LIBERATING THE VOICE OF NURSE LEADERS:
IMPROVING NURSE MANAGER SATISFACTION

by
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Abstract

Achievement of strategic priorities in one rural health system is predicated on a foundational goal—creating an ideal work environment. As such, sustaining a work environment that supports team cohesion and staff empowerment is an organizational imperative and a primary responsibility for leaders at all levels. In a biennial employee partnership assessment, nurse manager survey scores experienced double digit declines for three questions related to communication and professional influence over work. Low satisfaction and engagement of nurse managers affect role performance, the unit culture and practice environment. Lack of role power and influence inhibits goal attainment and further erodes organizational commitment. Nurse managers exhibiting behaviors of marginalization and disempowerment requested organizational support to address powerlessness and low self-esteem. Innovative strategies and nurse manager support are required to manage an increasingly complex workload and mitigate stress. Improvements are needed in nurse managers’ perception of organizational support and self-empowerment. Each nurse manager needs from his or her superior what subordinates need from nurse managers—visible commitment and tangible support. Research related to nurse leader work life and satisfaction demonstrates that in addition to senior leader support, engagement of those affected by change is an important requirement for success. These findings support this capstone project, offering strategies consistent with overcoming oppression using a group intervention model. A facilitated group process was implemented to improve nurse manager self-awareness and empowerment, including introduction of appreciative inquiry as a paradigm shift from the traditional problem-oriented perspective, compelling leaders to envision transformation of what is to what
may be possible (Cooperrider & Srivastva, 1987). Reframing negativity associated with constructive feedback and change into positive dream and design processes aligns with current organizational culture imperatives. While statistically significant change was not demonstrated in pre- and post-assessment scores, participant nurse managers actively engaged in group intervention as evidenced by attendance and successful completion of a self-directed action plan. Post-intervention evaluation included the recommendation to share the appreciative inquiry model with leadership team and continue group sessions, including all nurse managers in continued supportive environment of self-awareness and advocacy. When nurse managers find their voice, they are able to transform the work environment.
Dedication

I dedicate my dissertation work to my daughter, Amanda Mary-Rose Laufer—she is the most important “work” of my life, truly the best of who I am and strive to be. I owe a debt of gratitude to my parents, Tom and Colleen Ciriacks, for encouraging excellence throughout my life. I am inspired by my siblings, Patrick Ciriacks, Julie (Ciriacks) Brylow, Thomas Ciriacks, Jim Ciriacks (missing you every day!), and Paul Ciriacks, who are each supremely talented and accomplished. It is my fondest wish to, in turn, inspire our family’s next generation through my nieces and nephews, Kevin, Jennifer, Lindsey, Lauren, Hailley, Callahan, Samantha, Caleb and Liam in their own unique pursuits of excellence and knowledge.

I also dedicate this dissertation to my friends Cindy and Courtney, Fran, Emelie and Mary, Dru and Judy, Heidi, Kristy, Christine, Don and many others who have supported me in person and long distance with words of encouragement, humor, food and favors! A note of thanks to my mentor and friend, Linda Pruett, for her unwavering belief in me.

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CHAPTER 1. INTRODUCTION

In July 2013, the board of directors and executive leaders of a rural health system in California identified creating an ideal work environment as a strategic priority. To assess employee perceptions of the workplace and identify opportunities for improvement, a biennial employee partnership survey was administered, evaluating satisfaction and engagement (Press Ganey Associates, 2013). With 96% of nurse managers participating in the 2013 survey, low satisfaction and engagement scores demonstrated the organization’s inability to meet this work group’s needs and expectations.

