philip
Doctoral Learner
University of Phoenix

University of Phoenix®

Informed Consent: Participants 18 years of age and older

Dear [redacted]

My name is _Neena S. Philip____ and I am a student at the University of Phoenix working on a doctoral degree. I am doing a research study entitled Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations. The purpose of the research study is to explore the comprehensive, holistic, and changing nature of the projected contemporary nurse manager roles, cross functional practices, and skills that align with the newer dimensions and expectations of increased patient satisfaction.

Your participation will involve an informal, appoximately 60 minute, audio recorded, face-to-face interview covering the new emerging phenomenon of roles, practices, skills, and dimensions of front line nurse managers that align with the new expectations of patient satisfaction. Your background, knowledge, and experience in this area make you an ideal candidate for participation in this research study. The study participants include 15 nurse managers, and five CNO or immediate supervisors with experience and understanding of dimensions and expectations for improving patient satisfaction. You may be asked to participate in a brief follow-up interview to confirm my understanding of your responses. You can decide to be a part of this study or not. Once you start, you can withdraw from the study at any time without any penalty or loss of benefits. The results of the research study may be published but your identity will remain confidential and your name will not be made known to any outside party. In this research, there are no foreseeable risks to you.

Although there may be no direct benefit to you, a possible benefit from your being part of this study may assist in the development of nurse manager role and competencies to improve patient care in health care organizations, nurse manager education, training, and leadership studies. Your participation will not involve any costs associated to you or your organization..If you have any questions about the research study, please call me- Neena S. Philip at [redacted] or email to [redacted] For questions about your rights as a study participant, or any concerns or complaints, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.

As a participant in this study, you should understand the following:

1. You may decide not to be part of this study or you may want to withdraw from the study at any time. If you want to withdraw, you can do so without any problems.
2. Your identity will be kept confidential.
3. _Neena S. Philip, the researcher, has fully explained the nature of the research study and has answered all of your questions and concerns.
4. If interviews are done, they may be recorded. If they are recorded, you must give permission for the researcher, Neena S. Philip to record the interviews. You

understand that the information from the recorded interviews may be transcribed. The researcher will develop a way to code the data to assure that your name is protected.

5. Data will be kept in a secure and locked area. The data will be kept for three years, and then destroyed.
6. The results of this study may be published.

"By signing this form, you agree that you understand the nature of the study, the possible risks to you as a participant, and how your identity will be kept confidential. When you sign this form, this means that you are 18 years old or older and that you give your permission to volunteer as a participant in the study that is described here."

(☐) I accept the above terms. (☐) I do not accept the above terms. (CHECK ONE)

Signature of the interviewee _____Date _____

Signature of the researcher _____ Date _____

Neena S. Philip, Doctoral Learner, University of Phoenix

Appendix E

Request Permission to Use Existing Survey

March 24, 2012

To,
Ms. Connie Cline
Sr. Privacy Counsel
Press Ganey Associates, Inc.
Dear Ms. Cline,

I am a student at the University of Phoenix working on a doctoral dissertation in partial fulfillment of a requirement for a doctoral degree in Health Care Administration. I am seeking your assistance in conducting a research study entitled *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations"* I am writing to request your permission to publish the Press Ganey™ patient satisfaction survey in my dissertation for informational purposes only.

The purpose of the qualitative phenomenological study is to explore the comprehensive, holistic, and changing nature of the projected contemporary nurse manager roles, cross-functional practices, and skills that align with the newer dimensions and expectations of increased patient satisfaction. The intent of my letter is to request permission to publish the survey to inform readers regarding the elements of the patient satisfaction survey. I have attached the "Permission to Use Existing Survey" form to be signed by responsible parties in your institution granting this request.

Your approval to publish this survey is greatly appreciated. You may also contact me at [redacted] or [redacted] or my professor, Dr. Patricia Traynor at [redacted]. If you agree, kindly sign the " Permission to Use Survey" form acknowledging your permission to publish the survey under specified conditions.

Sincerely,
(s/d) Neena S. Philip
Doctoral Candidate,
University Of Phoenix

cc: Dr. Patricia S. Traynor, Ph.D. University of Phoenix. School of Advanced Studies

Appendix F

Signed Permission to Use Existing Survey

UNIVERSITY OF PHOENIX

PERMISSION TO USE AN EXISTING SURVEY

03/30/2012

Mrs. Neena S. Philip
29 High Mountain Drive,
Boonton, NJ 07005

Dear Neena,

Thank you for your request for permission to use Press Ganey Patient Satisfaction Survey in your research study for informational purposes only. We are willing to allow you to publish the instrument as outlined in your letter at no charge with the following understanding:

- You will use this survey only for your research study and will not sell or use it with any compensated management/curriculum development activities.
- You will not claim a copyright to the survey.
- You will include the copyright statement on the published copy of the instrument.
- You will send your research study and one copy of reports, articles, and the like that make use of this survey data promptly to our attention.

If these are acceptable terms and conditions, please indicate so by signing one copy of this letter and returning it to us.

Best wishes with your study.

Sincerely,

Signature
Manuj Lal, VP, Legal Affairs

I understand these conditions and agree to abide by these terms and conditions.

Date 03/24/2012

Neena S. Philip (sd)
Doctoral Candidate
University of Phoenix

Expected date of completion: 4/16/2013

1

Appendix G

Copy of Survey Instrument: HCAHPS and Press Ganey Patient Satisfaction Survey

OMB Control Number: 0938-0981

SURVEY INSTRUCTIONS: You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient. Answer all the questions by completely filling in the circle to the left of your answer. You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this: ○ Yes
● No → **If No, Go to Question 1**

Please answer the questions in this survey about your stay at . Do not include any other hospital stays in your answers.

Please use black or blue ink to fill in the circle completely.
Example: ●

YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

2. During this hospital stay, how often did nurses listen carefully to you?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

3. During this hospital stay, how often did nurses explain things in a way you could understand?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always
   ○ I never pressed the call button

YOUR CARE FROM DOCTORS

5. During this hospital stay, how often did doctors treat you with courtesy and respect?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

6. During this hospital stay, how often did doctors listen carefully to you?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

7. During this hospital stay, how often did doctors explain things in a way you could understand?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

THE HOSPITAL ENVIRONMENT

8. During this hospital stay, how often were your room and bathroom kept clean?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

9. During this hospital stay, how often was the area around your room quiet at night?
   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

YOUR EXPERIENCES IN THIS HOSPITAL

10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
    ○ Yes
    ○ No → **If No, Go to Question 12**

11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
    ○ Never
    ○ Sometimes
    ○ Usually
    ○ Always

12. During this hospital stay, did you need medicine for pain?
    ○ Yes
    ○ No → **If No, Go to Question 15**

13. During this hospital stay, how often was your pain well controlled?
    ○ Never
    ○ Sometimes
    ○ Usually
    ○ Always

14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
    ○ Never
    ○ Sometimes
    ○ Usually
    ○ Always

15. During this hospital stay, were you given any medicine that you had not taken before?
    ○ Yes
    ○ No → **If No, Go to Question 18**

(continued...)

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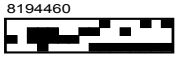

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
- O Never
- O Sometimes
- O Usually
- O Always

17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
- O Never
- O Sometimes
- O Usually
- O Always

WHEN YOU LEFT THE HOSPITAL

18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?
- O Own home
- O Someone else's home
- O Another health facility → **If Another, Go to Question 21**

19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
- O Yes
- O No

20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
- O Yes
- O No

OVERALL RATING OF HOSPITAL

Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
- O 0 Worst hospital possible
- O 1
- O 2
- O 3
- O 4
- O 5
- O 6
- O 7
- O 8
- O 9
- O 10 Best hospital possible

22. Would you recommend this hospital to your friends and family?
- O Definitely no
- O Probably no
- O Probably yes
- O Definitely yes

ABOUT YOU

23. In general, how would you rate your overall health?
- O Excellent
- O Very good
- O Good
- O Fair
- O Poor

24. What is the highest grade or level of school that you have completed?
- O 8th grade or less
- O Some high school, but did not graduate
- O High school graduate or GED
- O Some college or 2-year degree
- O 4-year college graduate
- O More than 4-year college degree

25. Are you of Spanish, Hispanic or Latino origin or descent?
- O No, not Spanish/Hispanic/Latino
- O Yes, Puerto Rican
- O Yes, Mexican, Mexican American, Chicano
- O Yes, Cuban
- O Yes, other Spanish/Hispanic/Latino

26. What is your race? Please choose one or more.
- O White
- O Black or African American
- O Asian
- O Native Hawaiian or other Pacific Islander
- O American Indian or Alaska Native

27. What language do you mainly speak at home?
- O English
- O Spanish
- O Chinese
- O Russian
- O Vietnamese
- O Some other language (please print): _____

Patient's Name: _____ (optional) Telephone Number: _____ (optional)

THANK YOU. Please return the completed survey in the postage-paid envelope.

8194460

PRESS GANEY™

This survey was current at the time of printing and distribution to you. If you would like to confirm that it is still the most recent version, please contact your Account Manager or CRE.