In addition to representing a statistically significant decrease from 2011 survey results, nurse managers’ 2013 mean scores were lower than nursing directors, clinical nurses and the aggregate mean scores for all employees across five of seven domains. Notably, three nurse manager survey scores experienced double-digit declines in questions pertaining to communication within systems and leadership: work group is asked for opinions before decisions are made, there are opportunities to influence policies and decisions affecting work, and leaders really listen to employees (Press Ganey Associates, 2013). These results are consistent with findings of Laschinger, Purdy, Cho, and Almost (2006), linking perception of organizational support through autonomy, empowerment, professional respect and recognition to nurse manager satisfaction, engagement and retention.
Expressing lack of control over role responsibilities and input into decisions as key contributing factors to their disempowered silence, nurse managers in this organization exhibited behavioral characteristics consistent with oppressed groups (Daiski, 2004; Freire, 2012; Paliadelis, Cruickshank, & Sheridan, 2007; Pannowitz, Glass, & Davis, 2009; Roberts, DeMarco, & Griffin, 2009). Features of oppression and subjugation include lack of organizational support and respect, intimidation, low self-esteem, passive communication, and minimization of self (Daiski, 2004; DeMarco, Roberts, Norris, & McCurry, 2007; Fletcher, 2006; Garon, 2012; Mooney & Nolan, 2006; Roberts et al., 2009). Formal and informal power are necessary to access essential resources and information, facilitate change, and achieve professional goals (Gianfermi & Buchholz, 2011; Mackoff & Triolo, 2008; Parsons & Stonestreet, 2003). Self-silencing behaviors result from marginalization; nurse managers effectively have no voice when they are not listened to, as indicated by the aforementioned survey results (Garon, 2012; Paliadelis et al., 2007).

**Nature of the Capstone Project**

Lack of organizational structures and processes to address nurse manager survey results provided the impetus to explore these issues further in a capstone project based on the following PICOT practice question: *In nurse managers exhibiting behaviors of marginalization and disempowerment, how does taking part in four monthly therapeutic group sessions affect satisfaction (as evidenced by employee pre- and post-survey), compared to marginalized and disempowered nurse managers who do not participate in group sessions, as measured three months after intervention?* Using therapeutic
techniques in a group setting, this project focused on development of a supportive environment for nurse managers to explore oppressed group experiences through education, dialogue, and self-awareness (Daiski, 2004; Fletcher, 2006; Freire, 2012; Mooney & Nolan, 2006; Pannowitz et al., 2009).

Description of the Problem, Environment, and Target Population

Health care leaders strive to create an ideal work environment that inspires followers to commit to a shared vision. A mind map of 2013 satisfaction survey results highlighted significant communication concerns, validating the disempowerment nurse managers expressed related to: not being asked for opinions before decisions are made, not having an opportunity to influence their work, and not being listened to or heard by leaders. Complexity of the nurse manager role and unmet needs were also reflected in the 26% vacancy of nurse manager positions organization-wide.

Problem

Nurse manager engagement not only influences retention, but also impacts safe patient care and quality outcomes through the leader’s ability to motivate and engage their team (Hartung & Miller, 2013; Mackoff & Triolo, 2008; Spence Laschinger, Wong, Grau, Read & Pineau Stam, 2011; Warshawsky, Havens, & Knafl, 2012). While the causes and consequences of nurse manager dissatisfaction and disengagement were explored locally in one rural California hospital, global concern is evidenced by descriptive and exploratory studies from countries outside the United States, such as Ireland, Taiwan, Canada, Australia, and Sweden (Casey, Saunders, & O’Hara, 2010; Chang, Liu, & Yen, 2008; Daiski, 2004; Paliadelis et al., 2007; Skytt, Ljunggren, &
Carlsson, 2007). Practice problems experienced by this organization’s nurse managers were comparable to evidence found in professional literature; nurse managers exhibited characteristics consistent with oppressed groups.

Referencing experience with prior surveys and the lack of sustainable improvements resulting from poorly designed action plans, nurse managers expressed disenchantment with organizational support for work group data review. Translating survey results into meaningful change involves the ability to analyze data without emotion and personal bias, ensure key stakeholders are present, and integrate plans across nursing units and campuses (Gebelein et al., 2010). However, no reliable structures and processes existed to support successful development and execution of action plans. In pursuit of organizational support, nurse managers requested help with problem solving issues that negatively impacted their role and function.

**Environment**

When nurse managers lose their voice to intimidation or defeat, they are unable to advocate for themselves, their staff or patients—creating an unhealthy and potentially unsafe work environment (DeMarco, Roberts, & Chandler, 2005; DeMarco et al., 2007; Espinoza, Lopez-Saldana, & Stonestreet, 2009; Garon, 2012; Tillot, 2013). Nurse managers in this organization identified two key factors sustaining the negative work environment, the first being low self-esteem. Negative self-image may lead to horizontal violence among subjugated groups, manifested by undermining, sabotage and criticism (Fletcher, 2006).
The second contributory factor identified by nurse managers was normalization of oppression. Rather than blatant oppression, power inequities and closed communication were aspects of the routine leadership culture. Based on employee partnership survey results and self-report, nurse manager adaptive strategies were not effective; they could no longer act as if nothing was wrong (Boyd, 2010). Nurse managers lost confidence in both collective and individual ability to lead or affect change (Espinoza et al., 2009; Gianfermi & Buchholz, 2011; Parsons & Stonestreet, 2003).

In contrast, the desired work environment is one in which nurse managers are empowered, included in planned change and decisions, and receive support from senior leadership (Skytt et al., 2007). Nurse managers established a network of peer support through a monthly lunch meeting used to vent frustration and identify issues. This meeting, however, was not facilitated or structured in any way to generate productive actions or solutions.

**Target Population**

The target population for this project was comprised of mid-level nurse managers at a rural California health care organization. There were four men among the 22 eligible nurse managers of inpatient and outpatient services, spread across multiple campuses. Ages of nurse managers ranged from 25 to 65 years, with varying levels of leadership experience and role tenure. Notably, five nurse managers had been in their leadership role less than eight months at project inception. Three interim nurse managers classified as regular employees were included in the project intervention; three interim nurse managers functioning under limited contractual agreements were excluded. As defined in
the role description by the organization, a baccalaureate degree in nursing (BSN) was the minimal education preparation required for all nurse managers.

**Purpose of the Capstone Project**

The purpose of this capstone project was to design and implement an evidence-based practice change to benefit the nurse managers based on their low satisfaction and engagement scores. The expected outcome was development of positive professional identities among the nurse manager work group (Roberts, 2000). Using therapeutic techniques in a group setting, project intent was to develop a supportive environment for nurse managers to explore oppressed group experiences through education, dialogue, and self-awareness (Daiski, 2004; Fletcher, 2006; Pannowitz et al., 2009).

Over time, without awareness or intervention, oppressive leadership behaviors had become normalized, integrated into routine structures and processes which were exposed as “broken” by nurse managers and for which they requested assistance. Sensitivity to leadership culture was essential as sustainability of change depends upon nurse manager motivation to participate in his or her own liberating transformation (Daiski, 2004; Freire, 2012; Pannowitz et al., 2009). Demonstrating recognition of marginalization, the chief nursing officer (CNO) and senior patient care leaders fully supported the request by nurse managers for assistance in improving their work environment. And, while the nurse managers had not caused their own powerlessness, active involvement in creating change would be a first step toward empowerment (DeMarco et al., 2005; Mackoff, Glassman, & Budin, 2013).
Significance of the Capstone Project

Interest in nurse manager satisfaction and engagement was twofold. First was the role each nurse manager plays in creating a healthy practice environment and promoting a stable workforce (Andrews & Dziegielewski, 2005; Kramer et al., 2007; Manojlovich & Laschinger, 2007; Warshawsky, Rayens, Lake, & Havens, 2013). Providing consistently high quality patient care safely requires a motivated team working collaboratively in an engaging culture; creating a stimulating work environment for employees requires nurse managers to be engaged in their own work (Warshawsky et al., 2012). The nurse manager’s ability to consistently provide a professional practice environment that supports quality patient outcomes and staff satisfaction influences recruitment and retention of new and experienced nurses (American Nurses Association, 2009).