CLIENT LOGO

INPATIENT SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

BACKGROUND QUESTIONS

1. Patient's first stay here..... O Yes O No
2. Admitted through the Emergency Department ..... O Yes O No
3. Was your admission unexpected? O Yes O No
4. Did you have a roommate?..... O Yes O No
5. Were you placed on a special or restricted diet during most of your stay?..... O Yes O No

INSTRUCTIONS: Please rate the services you received from our facility. Select the response that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely. Example: ●

ADMISSION	very poor 1	poor 2	fair 3	good 4	very good 5
1. Speed of admission process	O	O	O	O	O
2. Courtesy of the person who admitted you	O	O	O	O	O

Comments (describe good or bad experience): _____

ROOM	very poor 1	poor 2	fair 3	good 4	very good 5
1. Pleasantness of room decor	O	O	O	O	O
2. Room cleanliness	O	O	O	O	O
3. Courtesy of the person who cleaned your room	O	O	O	O	O
4. Room temperature	O	O	O	O	O
5. Noise level in and around room	O	O	O	O	O

Comments (describe good or bad experience): _____

continued...

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This survey was current at the time of printing and distribution to you. If you would like to confirm that it is still the most recent version, please contact your Account Manager or CRE.

PRESS GANEY®

MEALS	very poor 1	poor 2	fair 3	good 4	very good 5
1. Temperature of the food (cold foods cold, hot foods hot)	O	O	O	O	O
2. Quality of the food	O	O	O	O	O
3. Courtesy of the person who served your food	O	O	O	O	O

Comments (describe good or bad experience): _____

NURSES	very poor 1	poor 2	fair 3	good 4	very good 5
1. Friendliness/courtesy of the nurses	O	O	O	O	O
2. Promptness in responding to the call button	O	O	O	O	O
3. Nurses' attitude toward your requests	O	O	O	O	O
4. Amount of attention paid to your special or personal needs	O	O	O	O	O
5. How well the nurses kept you informed	O	O	O	O	O
6. Skill of the nurses	O	O	O	O	O

Comments (describe good or bad experience): _____

TESTS AND TREATMENTS	very poor 1	poor 2	fair 3	good 4	very good 5
1. Waiting time for tests or treatments	O	O	O	O	O
2. Explanations about what would happen during tests or treatments	O	O	O	O	O
3. Courtesy of the person who took your blood	O	O	O	O	O
4. Courtesy of the person who started the IV	O	O	O	O	O

Comments (describe good or bad experience): _____

VISITORS AND FAMILY	very poor 1	poor 2	fair 3	good 4	very good 5
1. Accommodations and comfort for visitors	O	O	O	O	O
2. Staff attitude toward your visitors	O	O	O	O	O

Comments (describe good or bad experience): _____

PHYSICIAN	very poor 1	poor 2	fair 3	good 4	very good 5
1. Time physician spent with you	O	O	O	O	O
2. Physician's concern for your questions and worries	O	O	O	O	O
3. How well physician kept you informed	O	O	O	O	O
4. Friendliness/courtesy of physician	O	O	O	O	O
5. Skill of physician	O	O	O	O	O

Comments (describe good or bad experience): _____

DISCHARGE	very poor 1	poor 2	fair 3	good 4	very good 5
1. Extent to which you felt ready to be discharged	O	O	O	O	O
2. Speed of discharge process after you were told you could go home	O	O	O	O	O
3. Instructions given about how to care for yourself at home	O	O	O	O	O

Comments (describe good or bad experience): _____

PERSONAL ISSUES	very poor 1	poor 2	fair 3	good 4	very good 5
1. Staff concern for your privacy	O	O	O	O	O
2. How well your pain was controlled	O	O	O	O	O
3. Degree to which hospital staff addressed your emotional needs	O	O	O	O	O
4. Response to concerns/complaints made during your stay	O	O	O	O	O
5. Staff effort to include you in decisions about your treatment	O	O	O	O	O

Comments (describe good or bad experience): _____

OVERALL ASSESSMENT	very poor 1	poor 2	fair 3	good 4	very good 5
1. How well staff worked together to care for you	O	O	O	O	O
2. Likelihood of your recommending this hospital to others	O	O	O	O	O
3. Overall rating of care given at hospital	O	O	O	O	O

Comments (describe good or bad experience): _____

Patient's Name: *(optional)* _____

Telephone Number: *(optional)* _____

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Appendix H

Confidentiality Statement

EXPLORING HOLISTIC NURSE MANAGER ROLES WITH NEW PATIENT SATISFACTION DIMENSIONS AND EXPECTATIONS

Neena S. Philip

CONFIDENTIALITY STATEMENT

As a researcher working on the above research study at the University of Phoenix, I understand that I must maintain the confidentiality of all information concerning all research participants as required by law. Only the University of Phoenix Institutional Review Board may have access to this information. "Confidential Information" of participants includes but is not limited to: names, characteristics, or other identifying information, questionnaire scores, ratings, incidental comments, other information accrued either directly or indirectly through contact with any participant, and/or any other information that by its nature would be considered confidential. In order to maintain the confidentiality of the information, I hereby agree to refrain from discussing or disclosing any Confidential Information regarding research participants, to any individual who is not part of the above research study or in need of the information for the expressed purposes on the research program. This includes having a conversation regarding the research project or its participants in a place where such a discussion might be overheard; or discussing any Confidential Information in a way that would allow an unauthorized person to associate (either correctly or incorrectly) an identity with such information. I further agree to store research records whether paper, electronic or otherwise in a secure locked location under my direct control or with appropriate safe guards. I hereby further agree that if I have to use the services of a third party to assist in the research study, who will potentially have access to any Confidential Information of participants, that I will enter into an agreement with said third party prior to using any of the services,

which shall provide at a minimum the confidential obligations set forth herein. I agree that I will immediately report any known or suspected breach of this confidentiality statement regarding the above research project to the University of Phoenix, Institutional Review Board.

/s/ Neena S. Philip	Neena S. Philip	01/14/2014
Signature of Researcher	Printed Name	Date
/s/ Patricia S. Traynor	Patricia S. Traynor	0/14/2014
Signature of Witness	Printed Name	Date

Appendix I

Non-Disclosure Agreement

Non-Disclosure Agreement

BOLD Education Software acknowledges that in order to provide the services to Neena S. Philip who is a researcher in a confidential study with the University of Phoenix, Inc., BOLD Education Software must agree to keep the information obtained as part of its services (as more fully described below) confidential. Therefore the parties agree as follows:

1. L The information to be disclosed under this Non-disclosure Agreement ("Agreement") is described as follows and shall be considered "Confidential Information": Information contained in AP A BOLD review of Chapters 1-5 of the Dissertation. And possible transcription! statistical analysis of qualitative data. All information shall remain the property of Researcher.

2. BOLD Education Software agrees to keep in confidence and to use the Confidential Information for, *APA Review, transcription, and statistical analysis* only and for no other purposes.

3. BOLD Education Software further agrees to keep in confidence and not disclose any Confidential Information to a third party or parties for a period of five (5) years from the date of such disclosure. All oral disclosures of Confidential Information as well as written disclosures of the Confidential Information are covered by this Agreement.

4. BOLD Education Software shall upon Researcher's request either destroy or return the Confidential Information upon termination of this Agreement.

5. Any obligation of BOLD Education Software under this Agreement shall not apply to Confidential Information that:

    a. Is or becomes a part of the public knowledge through no fault of BOLD Education Software b) BOLD Education Software can demonstrate was rightfully in its possession before disclosure by Researcher/ research subjects; or
    b. BOLD Education Software can demonstrate was rightfully received from a third party who was not Researcher/research subjects and was not under confidentiality restriction on disclosure and without breach of any nondisclosure obligation.
6. BOLD Education Software agrees to obligate its employees or agents, if any, who have access to any portion of Confidential Information to protect the confidential nature of the Confidential Information as set forth herein.
7. BOLD Education Software shall defend, indemnify and hold the Researcher and the University of Phoenix harmless against any third party claims of damage or injury of any

kind resulting from BOLD Education Software use of the Confidential Information, or any violation of by BOLD Education Software of the terms of this Agreement.

8. In the event BOLD Education Software receives a subpoena and believes it has a legal obligation to disclose Confidential Information, then BOLD Education Software will notify Researcher as soon as possible, and in any event at least five (5) business days prior to the proposed release. If Researcher objects to the release of such Confidential Information, BOLD Education Software will allow Researcher to exercise any legal rights or remedies regarding the release and protection of the Confidential Information

9. BOLD Education Software expressly acknowledges and agrees that the breach, or threatened breach, by it through a disclosure of Confidential Information may cause irreparable harm and that Researcher may not have an adequate remedy at law. Therefore, BOLD Education Software agrees that upon such breach, or threatened breach, Researcher will be entitled to seek injunctive relief to prevent BOLD Education Software from commencing or continuing any action constituting such breach without showing or providing evidence of actual damage.

10. The interpretation and validity of this Agreement and the rights of the parties shall be governed by the laws of the State of New Jersey and California.

11. The parties to this Agreement agree that a copy of the original signature (including an electronic copy) may be used for any and all purposes for which the original signature may have been used. The parties further waive any right to challenge the admissibility or authenticity of this document in a court of law based solely on the absence of an original signature.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf:

Printed Name of Third Party/Vendor: BOLD Educational Software
Signature: Diane M. Bassid, Ph.D.
Address: 18250 Harley John Rd., Riverside, CA 92504
Date: 4/17/2012

Printed Name of Researcher: Neena S. Philip
Signature: Neena S. Philip (s/d)
Address: 29 High Mountain Drive, Boonton, NJ 07005
Date: 4/17/2012

Current version 032012

Appendix J

Hospital XYZ IRB Approval

[redacted]

The full circle of health and wellness dedicated to excellence.