Recruitment and retention of visionary leaders was another driving force behind the keen interest in nurse manager partnership scores. Seven of 27 nurse manager positions were vacant; five of the seven had been vacant for greater than six months. Experience has shown that this organization’s rural setting presents a significant recruitment challenge for all healthcare disciplines, including nurse managers. Mackoff and Triolo (2008) emphasize the need for senior nurse leaders to engage nurse managers, rather than focusing primarily on retention. Vacancies in nurse manager positions shift the burden of responsibility to the nursing director and other nurse managers; consequently, employee and patient satisfaction suffer. Reflected by these open positions, the 2013 employee partnership survey results highlighted role complexity and unmet
communication needs as contributing factors to overall decline in satisfaction and engagement among nurse managers.

The CNO, patient care directors, and nurse managers verbalized the potential benefits of this project, expressing relief that nurse manager satisfaction survey results would be explored in a systematic way, with evidence-based action steps identified and implemented. Consistent with oppressed group characteristics, many nurse managers verbalized feeling marginalized, undervalued and silenced by the senior and executive leaders (Pannowitz et al., 2009). Despite this, as a group, nurse managers remained cautiously optimistic that the capstone project would provide opportunities to create sustainable improvements in their role and nursing leadership culture. Overall, a positive impact on nurse manager satisfaction and engagement may also positively impact staff morale and practice, as well as patient outcomes and satisfaction (Ning, Zhong, Libo, & Qiujie, 2009).

**Definition of Relevant Terms**

The following definitions are provided to ensure uniformity and understanding of these terms throughout the capstone project. This writer developed all definitions not accompanied by citation.

**Empowerment**: Ability to influence decisions that affect own work, exercise professional autonomy, and access information and resources necessary to be effective in their role (Leiter & Maslach, 2011).

**Marginalized**: Excluded from power groups, isolated with practice barriers and little influence.
**Oppressed group behaviors**: Powerless, exhibiting low self-esteem, self-silencing, passive-aggressive actions and characteristics (DeMarco et al., 2005).

**Assumptions**

For this capstone project, it was assumed that:

1. Each nurse manager answered all survey questions honestly and to the best of his or her abilities. The key to usefulness of survey data is truthfulness of response; participants must not lie inadvertently or intentionally (Brase & Brase, 2009).

2. All patient care leaders supported the participation of nurse managers in all associated activities. Participation in development opportunities is an ethical obligation for nurses at all levels (American Nurses Association, 2001). As servant leaders, patient care directors must discover and meet the needs of their employees (Hunter, 1998).

**Limitations**

One identified project limitation was the possibility of nurse manager perceptions being gender-influenced. The dominance of the historically patriarchal medical community over nursing, a predominantly female profession, is well documented (Dong & Temple, 2011). Men in nursing may view their work and practice environment through a lens influenced by gender-based experiences different from their female co-workers (Brown, 2009).

Generalizability was another limitation. As this project involved nurse managers in a rural health care system located in California, findings may not be predictive of nurse
managers in other settings or nurses at all levels. Finally, the positionality of this writer as an insider at the project site was a potential limitation (Moore, 2012). Every effort was made to maintain professional boundaries throughout the capstone project to reduce the risk of undue influence or coercion.