Office of the Institutional Review Board

Notice of Approval

[redacted]

Protocol Title:
Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations
Principal Investigator:
Neena S. Philip

Type of Review:	Full ☐	Expedited ☒	Exempt ☐	Category# 7
Type of Approval:	Initial ☒	Revised ☐	Continuation ☐	Closure ☐

This is to advise you that the above referenced study has been presented to the Institutional Review Board (IRB) for the Protection of Human Subjects in Research, and the following action was taken subject to the conditions and explanations provided below:

Approval Date: **May 11, 2012** Expiration Date: **May 11, 2013**

This approval is based on the assumption that the materials you submitted to the IRB contain a complete and accurate description of the ways in which human subjects are involved in your research. The following conditions apply:

1. Adverse events: Any adverse event(s) or unexpected event(s) that occur in conjunction with this study must be reported to the Research office immediately (732-294-3874).
2. Protocol: The research will be conducted according to the most recent version of the protocol that was submitted. Proposed changes to the protocol will be submitted in writing to the IRB for approval prior to implementation.
3. Consent: The attached stamped consent has been approved by the IRB. All subjects must receive a copy of the approved consent form. The original must be kept in a secured place by the principal investigator.
4. Renewal: This approval is valid only for the dates listed above. A request for continuing review form must be submitted to the IRB for review and approval prior to the expiration date to extend the approval period.

Additional Conditions:

Failure to comply with these conditions will result in withdrawal of this approval.

[redacted] May 11, 2012
Date

DHSS Federal Wide Assurance Identifier: FWA00006563

[redacted]

[redacted]

REQUEST FOR CONTINUING REVIEW
INSTITUTIONAL REVIEW BOARD APPROVAL

[redacted]

ANSWER ALL QUESTIONS

Please provide an electronic file of the completed continuing review request form, a consent form with changes highlighted and a clean file of the consent form. If there are modifications and changes to the study, submit an electronic file of the protocol with the changes highlighted. These documents should be submitted for IRB review no less than two months before your expiration date.

Email these documents to jbreen@centrastate.com.

If you are closing this study, please submit one copy of your complete continuing review form and current consent form along with any publications, and/or final progress reports.

PROTOCOL TITLE: ***(Must be identical to the initial IRB application)***

Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations

SUMMARY OF STUDY (< 500 words – use summary from initial application):
The purpose of the qualitative transcendental phenomenological study is to explore the comprehensive, holistic, and changing nature of the projected contemporary nurse manager roles, cross-functional practices, and skills that align with the newer dimensions and expectations of increased patient satisfaction.

Principal Investigator

[redacted]

Neena S. Philip
Co-Investigator

Please identify any person(s) who may have joined or have left the group of investigators that were listed on the original IRB application for the project. ***If no changes, please check box*** ☒ There have been no changes to the protocol.

JOINED **LEFT**

1

[redacted]

[redacted]

February 12, 2013

Neena Philip, RN, MA
29 High Mountain Drive
Boonton, NJ 07005

Dear Ms. Philip,

PR#13-005 "Exploring Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations." Protocol, Informed Consent, Qualitative Open Ended Questions Questionnaire -as requested in the IRB application, - was approved through expedited review on February 12, 2013 by [redacted]

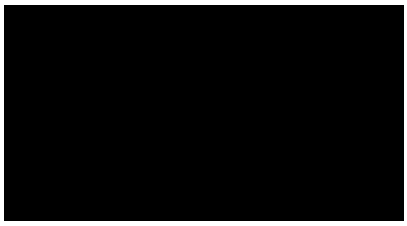
I have examined your study mentioned above along with its accompanying documents requested for expedited review and have determined that your study meets the conditions for approval through expedited review under 45 CFR 46 and 21 CFR 50, 56. Approval is granted.

As you know, the IRB is also responsible for monitoring the conduct of your project. This approval will be **TERMINATED on February 7, 2014.** Any project classified as TERMINATED –ALL ACTIVITY MUST CEASE. To that end, if it is your intention to continue this project beyond its approval date we require a written report approximately 1 month prior to it's TERMINATION date requesting its continuation. In addition, any circumstances, positive or negative of such importance as to warrant the immediate attention of the Board, **MUST** be reported immediately. Should this study be completed, please submit a closure letter along with any findings to the IRB.

Thank you for presenting this study for expedited review and I hope that your efforts in the proposed area of research you are conducting is fruitful and rewarding.

[redacted]

[redacted]



January 25, 2013

Neena S. Philip, PhD C, RN, Principal Investigator
University of Phoenix
29 High Mountain Drive
Boonton, NJ 07005

IRB13-16: Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations

Dear Ms. Philip,

Please be advised [redacted], granted an approval on an expedited basis for the above referenced protocol. In accordance with FDA regulations, 21 C.F.R. Section 56.110, approval has been granted for a twelve-month interval, which will end on January 24, 2014. At that time the IRB will appreciate receiving the outcome of your research activity. If the research is still ongoing at the time of the IRB expiration, an application for Continued Review must be submitted to the IRB.

It is your responsibility to promptly report, in writing any proposed changes in the research activity to the Chairperson of the IRB, for review by the IRB. Any changes in the approved research during the period for which approval has already been given may not be initiated without review and approval by the IRB, except where necessary to eliminate apparent immediate hazards to a participant in the study. Further, any unanticipated problems involving risks to study participants, or others, including adverse reactions, should be promptly reported in writing to the Chairperson of the IRB.

If you have any questions or concerns, please do not hesitate to contact, the IRB office at 908-243-8652.

Appendix K

Hospital XYZ Informed Consent

[redacted]

Consent for participation in the research study
EXPLORING HOLISTIC NURSE MANAGER ROLES WITH NEW PATIENT SATISFACTION DIMENSIONS AND EXPECTATIONS

This consent form is part of an informed consent process for a research study and it will give information that will help you to decide whether you wish to volunteer for this research study. It will help you to understand what the study is about and what will happen in the course of the study.

If you have questions at any time during the research study, you should feel free to ask them and should expect to be given answers that you completely understand.

After all of your questions have been answered, if you still wish to take part in the study, you will be asked to sign this informed consent form.

The principal investigator will also sign this informed consent. You will be given a copy of the signed consent form to keep.

You are not giving up any of your legal rights by volunteering for this research study or by signing this consent form.

Who is conducting this study?

Neena S. Philip

Why is this study being done?

The purpose of the qualitative transcendental phenomenological study is to explore the comprehensive, holistic, and changing nature of the projected contemporary nurse manager roles, cross-functional practices, and skills that align with the newer dimensions and expectations of increased patient satisfaction.

Why have I been asked to take part in this study?

You have been asked to take part in this study because you have the expertise and experience in improving patient satisfaction outcome measures

It is up to you to decide whether or not to take part in this study. You can ask the study investigator to explain any words or information that you do not clearly understand. You may take home an unsigned copy of this consent form to think about or discuss with family or friends before making your decision

[redacted]

Who may take part in this study? And who may not?

Full time nurse managers directly responsible for the operations of the diverse nursing departments in hospitals in New Jersey, r in the nurse manager position for at least one year, and with at least three years of clinical experience may take part in the study. Immediate supervisors and Chief Nursing Officers (CNOs) of nurse managers with at least one year in the current position and an understanding of the environmental contexts affecting organizational and patient satisfaction outcomes, nurse manager issues, and indicators for patient satisfaction may also take part in the study. Full time nurse managers, immediate supervisors, and CNOs who do not meet the criteria indicated above may not participate in the study.

How long will the study take and how many subjects will participate?

Qualitative data collection will consist of approximately 60-minute face-to-face interviews with open-ended questions using a semi-structured interview guide. A minimum of 15 nurse managers and five Chief Nursing Officers or direct supervisors from different nursing units meeting specific selection criteria within 10 acute care hospitals in New Jersey will participate in the study.

What will I be asked to do if I take part in this research study?

You may be asked to participate in a face to face interview to explore lived experience of a nurse manager with improving patient satisfaction. You may be asked to participate in a brief follow up interview to confirm my understanding of your responses.

What are the risks and/or discomforts I might experience if I take part in this study?

You may be uncomfortable talking about sensitive information or things that are upsetting. However, you are in control of the type and amount of information that you share. You can end the discussion at any time if it becomes too uncomfortable for you. You will have time at the end of the discussion to talk about how the discussion made you feel.

There is a very slight risk of the loss of confidential information. Your identity will be protected by storing all information in password protected computer files, on a password protected computer, behind a network firewall. All pen and paper notes will be stored in a secure location and will be destroyed at the completion of the study.

What are the benefits of taking part in this study?

The opportunity to discuss your experience as a nurse manger may be of benefit to you. You may also feel good that the information you share might help other nurse managers

In the future by increasing their knowledge about comprehensive, holistic, and changing nature of the projected contemporary nurse manager roles, cross-functional practices, and skills that align with the newer dimensions and expectations of increased patient satisfaction. The themes garnered from the experiences of expert nurse managers with the phenomenon will be essential to the potential development of a conceptual framework or model that identifies constructs for nursing managers to begin creating strategies for new competency-based outcomes for patient satisfaction standards. The model may help organizations to define newer contexts for nurse managers' work responsibilities and task-related competencies to address the new demands for improving patient satisfaction in various hospital settings. The study discoveries may contribute to healthcare organizations and the field by seeking to optimize skills and competencies among the nurse managers for organizational effectiveness, workforce planning, and redesigning health care delivery systems. However, there may be no direct benefit to you to participate in this study.

What are my alternatives if I don't want to take part in this study?

There are no alternatives to participation. Your only choice is not to take part in this study.

How will I know if new information is learned that may affect whether I am willing to stay in this research study?

During the course of the study, you will be updated about any new information that may affect whether you are willing to go on taking part in the study. If new information is learned that may affect you after the study or your follow-up is completed, you will be contacted. You may be asked to sign a revised consent or consent addendum. This will be at the discretion of the Institutional Review Board.

How will information about me be kept private?

Your identity and participation are confidential to the extent permitted by law. In addition, the Institutional Review Board may access to your original records for verification of study procedures and/or data without violating your confidentiality to the extent permitted by applicable laws and regulations. By signing this consent you, are authorizing such access.

Records identifying you will be kept confidential to the extent permitted by applicable law. If the results of the trial are published your identity and the site identity will remain confidential.

Who will be allowed to look at my research records from this study?

In addition to key members of the research team, the following people will be allowed to inspect parts of your research data related to this study:

[redacted]

- The Institutional Review Board (a committee that reviews research studies)
- Officials of the [redacted] who oversee this study
- Department of Health and Human Services (DHHS) (regulatory agency that oversees human subject research)
- U.S. Food and Drug Administration (FDA)
- Office for Human Research Protections (OHRP) (regulatory agency that oversees human subject research)
- The Health Administration Department of the University of Phoenix
- The doctoral dissertation committee of the principal investigator.

By taking part in this study, you understand that the study collects demographic data and data on your health. This data will be recorded by the study investigator who may store and process your data with electronic data processing systems. The data will be kept as long as the study is being conducted and for 3 years following the completion of the study. Your personal identity, that is your name, address, and other identifiers, will be kept confidential. You will have a code number and your actual name will not be used. Only the study investigator will be able to link the code number to your name and will keep this information for up to 3 years following the completion of the study..

Your data may be used in scientific publications. If the findings from the study are published, you will not be identified by name. Your identity will be kept confidential. The identity of your facility will be kept confidential.

The study investigator will be allowed to examine the data in order to analyze the information obtained from this study.

If you do not sign this approval form, you will not be able to take part in this research study.

You have the right to look at your study data and to ask for corrections of any kind to any of your data that is wrong.

Will there be any cost to me to take part in this study?

There will be no cost to you or to your facility for you to participate in this study.

Will I be paid to take part in this study?

You will not be paid to take part in this study. Your facility will not be paid to take part in this study.

What are my rights as a research participant?

You are not giving up any of your legal rights by signing this informed consent form or by taking part in this research study.

[redacted]

What will happen if I do not wish to take part in the study or if I later decide not to stay in the study?

You can choose not to be in the study. If you do choose to take part it is voluntary. You may refuse to take part or may change your mind at any time.

If you do not want to enter the study or decide to pull out of the study, your relationship with your facility will not change, and you may do so without penalty and without loss of benefits to which you are otherwise entitled.

If you change your mind, you may also withdraw your consent for the use of your data, but you understand that you must do this in writing to the investigator:

[redacted]

Beginning on the date you revoke your approval, no new information will be used for research. However, researchers may continue to use the information that was provided before you withdrew your approval.

Who can I call if I have any questions?

If you have any questions about taking part in this study, you can call the principal investigator(s):

[redacted]

If you have any questions about your rights as a research subject, you can call:

[redacted]

What are my rights if I decide to take part in this research study?

You have the right to ask questions about any part of the study at any time. You should not sign this form unless you have had a chance to ask questions and have been given answers to all of your questions.

[redacted]

I have read this entire form, or it has been read to me, and I believe that I understand what has been discussed. All of my questions about this form and this study have been answered.

I agree to take part in this research study.

Subject Name:_____

Subject Signature: _____ Date:_____

Signature of Investigator or Individual obtaining consent:

To the best of my ability, I have explained and discussed the full contents of the study, including all of the information contained in this consent form. All questions of the research subjects and those of his/her parent(s) or legal guardian have been accurately answered.

Investigator/Person Obtaining Consent: NEENA J. PHILIP

Signature: _____ **Date:**_____

[redacted]

[redacted]

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations

INVESTIGATOR: Neena S. Philip
Doctoral Student
University of Phoenix University
[redacted]

ADVISOR Dr. Patricia Traynor, Ph.D
School of Advanced Studies
University of Phoenix
[redacted]

PURPOSE: The purpose of the qualitative phenomenological study is to explore the comprehensive, holistic, and changing nature of the projected contemporary nurse manager roles, cross-functional practices, and skills that align with the newer dimensions and expectations of increased patient satisfaction. A qualitative transcendental phenomenological design will explore the essence and meaning of the nurse manager's perceptions and lived experience with new roles, skills, practices, and dimensions that align with the newer dimensions and expectations for increased patient satisfaction established by increased patient satisfaction scores.

RISKS AND BENEFITS: There are no known risks or direct benefits from participating in this study. You will not be paid for participating in this study, nor will you be required to pay to participate. There is no particular benefit to you except the knowledge that you will help in the

Participant's initials_____

understanding nurse manager roles to improve patient satisfaction. The possible benefits to participating in the study include the development of nurse manager roles and competencies to improve patient care in health care organizations, nurse manager education, training, and leadership studies.

CONFIDENTIALITY: The name and any identifier associated with your interview data will be kept confidential. Random identifier codes will be assigned to all participant responses or transcripts and the key to the codes available only to the principal investigator. A unique identifier code for each of the participant preserves participant unique identity and anonymity. The active informed consents, interview responses, and code keys to the responses will be kept separately in a locked cabinet in a secure home office area accessible only to the researcher. Records and documents will be maintained for a period not to exceed three years after which the researcher will shred and burn the documents. Electronic data on a desktop will be archived for a minimum of three years secured under two levels of password protection, then permanently deleted from hard drives.

RIGHT TO WITHDRAW: You are under no obligation to participate in this study, and you may withdraw at any time. There is no penalty for withdrawing. If you choose to withdraw after starting the audiotaped interview, the data will not be used. There are no alternatives to participating in the study. You may refuse to answer any question that you feel is distressing. If you feel any emotional distress in answering the survey questions, you may withdraw from the study and contact Neena S. Philip Principal Investigator at [redacted] for assistance and referral to appropriate health care personnel as needed.

VOLUNTARY CONSENT: I understand that my participation in this study will include questions about my experiences, perceptions, knowledge and attitudes regarding Holistic Nurse Manager Roles in new Patient satisfaction dimensions and expectations. I agree to participate by consenting to the audiotaped interview. I understand that the interview may take about 1 – 2 hours of my time for the initial interview. A second interview may be necessary to confirm and clarify data from the first interview. A final interview will validate

Participant's initials_____

data. The interview will be completed at a time and place of my choosing to assure comfort and confidentiality.

I understand that the information obtained from the interview will be studied and used for the purposes of increasing the understanding of nurse manager roles and competencies to improve patient satisfaction. I have been assured of the confidentiality of this study, and I understand that the results of this study may be published or presented at conferences. My name will not be associated with the questionnaire and no individual data will be reported. The researchers have offered to answer any questions I may have about the study and my participation. I understand there are no known risks involved in participating in this study. If I sign a written consent, I will be given a copy. My signature indicates that I have read and understood the information and that I have agreed to participate in the study based on the information I have received. I further understand that if I should have further questions about my participating in this study, I may call Neena S. Philip Principal Investigator at [redacted]. For questions about my rights as a study participant, or any concerns or complaints I can contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu. A copy of the research results will be provided to you on request.

_____

Participant's Name (Print) Date

_____

Participant's Signature Date

_____

Researcher's Name (Print) Date

_____

Researcher's Signature Date

Participant's initials_____

Appendix L

Request for List of Participants for Study

December 20, 2012

To,
RE: Request for List of Research Participants for Research Study
Dear Ms.

My name is Neena Philip and I am working on a doctoral dissertation in partial fulfillment of a requirement for a doctoral degree in Health Care Administration at the University of Phoenix. The title of my study is *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations.*

I would like to thank you for your kind approval and consent to conduct the study on March 26, 2012. Please see attached informed consent as a kind reminder to the request. The research proposal has satisfied the University of Phoenix IRB and ARB requirements and I am now permitted to proceed with the next phase of the study.

The intent of my letter is to seek your assistance in providing the list of participants (expert inpatient nurse managers, immediate supervisors and Chief Nursing Officers) meeting research study requirements. The target population for the study includes full time expert nurse managers of inpatient nursing departments with in-depth knowledge and experience in improving patient satisfaction. The inpatient satisfaction survey and HCAHPS survey scores from 2011 and 2012 will provide the basis for selecting nurse managers with highest scores. The selective sampling for the phenomenological study also includes Chief Nursing Officers or immediate supervisors (Directors, Vice Presidents) with in-depth perspectives and insights on environmental and organizational contexts affecting patient satisfaction outcomes.

Once I receive the list, I will invite the selective members of your organization to participate in the study, to conduct the interviews on your premises, and to review patient satisfaction scores from selected the nurse manager's department to formulate qualitative survey questions. The study participants meeting selection criteria and consenting to participate in the study will be interviewed for approximately 60 minutes.