**Capstone Project Objectives**

The primary goal of this project intervention was to improve role satisfaction and engagement of nurse managers. Achievement of this goal was predicated upon the following two objectives: (1) facilitate nurse manager recognition of negative workplace behaviors as characteristics of oppressed groups; and, (2) apply therapeutic group process techniques to support nurse manager self-awareness and expression of liberation strategies. Through discovery and understanding of oppression, nurse managers may mitigate marginalization through empowerment (Freire, 2012; Hall, 1999).
CHAPTER 2. THEORETICAL FRAMEWORK AND LITERATURE REVIEW

Theoretical Framework

Three theories clarify and provide meaning to nurse manager engagement, empowerment, and satisfaction. First, Watson’s (2005) theory of human caring applies not only to nurse-patient relationships, but also nurse-nurse or other and nurse-self relationships. Caring for self, as applied to the nurse manager, includes hope for the future, authentic presence, developing trusting relationships, accepting positive and negative feelings, seeking innovative solutions, creating a healthy environment, and being open to the unexpected (Watson, 2005).

Next, Kanter’s structural empowerment theory defines empowerment as access to key criteria for effective performance, including information, support, resources, and opportunities to learn and develop professionally (Engstrom, Wadensten, & Haggstrom, 2010). Creating and sustaining an empowering professional practice environment has been found to improve nursing satisfaction (Casey et al., 2010; Engstrom et al., 2010; Gilbert, Laschinger, & Leiter, 2010; Ning et al., 2009). Empowered nurse managers report validation of professional role capabilities, confidence in developing their own leadership style, as well as empowerment of staff (MacPhee, Skelton-Green, Bouthillette, & Suryaprakash, 2012).

Finally, nursing has a long history of oppression based on fundamental submission to the authority of physicians (Daiski, 2004; DeMarco et al., 2005; Fletcher, 2006; Matheson & Bobay, 2007; Rather, 1994; Roberts et al., 2009). In Pedagogy of the Oppressed, Freire (2012) describes characteristics of oppressed groups, linking self-awareness to solution. Understanding the cycle of oppression through education and
critical self-reflection may lead to liberation from low self-esteem, self-silencing and other negative behaviors (Freire, 2012; Fletcher, 2006; Roberts et al., 2009).

Together these theories provided a framework for interceding with nurse managers exhibiting marginalized, self-silencing behaviors. In addition to trusting relationships, self-advocacy—the opposite of self-silencing—is fundamental to empowerment (Engstrom et al., 2010; Freire, 2012; Watson, 2005). Hope for the future, engagement in meaningful work and liberation from oppression all contribute to nurse manager satisfaction (Casey et al., 2010; Gianfermi & Buchholz, 2011).

**Summary of Relevant Research**

Review of the literature included searches of the following electronic databases: CINAHL Complete, ERIC, Ovid Nursing Full Text PLUS, ProQuest, PsycARTICLES, PsycINFO, PubMed and SocINDEX. In addition, one website was searched for relevant empirical evidence: Sigma Theta Tau Honor Society of Nursing, http://www.nursingsociety.org/. Limiting searches to scholarly, peer reviewed or refereed English publications, the following search terms were used singly and in combination: nurse manager, satisfaction, engagement, organization support, burnout, oppressed group behaviors, overcoming oppression, marginalized nurse leaders, and subjugated nurses.

The Johns Hopkins School of Nursing (n.d.) tool, Johns Hopkins Nursing Evidence Based Practice (JHNEBP), available in the public domain, was used to appraise strength and quality of research evidence. Each of the research studies reviewed here was conducted to generate knowledge or validate existing understanding of the characteristics
and impact of oppressed group behaviors or power inequities experienced by nurses around the world.

**Design**

Non-experimental studies focused on the impact, mitigation and measurement of oppressed group behaviors. Three studies examined the association between stressors, potential moderators and work engagement, work commitment and well-being as nurse leader outcomes (Kanste, 2011; Kath, Stichler, Ehrhart, & Schultze, 2013; Wong & Laschinger, 2013). Leiter and Maslach (2009) studied the burnout-engagement continuum, testing models predictive of turnover intentions; Suzuki et al. (2009) also explored connections between assertiveness and burnout. Warshawsky et al. (2012) examined effects of nurse manager interpersonal relationships on work engagement.