Your assistance in providing the names, contact number, and email address of selected inpatient nurse managers, direct supervisors and CNO s is greatly appreciated. I will follow up with telephone call next week and will be happy to answer any questions and provide any further information you may require. You may also contact me at [redacted] or [redacted].

Sincerely,
(s/d) Neena S. Philip, RN, MA
Doctoral Candidate, University Of Phoenix
cc: Dr. Patricia S.Traynor, Ph.D.,
University of Phoenix School of Advanced Studies

Appendix M

Pilot Test

Sub RQ1. What are the current practices, dimensions, indicators, and expectations for the nurse manager to monitor, measure, or influence patient satisfaction on their units?

Interview Open ended questions:

1. Please describe in your own words the successes and increases, if any, in your department's 2011 and 2012 patient satisfaction scores and HCAHPS scores.
   Rate Clarity: (1 being very unclear to 5 being very clear):

   _____
2. In current situations, how does using a holistic or more comprehensive approach as a nurse manager help to monitor, measure, or improve patient satisfaction in the unit?
   Rate Clarity: (1 being very unclear to 5 being very clear):

   _____
3. What are the most important dimensions or indicators on the HCAHPS survey that nurse managers can influence? Why are these indicators more important than others?
   Rate Clarity: (1 being very unclear to 5 being very clear):

_____

4. In contrast, from your current experiences, what are some of the indictors on the HCAHPS survey that you as a nurse manager cannot influence and why?
   Rate Clarity: (1 being very unclear to 5 being very clear):

   _____
5. Please describe your experience of your processes, practices, initiatives, techniques or actions in the journey to improve patient satisfaction that have helped to improve the scores in your department?
   Rate Clarity: (1 being very unclear to 5 being very clear):

   _____
6. What were some of your self-imposed initiatives/practices that contributed to the high patient satisfaction scores that differed from other nurse managers? Why do you believe the initiatives were effective?
   Rate Clarity: (1 being very unclear to 5 being very clear):

_____

7. In your experience what have been among some of the best practices or initiatives in the department that did not have a desired outcome in increasing patient satisfaction scores despite major efforts and resources to support the effort? And why? (Probing question)
   Rate Clarity: (1 being very unclear to 5 being very clear): _____

Sub RQ2. What were some of the essential themes from past nurse experiences that should be maintained with the new nurse manager role, practices, attributes,

functions, strategies, or performance improvement initiatives that may continue to influence improved patient satisfaction in current and future times?

Interview Open ended questions:

1. Reflecting on your past experiences and practices what have been some of the important nurse managerial functions and practices that should be maintained to improve patient satisfaction score?

Rate Clarity: (1 being very unclear to 5 being very clear):

_____

2. In your experience what are some of the influential nurse manager leadership attributes or behaviors that should be sustained to influence increased patient satisfaction scores?

Rate Clarity: (1 being very unclear to 5 being very clear):

_____

3. What are some of the important leadership skills and competencies demonstrated by nurse managers in the last few years to improve patient satisfaction score if at all?

Rate Clarity: (1 being very unclear to 5 being very clear):

_____

4. How have some of the existing organizational quality initiatives assisted the nurse manager to improve patient satisfaction scores?

Rate Clarity: (1 being very unclear to 5 being very clear):

_____

5. What if any past organizational strategies, goals, and objectives helped you improve patient satisfaction scores on your unit?

Rate Clarity: (1 being very unclear to 5 being very clear):

_____

Sub RQ3. What is the essence of the new complex and transformative changes in the projected nurse manager leadership roles and trends for best practices in the context of new regulatory requirements to improve patient satisfaction in highly competitive health care environments?

Interview Open Ended questions:

1. What is your perception regarding the new focus on patient satisfaction survey scores such as HCAHPS and patient satisfaction survey through market and regulatory forces for example Value Based Purchasing?

Rate Clarity: (1 being very unclear to 5 being very clear): _____

2. What are some of changes in your leadership/management role as a result of the changes and focus in the healthcare environment for improving patient satisfaction?

Rate Clarity: (1 being very unclear to 5 being very clear): _____

3. How, if at all, do these changes in your leadership style, attributes, and behaviors influence or motivate nurses and staff in your department to achieve patient satisfaction goals and activities?

Rate Clarity: (1 being very unclear to 5 being very clear): _____

4. What types of education and training curricula can help you to optimize organizational goals to improve patient satisfaction**?**

Rate Clarity: (1 being very unclear to 5 being very clear): _____

5. To what extent does organizational culture play a role in new regulatory changes to improve patient satisfaction? Why or why not?

Rate Clarity: (1 being very unclear to 5 being very clear): _____

Sub RQ4: What is the overall value or benefit of the newer nurse manager position and opportunities in meeting requirements for improving patient satisfaction?

Interview Open ended questions:

1. In your experience how have the changes in health care affected nurse manager's role to improve patient satisfaction?

Rate Clarity: (1 being very unclear to 5 being very clear): _____

2. In your perception how can the nurse manager contribute to improving patient satisfaction and how?

Rate Clarity: (1 being very unclear to 5 being very clear): _____

3. What important skill and competencies do nurse managers need to demonstrate in this new transforming health care environment to meet quality and customer service needs

Rate Clarity: (1 being very unclear to 5 being very clear): _____

4. In light of the new demands for improved patient satisfaction, what are some of the new beneficial functions and responsibilities of the nurse manager leadership role and how are these functions different from the past roles?

Rate Clarity: (1 being very unclear to 5 being very clear): _____

Sub RQ5: What are the overall obstacles barriers, or complexities that may challenge the nurse manager within the organizational culture to meet requirements for improving patient satisfaction?

Interview Open ended questions:

1. In your perception how has the focus on improving patient satisfaction scores provided major obstacles to the nurse manager's role and responsibility?

Rate Clarity: (1 being very unclear to 5 being very clear): _____

2. In your experience what are some of the major challenges facing the nurse manager to improve patient satisfaction scores on his or her unit?

Rate Clarity: (1 being very unclear to 5 being very clear): _____

3. Can you describe the barriers or obstacles that may influence the following factors to improve patient satisfaction?
    a. Organizational mission/ vision/ culture
    b. Leadership support
    c. Staff alignment
    d. Customers or patients
    e. Other Departments
    f. Other professional staff
    g. Other stakeholders

Rate Clarity: (1 being very unclear to 5 being very clear): _____

How long did it take to complete the test: _____

Were the instructions Clear? Y/N

Suggestions:_____

_____

_____

What the sequence of questions easy to follow: Y/N

Suggestions:_____

_____

_____

Any Questions Objectionable: Y/N

Suggestions:_____

_____

_____

Any Topics Omitted: Y/N

Suggestions:_____

_____

_____

Any Other Comments:

_____

Appendix N

Dissertation Research Participant Identifier Code

NAME	PN	GN	TI	YE	EL	DATE OF INTERVIEW		
						MO	DY	YR
LEADER 1	01							13
LEADER 2	02							13
LEADER 3	03							13
LEADER 4	04							13
LEADER 5	05							13
LEADER 6	06							13
LEADER 7	07							13
LEADER 8	08							13
LEADER 9	09							13
LEADER 10	10							13
LEADER 11	11							13
LEADER 12	12							13
LEADER 13	13							13
LEADER 14	14							13
LEADER 15	14							13
LEADER 16	16							13
LEADER 17	17							13
LEADER 18	18							13
LEADER 19	19							13
LEADER 20	20							13
LEADER 21	21							13

PNGNTIYEELMODYYR (16 Digit Participant Identifier Code

PN	Participant number	01-20
GN	Gender	01- Female 02- Male
TI	Title	NM-Nurse Manager, SU- Supervisor, DR= Director, VP= Vice President, CN- Chief Nursing Officer
YE	Years of experience	02-30
EL	Educational Level	DI- Diploma, AS- Associate Degree, BS= Bachelors, MS-Masters, DO- Doctorate
MO	Month	01-12
DY	Day	01-31
YR	Year	13

Example: 0101NM05AS012013- Participant number is 01: Gender is Female, Title is Nurse Manager, 5 years of Experience as a Nurse Manager, Highest degree achieved is an Associates Degree, Month of interview of 01, Day is 20 and Year is 2013)

Appendix O

Participant Notes and Observation Form

Name:	**PN**	**GN**	**TI**	**YE**	**EL**	**MO**	**DY**	**YR**
Leader:								13
Time Started: Time End:								

PN	Participant number	01-20
GN	Gender	01- Female 02- Male
TI	Title	NM-Nurse Manager, SU- Supervisor, DR= Director, VP- Vice President, CN- Chief Nursing Officer
YE	Years of experience	02-30
EL	Educational Level	DI- Diploma, AS- Associate Degree, BS- Bachelors, MS-Masters, DO- Doctorate
MO	Month	01-12
DY	Day	01-31
YR	Year	13

Notes
Observation
Comments

Appendix P

Interview Protocol Script

Interview Code: _____

Date: ____/_____/_____

Hello,

Good Morning/Afternoon/Evening

Thank you for your participation in the research study today covering the new emerging phenomenon of roles, practices, skills, and dimensions of front-line nurse managers that align with the new expectations of improving patient satisfaction.

My name is Neena S. Philip and I am a student at the University of Phoenix working on a doctoral dissertation in partial fulfillment of a requirement for a doctoral degree in Health Care Administration. My study is titled *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations"*

The purpose of the qualitative phenomenological study is to explore the lived experiences and perceptions of the comprehensive, holistic, and changing nature of the projected contemporary nurse manager roles, cross-functional practices, and skills that align with the newer dimensions and expectations of increased patient satisfaction.

Your participation is this study is completely voluntary. I would like to remind you of your written consent to participate in the study. Please review the written consent that explains the nature, potential risks, and benefits of the study. In this research there are no foreseeable risks to you. Although there will be no direct benefits to you, your participation may benefit health care organizations, nursing education, and leadership studies in the development of nurse manager roles and competencies to improve quality of patient care. You may be asked to participate in a follow up interview to confirm my understanding of your responses. As discussed in the Informed consent I will audiotape the interview to accurately document all responses.

This face-to-face interview will take approximately 60 minutes and consist of multiple demographic and open-ended interview questions. As discussed in the written informed consent, once you start, you can withdraw from the study at any time without any consequences. Do you have any concerns before we begin? Then with your permission may we begin the interview?

Demographic and Interview Questions (see attached)

Before we conclude is there any thing else you would like to share?

Your insights and experiences are valuable to the study, and I am very grateful that you have taken the time to share them with me during this interview. When my dissertation is approved, I will forward you a written summary of my findings by email or registered mail. Thank you for your participation in this study.

Appendix Q

Demographic Survey

Name:(Last)_____
(First)_____ (MI)_____
Code: _____

1. Gender:
   - ☐ Male
   - ☐ Female
2. Position/Title:
   - ☐ Nurse Manager
   - ☐ Supervisor
   - ☐ Director
   - ☐ Vice President
   - ☐ Chief Nursing Officer
   - ☐ Other:
3. Department: _____
4. Years in Position: _____(Specify)
   - ☐ 1-5
   - ☐ 6-10
   - ☐ 11-15
   - ☐ 16-20
   - ☐ >20
5. Scope of Control:
   - ☐ 0-20
   - ☐ 21-40
   - ☐ 41-60
   - ☐ 61-80
   - ☐ 81-100
   - ☐ >101
6. Highest Educational Level:
   - ☐ RN
   - ☐ BSN/BS
   - ☐ MSN/Masters
   - ☐ Doctorate
7. Certifications: _____
8. Organization Type:
   - ☐ Acute care
   - ☐ Community
   - ☐ Tertiary care
   - ☐ Teaching
   - ☐ Profit
   - ☐ Not-for-profit/ Religious

☐ Other

9. Bed Capacity:
   - ☐ 0-100
   - ☐ 101-200
   - ☐ 201-300
   - ☐ 301-400
   - ☐ 400-500
   - ☐ >500
10. Magnet Status:
    Yes No Pending
11. Organizational Characteristics:
    a. Mission: _____
    b. Vision: _____
    c. Shared Governance:
       Y N
    d. Patient Centered Care
       Y N
12. 2011 or 2012 aggregate patient satisfaction HCAHPS score:
13. 2012 Patient satisfaction Overall Department score:
14. Percentile ranking:
15. Greatest gain or success in HCAHPS or Press Ganey™ Patient satisfaction Questions:

Appendix R

Interview Questions

Sub RQ1. What are the current practices, dimensions, indicators, and expectations for the nurse manager to monitor, measure, or influence patient satisfaction on their units?

Interview Open ended questions:

1. Please describe in your own words the successes and increases, if any, in your department's 2011 or 2012 patient satisfaction scores and HCAHPS scores. (Please review the Patient Satisfaction Scores)
2. In current situations, how does using a holistic or more comprehensive approach as a nurse manager help to monitor, measure, or improve patient satisfaction in the unit?
3. What are the most important dimensions or indicators on the HCAHPS survey that nurse managers can influence? Why are these indicators more important than others?
4. In contrast, from your current experiences, what are some of the indictors on the HCAHPS survey that you as a nurse manager cannot influence and why?
5. Please describe your experience of your processes, practices, initiatives, techniques or actions in the journey to improve patient satisfaction that have helped to improve the scores in your department?
6. What were some of your self-imposed initiatives/practices that contributed to the high patient satisfaction scores that differed from other nurse managers? Why do you believe the initiatives were effective?
7. In your experience what have been among some of the best practices or initiatives in the department that did not have a desired outcome in increasing patient satisfaction scores despite major efforts and resources to support the effort? And why? (Probing question)

Sub RQ2. What were some of the essential themes from past nurse manager experiences that should be maintained with the new nurse manager role, practices, attributes, functions, strategies, or performance improvement initiatives that may continue to influence improved patient satisfaction in current and future times?

Interview Open ended questions:

1. Reflecting on your past experiences and practices what have been some of the important nurse managerial functions and practices that should be maintained to improve patient satisfaction score?
2. In your experience what are some of the influential nurse manager leadership attributes or behaviors that should be sustained to influence increased patient satisfaction scores?
3. What are some of the important leadership skills and competencies demonstrated by nurse managers in the last few years to improve patient satisfaction score if at all?

4. How have some of the existing organizational quality initiatives assisted the nurse manager to improve patient satisfaction scores? (Please explain a few that you perceive to have helped patient satisfaction scores)
5. What if any past organizational strategies, goals, and objectives helped you improve patient satisfaction scores on your unit?
6. What if any past organizational best practice adopted strategies helped you improve patient satisfaction scores on your unit?
(Shared Governance/ Magnet/ Patient Centered Care/ Healthy Work environments)

Sub RQ3. What is the essence of the new complex and transformative changes in the projected nurse manager leadership roles and trends for best practices in the context of new regulatory requirements to improve patient satisfaction in highly competitive health care environments?

Interview Open Ended questions:

1. What is your perception/thoughts regarding the new focus on patient satisfaction survey scores such as HCAHPS and patient satisfaction survey through market and regulatory forces for example Value Based Purchasing?
2. What are some of changes in your leadership/management role as a result of the changes and focus in the healthcare environment for improving patient satisfaction?
3. How, if at all, do these changes in your leadership style, attributes, and behaviors influence or motivate nurses and staff in your department to achieve patient satisfaction goals and activities?
4. What types of education and training curricula in nursing leadership schools/ CE / institutional programs etc. can help you to optimize organizational goals to improve patient satisfaction**?**
5. To what extent does organizational culture play a role in new regulatory changes to improve patient satisfaction? Why or why not?

Sub RQ4: What is the overall value or benefit of the newer nurse manager position and opportunities in meeting requirements for improving patient satisfaction?

Interview Open ended questions:

1. In your opinion what is the essence of the nurse manager's holistic and comprehensive role in this new transforming health care environment to meet quality and customer service needs
2. In light of the new demands for improved patient satisfaction, what are some of the essential functions /responsibilities/skills/competencies/ of the nurse manager leadership role to improve patient satisfaction.

(Probing- how are these new nurse manager functions/responsibilities/ skills required that is different from the other roles/functions?)
(Probing: What is the percentage of time (total function/role) do you as a nurse manager actually contributes to improving patient/customer satisfaction on the unit?

(Probing- In your experience- how does the nurse manager role of improving Pat Satisfaction rate to the other functions/role/responsibility such as budgeting/ human resource management/ of the nurse manager? And why
(Probing- why are _____ function/roles more important than other and why
(Probing- How do you see the your new role evolving in this transformative health changes with demands for improved patient satisfaction)

RQ5: What are the influences and or overall obstacles barriers, or complexities that may challenge the nurse manager within the organizational culture to meet requirements for improving patient satisfaction?

Interview Open ended questions:

1. In your perception how has the focus on improving patient satisfaction scores influenced he nurse manager's new role and responsibility? Has it provided any obstacles/barrier?)
2. In your experience what are some of the major challenges facing the nurse manager to improve patient satisfaction scores on his or her unit?

(Probing -What are some skills/competencies/role of the nurse manager to address these challenges?)

3. In examining the following variables, please describe the influences both positive and or negative on the nurse manager's new role to improve patient satisfaction
    a. Organizational mission/ vision/ culture
    b. Leadership support – Nursing/ Administrative
    c. Staff alignment
    d. Customers or patients
    e. Other Departments
    f. Other professional staff/ Customers –Physician
    g. Other stakeholders- Community/ Board/ Regulatory agencies.

Appendix S

Non Disclosure Agreement: Accurate Transcriptions

February 3, 2013

Dr. Ravi Rathi
Accurate Transcriptions
Re: Transcription Service for Research interviews

Dear Dr. Rathi,

My name is Neena S. Philip and I am a student at the University of Phoenix working on a doctoral dissertation in partial fulfillment of a requirement for a doctoral degree in Health Care Administration. I am seeking your assistance in conducting a research study entitled *"Exploring Holistic Nurse Manager Roles with New Patient Satisfaction Dimensions and Expectations."*

I am requesting your company's valuable transcription services for audio-recorded files that contain research interviews with research participants. The audio-recorded files are in MP3 format and need to be transcribed as is (word for word) into Microsoft word format. Once transcribed, I will edit the data and insert it into the data analysis software. Due to the nature of the study all data is to be kept confidential. Please review and sign the Non Disclosure Agreement as per IRB research requirements from the University of Phoenix to maintain confidentiality of research participants.

I would like to thank you for your kind assistance in transcribing the qualitative research data. Please do not hesitate to call me at 973-727-9335 or email me at nsphilip3@gmail.com for any questions or concerns.

Sincerely,

Neena S. Philip
Doctoral Learner
University of Phoenix University

Non-Disclosure Agreement

Accurate Transcriptions acknowledges that in order to provide the services to Neena S. Philip (hereinafter "Researcher") who is a researcher in a confidential study with the University of Phoenix, Inc., **Accurate Transcriptions** must agree to keep the information obtained as part of its services (as more fully described below) confidential. Therefore the parties agree as follows:

1. The information to be disclosed under this Non-disclosure Agreement ("Agreement") is described as follows and shall be considered "Confidential Information": All audio recorded interviews for the purposes of transcription. All information shall remain the property of Researcher.

2. **Accurate Transcriptions** agrees to keep in confidence and to use the Confidential Information for *transcription* only and for no other purposes.

3. **Accurate Transcriptions** further agrees to keep in confidence and not disclose any Confidential Information to a third party or parties for a period of five (5) years from the date of such disclosure. All oral disclosures of Confidential Information as well as written disclosures of the Confidential Information are covered by this Agreement.

4. **Accurate Transcriptions** shall upon Researcher's request either destroy or return the Confidential Information upon termination of this Agreement.

5. Any obligation of **Accurate Transcriptions** under this Agreement shall not apply to Confidential Information that:

    a) Is or becomes a part of the public knowledge through no fault of **Accurate Transcriptions**
    b) **Accurate Transcriptions** can demonstrate was rightfully in its possession before disclosure by Researcher/ research subjects; or
    c) **Accurate Transcriptions** can demonstrate was rightfully received from a third party who was not Researcher/research subjects and was not under confidentiality restriction on disclosure and without breach of any nondisclosure obligation.

6. **Accurate Transcriptions** agrees to obligate its employees or agents, if any, who have access to any portion of Confidential Information to protect the confidential nature of the Confidential Information as set forth herein.

7. **Accurate Transcriptions** shall defend, indemnify and hold the Researcher and the University of Phoenix harmless against any third party claims of damage or injury of any

kind resulting from **Accurate Transcriptions** use of the Confidential Information, or any violation of by **Accurate Transcriptions** of the terms of this Agreement.

8. In the event **Accurate Transcriptions** receives a subpoena and believes it has a legal obligation to disclose Confidential Information, then **Accurate Transcriptions** will notify Researcher as soon as possible, and in any event at least five (5) business days prior to the proposed release. If Researcher objects to the release of such Confidential Information, **Accurate Transcriptions** will allow Researcher to exercise any legal rights or remedies regarding the release and protection of the Confidential Information.

9. **Accurate Transcriptions** expressly acknowledges and agrees that the breach, or threatened breach, by it through a disclosure of Confidential Information may cause irreparable harm and that Researcher may not have an adequate remedy at law. Therefore, **Accurate Transcriptions** agrees that upon such breach, or threatened breach, Researcher will be entitled to seek injunctive relief to prevent **Accurate Transcriptions** from commencing or continuing any action constituting such breach without showing or providing evidence of actual damage.

10. The interpretation and validity of this Agreement and the rights of the parties shall be governed by the laws of the State of New Jersey.

11. The parties to this Agreement agree that a copy of the original signature (including an electronic copy) may be used for any and all purposes for which the original signature may have been used. The parties further waive any right to challenge the admissibility or authenticity of this document in a court of law based solely on the absence of an original signature.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf:

Printed Name of Third Party/Vendor: Accurate Transcriptions
Signature:

_____

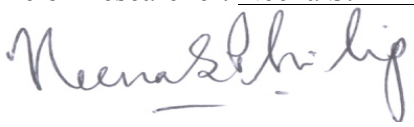
Address:

_____

Date:

_____

Printed Name of Researcher: Neena S. Philip



Signature:
Address: [redacted]
Date: 2/3/2013

Appendix T

Non Disclosure Agreement QSR International (Americas) Inc.

Non-Disclosure Agreement

QSR International (Americas) Inc. acknowledges that in order to provide the services to Neena S. Philip (hereinafter "Researcher") who is a researcher in a confidential study with the University of Phoenix, Inc., **QSR International (Americas) Inc.** must agree to keep the information obtained as part of its services (as more fully described below) confidential. Therefore the parties agree as follows:

12. The information to be disclosed under this Non-disclosure Agreement ("Agreement") is described as follows and shall be considered "Confidential Information": All coded data in the QSR NVIVO 10 file " Exploring Holistic Nurse Manager Roles" for the purposes of training and consultancy on qualitative coded data evaluation and data analysis. All information shall remain the property of Researcher.

13. **QSR International (Americas) Inc.** agrees to keep in confidence and to use the Confidential Information for training and *evaluation of qualitative data and data analysis* only and for no other purposes.

14. **QSR International (Americas) Inc.** further agrees to keep in confidence and not disclose any Confidential Information to a third party or parties for a period of five (5) years from the date of such disclosure. All oral disclosures of Confidential Information as well as written disclosures of the Confidential Information are covered by this Agreement.

15. **QSR International (Americas) Inc.** shall upon Researcher's request either destroy or return the Confidential Information upon termination of this Agreement.

16. Any obligation of **QSR International (Americas) Inc.** under this Agreement shall not apply to Confidential Information that:

    d) Is or becomes a part of the public knowledge through no fault of **QSR International (Americas) Inc.**
    e) **QSR International (Americas) Inc.** can demonstrate was rightfully in its possession before disclosure by Researcher/ research subjects; or
    f) **QSR International (Americas) Inc.** can demonstrate was rightfully received from a third party who was not Researcher/research subjects and was not under confidentiality restriction on disclosure and without breach of any nondisclosure obligation.

17. **QSR International (Americas) Inc.** agrees to obligate its employees or agents, if any, who have access to any portion of Confidential Information to protect the confidential nature of the Confidential Information as set forth herein.

18. **QSR International (Americas) Inc.** shall defend, indemnify and hold the Researcher and the University of Phoenix harmless against any third party claims of damage or injury of any kind resulting from **QSR International (Americas) Inc.** use of the Confidential Information, or any violation of by **QSR International (Americas) Inc.** of the terms of this Agreement.

19. In the event **QSR International (Americas) Inc.** receives a subpoena and believes it has a legal obligation to disclose Confidential Information, then **QSR International (Americas) Inc.** will notify Researcher as soon as possible, and in any event at least five (5) business days prior to the proposed release. If Researcher objects to the release of such Confidential Information, **QSR International (Americas) Inc.** will allow Researcher to exercise any legal rights or remedies regarding the release and protection of the Confidential Information.

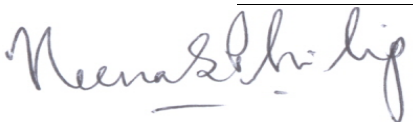
20. **QSR International (Americas) Inc.** expressly acknowledges and agrees that the breach, or threatened breach, by it through a disclosure of Confidential Information may cause irreparable harm and that Researcher may not have an adequate remedy at law. Therefore **QSR International (Americas) Inc.** agrees that upon such breach, or threatened breach, Researcher will be entitled to seek injunctive relief to prevent **QSR International (Americas) Inc.** from commencing or continuing any action constituting such breach without showing or providing evidence of actual damage.
21. The interpretation and validity of this Agreement and the rights of the parties shall be governed by the laws of the State of New Jersey.

22. The parties to this Agreement agree that a copy of the original signature (including an electronic copy) may be used for any and all purposes for which the original signature may have been used. The parties further waive any right to challenge the admissibility or authenticity of this document in a court of law based solely on the absence of an original signature.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf:

Printed Name of Third Party/Vendor: **Cynthia Jacobs**
QSR International (Americas) Inc.
Signature:_____
Address:_____
Date: _____

Printed Name of Researcher: Neena S. Philip



Signature:
Address: [redacted]
Date:10/29/2013

Appendix U

Tree and Child Node Sources and References

Nodes	Sources	References
Best Practice that did not help with Patient satisfaction	1	1
Magnet	5	9
Shared Governance	1	2
Best Practice that has helped Nurse Manager	1	1
Healthy Working Environments	2	4
Magnet	13	20
Patient Centered Care	15	34
Patient engagement	7	11
Relationship Based Care	6	22
Shared Governance	15	23
TEAM STEPPS	1	5
Unit Councils	12	20
Challenges Facing Nurse Managers	14	30
Address the challenges	12	28
Communication	4	7
Community	2	2
Economy	3	6
EMR	8	9
Environment	4	4
Excuses for poor scores	3	6
Lack of buying from other departments and disciplines	12	33
Lack of Communication skills	2	3
Lack of coordinated care and communication	1	2
Lack of Training	3	5
Large Span of control	1	1
Leadership support	2	9
Multiple initiatives	9	12
Multiple Demands	10	22
Lack of experience	1	1
Meeting both staff and administration's experience	3	4
Patients	8	17
Reducing Length of stay	1	1
Resources	11	24

Amenities	4	4
Financial Constraints of the Hospital	6	10
Inconsistency of Survey Scores	2	2
Technology	1	1
Staff Challenges	3	5
Burnout	3	5
Changing current habits	8	9
Generational Differences	3	4
Lack of buy-in	9	19
Staff See a lack of leadership	1	1
Task or Clinical Oriented less customer oriented	4	6
Uncaring individuals	5	8
Staffing	15	29
Sustainability	14	30
Time	6	13
Understanding patient satisfaction surveys	7	9
Describe experience in journey to improve patient satisfaction	26	144
Perspectives on Patient Satisfaction Experience	21	74
Dimensions and Indicators Nurse Managers cannot influence	14	32
Dimensions and Indicators on Survey Nurse Managers can Influence	20	34
Issues with Nurse Manager Influences	6	8
Education and Training for Nurse Managers	10	23
Leadership Training for Nurse Managers	11	17
Learning from Other managers	2	4
Other educational focus for Nurse Managers	7	8
Health Care Organizations and Patient Satisfaction	13	28
Indicators on Survey that Organizations are struggling with	5	10
Organizational goals for patient satisfaction	6	7
Patient Satisfaction philosophy	15	53
Behavioral Standards	9	19

Changing organizational culture	1	2
Expectation of high patient satisfaction scores from managers	13	26
Learning organizations	6	8
Nurse manager selection	2	2
Organize Committees and Planning	14	26
Bringing all disciplines and departments	12	24
Perceptions of organizational culture	2	2
Religious and spirituality	3	3
Organizational Strategies to improve patient satisfaction	10	42
AIDET	1	1
Assistant Nurse Managers	7	9
Community Outreach	3	3
Cultural Competency	1	3
Develop and mentor nurse managers	6	14
Educate Staff	11	23
Employee Centered	6	9
Gain sharing	1	1
Leadership Rounding	1	5
Marketing	2	2
Patient Satisfaction Coordinator	4	8
Providing resources	8	10
Rewards and Recognition	9	14
Service Excellence Initiatives	3	3
Initiatives or Practices that did not work or sustain	9	17
Discharge Medication list	1	1
Discharge Rounds	2	3
Hourly Rounding	10	16
No Pass Zone	2	3
Noise Initiatives	1	3
Nurse Manager Rounding	2	2
Organizational Strategies that are not working	4	9
Reason for failures of initiatives	9	31
Scripting	1	1
Initiatives or Practices that has contributed to High patient satisfaction scores	4	7
Hourly Rounding	9	15
Service Recovery	3	3
White Boards	4	5

Bedside reporting	7	14
Multidisciplinary Rounds	2	2
Transforming Care at The Bedside	6	11
Discharge Phone Calls	5	11
Providing amenities	2	2
Staffing and scheduling	2	3
Discharge RN	2	6
Discharge Rounds	1	1
Using patient education technology	4	4
Other Initiatives	5	8
Scripting	3	4
AIDET	1	1
Self Imposed Initiatives That contributed to high Satisfactions scores	6	12
Different Initiatives from other managers	10	14
New Initiatives for Improving Patient Satisfaction	14	34
Negative Influences to improve patient satisfaction	0	0
Administrative leadership support	5	7
Board of trustees	0	0
Community	3	6
Culture	10	18
Customer or patients	12	25
Departments	12	31
Mission Vision	0	0
Nursing Leadership Support	0	0
Physicians	11	20
Regulatory agencies	1	2
Staff Alignment	6	14
Nurse Manager Attributes and Behaviors	4	11
Caring Patient Centered Philosophy	21	79
Consistency	10	17
Diligence	11	26
Drive for excellence	9	12
Empathy	12	25
Flexible	7	11
Forward Thinking	1	1
Goal Oriented	13	26
Honesty	6	6

Learner	6	12
Motivate Staff	11	19
Non- punitive	7	9
Open Door Policy	11	13
Overcoming challenges	5	5
Passionate	4	5
Professionalism	6	8
Reflective and Reflexive	7	10
Respect	6	11
Risk Taking	10	12
Transparency	5	9
Trust	6	10
Nurse Manager Functions and Practices	3	8
Communicating and Coordinating with other Departments	18	55
Feedback and Reinforcement	18	64
Rewards and recognition	10	17
Holding Staff Accountable	19	83
Addressing issues in real time	13	26
Nurse Manager Rounding	25	99
Seeking Patient Perspectives	13	22
Service Recovery	9	14
Process Improvement	18	104
Creative	8	9
Data Management	5	9
Researching and adopting best practice	11	29
Develop Staff	5	9
Sharing Results of Initiatives and adopting	5	7
Providing or facilitating resources for staff	10	20
Recruitment right candidates	6	10
Staying clinical or bedside interaction	12	23
Knowing the process	6	8
Nurse Manager Leadership styles	9	13
Transformational leadership characteristics	12	67
Idealized Influence	8	19
Individualized consideration	4	10
Inspirational Motivation	10	17
Intellectual Stimulation	5	9
Visionary	3	4
Authentic Leadership	5	13
Change Agent	11	19
Situational	5	7
Perspectives on autocratic leadership	1	1

Participative	15	33
Servant Leader	3	7
Maturity	2	3
Changes in Leadership style due to transformation in healthcare	6	16
Nurse Manager Role in Improving Patient Satisfaction	4	15
Accessibility to staff and patients	6	10
Building Relationships	9	19
Constant Oversight	13	27
Creating a healthy working environment for staff	16	39
Creating Patient satisfaction culture	21	248
Communication with Staff regarding Patient Satisfaction	16	45
Communicating Vision	5	10
Expanding Visiting hours	2	2
Creating a culture or mindset of caring	16	29
Developing Emotional Intelligence among staff	5	14
Developing staff with communication initiatives	11	13
Having the right staff	6	15
High Middle low performer	3	3
Meeting customer expectations	9	12
Setting expectation for high patient satisfaction with staff	15	40
Story Telling	7	12
Develop Mentor and Coach Staff	21	105
Education	18	42
Empowering Staff	21	85
Identify champions and develop staff	10	21
Value Staff	13	15
Engagement	21	115
Know the staff	9	12
Open to suggestions and feedback	6	8
Follow Through	7	12
Holistic Role of a Manager to Monitor, Measure and Improve	17	54
Managing up	1	1
Meaning of new nurse manager role	22	90
Modeling	19	49
Percentage of time	21	38
Staff Satisfaction	18	32
Support staff	10	17
Team Building	12	33

Trouble shooter	3	3
Visibility	18	37
Nurse Manager Skills and Competencies	6	9
Analytical Skills	5	8
Business Skills	4	4
Clinical expertise	8	13
Communication	15	46
Listening skills	10	15
Detail oriented	1	1
Efficiency	2	4
Emotional intelligence	9	12
Human Interaction and building relationships	6	10
Maturity as a leader	2	2
Patience	3	3
Process Improvement skills	10	18
Time management	2	2
Perceptions on Nursing leadership	2	4
Perspectives on Nurse Manager Role and Staff	2	7
Staff Satisfaction affects Patient satisfaction	9	13
Perspectives on Nurse Managers and patient satisfaction	16	43
Perspectives on Nursing	10	21
Positive Influences on Nurse Managers	0	0
Mission Vision	14	17
Culture	14	40
Nursing Leadership support	23	53
Administrative Leadership support	19	45
Customers patients	11	13
Physicians	13	19
Departments	14	21
Community	13	19
Board	8	9
Regulatory Agencies	12	15
Staff alignment	20	36
Perceptions on Transformation in Healthcare	6	15
Readmissions	6	7
Accountable Care Organizations	2	2
Future of Nurse Manager Role	13	21
Value Based Purchasing	16	45
Patient satisfaction Surveys	14	40
Future of Healthcare and hospitals	7	15

Success or Increases in 2012 Patient Satisfaction or HCAHPS scores	15	21

Appendix V

Themes and Major Findings Supporting Themes

Theme1: Expectations of the nurse manager to improve patient satisfaction	Theme 2: Building a patient caring culture
• Regulatory Forces • Market forces • Expectations • Important role of the nurse manager to improve patient outcome	• Nurse manager caring philosophy • Visionary • Setting clear expectations, goals and objectives • Drive for excellence • Communicate a clear vision • Commitment, diligence, and consistency • Authentic leadership style • Modeling patient satisfaction behaviors

Theme 3: Leader Rounding	Theme 4: Creating a healthy working environment
• Accessible to patients and staff • Servant leadership • Seek patient expectations, perceptions, feedback • Service recovery • Modeling • Building relationships • Visibility	• Caring, empathy, respect, and emotional intelligence • Leader-follower influence • Staff satisfaction • Model behaviors to staff: Caring, respect, communication, listening, value staff, facilitating resources, and removing work barriers • Right staff- hiring • Know staff, develop champions, and educate staff • Develop, coach, and mentor staff • Consistency • Feedback, rewards and recognitions for positive reinforcement • Accountability


Theme 5: Staff engagement and empowerment
• Staff satisfaction through engagement leads to patient satisfaction
• Transformational leader
• Shared governance, unit based councils, Transforming Care at Bedside (TCAB), and Magnet Recognition
• Respect, risk taking, and open door policy
• Communication skills-listening
Theme 6: Change agent-continuous quality improvement
• Change management
• Process improvement skills
• Learner, open minded, and creative
• Communicate with staff regarding improvement process
• Researching best practices
• Team effort
• Patient centered care, relationship based care, shared governance
Theme 7: Impact of organizational focus and culture
• Organizational philosophy of patient centeredness and caring
• Influence of top level administrative and nursing leadership
• Culture of excellence
• Behavioral standards
• Leadership support
• Resources
• Engage all departments and disciplines: Team based approach, accountability
• Employee centered culture
• Top level leader visibility, transformational style,
• Mentor managers
Theme 8a: Challenges facing nurse managers: Sustainability
• Lack of top level leadership focus
• Staff: resistance to change
• Multiple initiatives, and priorities
• Staffing
• One initiative at a time
• Consistency
• Visibility
Theme 8b: Challenges facing nurse managers: Lack of interdisciplinary teamwork
• Lack of collaboration from other departments
• Lack of accountability from other disciplines
• Lack of training