Casey et al. (2010) described the relatedness of empowerment to job satisfaction, DeMarco et al. (2005) studied writing as an intervention for self-esteem and silencing, and Gianfermi and Buchholz (2011) explored the relationship between nursing group outcome attainment and job satisfaction. Spence Laschinger et al. (2011) examined the influence of power and support perceptions on nurse manager retention. Quasi-experimental research utilized various surveys and questionnaires to measure empowerment and other leadership behaviors. Pedaline et al. (2012) assessed exemplary leadership practices; the effects of empowerment and oppressive group behaviors on job satisfaction and performance were evaluated in the remaining four studies (Chang et al., 2008; DeMarco et al., 2007; Engstrom et al., 2010; Lee et al., 2010).
Qualitative studies used interviews, focus groups, surveys and observations to explore perceived meaning and effects of powerlessness, burnout, disengagement and other negative behaviors associated with oppressed groups (Arman, Dellve, Wikstrom, & Tornstrom, 2009; Clark et al., 2012; Daiki, 2004; Freeney & Tiernan, 2009; Garon, 2012; MacPhee et al., 2012; Paliadelis, 2013; Paliadelis et al., 2007; Pannowitz et al., 2009; Parsons & Stonestreet, 2003; Rather, 1994; Sieloff & Bularzik, 2011; Upenieks, 2003). Three studies also integrated a feminist perspective (Paliadelis, 2013; Paliadelis et al., 2007; Pannowitz et al., 2009). Hartung and Miller (2013) focused on the contribution of communication patterns to health work environments and required nurse manager skill sets. Judkins, Reid, and Furlow (2006) conducted an exploratory pilot study on nurse manager job stress and hardiness; similarly, Shirey, Ebright and McDaniel (2013) explored critical thinking and decision making abilities related to stress among nurse managers. The final two pilot studies explored predictability of burnout (Maslach & Leiter, 2008) and co-creating a unique learning experience with nurse manager participants using action research methodology (Mackoff et al., 2013).

Overall, study designs and frameworks highlighted perceptions and effects of role power in nursing (Arman et al., 2009; Casey et al., 2010; Daiki, 20014; Chang et al., 2008; Kath et al., 2013; Paliadelis, 2013; Pannowitz et al., 2009; Pedaline et al., 2012; Sieloff & Bularzik, 2011; Upenieks, 2003), burnout (Kath et al., 2013; Leiter, & Maslach, 2009; Maslach & Leiter, 2008; Suzuki et al., 2009) and mitigating or liberating factors (Kath et al., 2013; Paliadelis, 2013; Suzuki et al., 2009; Warshawsky et al., 2012).
Informing this capstone project, study designs highlighted the significance of the cascading effect of leader behavior at all levels of the management hierarchy, including
support (Clarke et al., 2012; Freeney & Tiernan, 2009; Gianfermi & Buchholz, 2011; Hartung & Miller, 2013; Judkins et al., 2006; Mackoff et al., 2013; Shirey et al., 2013; Spence Laschinger et al., 2011), empowerment (DeMarco et al., 2005; Engstrom et al., 2010; Kanste, 2011; Leiter & Maslach, 2009; MacPhee et al., 2012; Shirey et al., 2013; Paliadelis et al., 2007; Rather, 1994; Spence Laschinger et al., 2011; Wong & Laschinger, 2013) and communication (DeMarco et al., 2007; Garon, 2012; Hartung & Miller, 2013; Lee et al., 2010; Maslach & Leiter, 2008; Parsons & Stonestreet, 2003; Shirey et al., 2013; Wong & Laschinger, 2013).

**Setting and Sample**

International concern for oppression in nursing is supported by studies conducted in Australia (Clarke et al., 2012; Paliadelis, 2013; Paliadelis et al., 2007; Pannowitz et al., 2009), Canada (Daiski, 2004; Lee et al., 2010; Leiter & Maslach, 2009; MacPhee et al., 2012; Spence Laschinger et al., 2011; Wong & Laschinger, 2013), Finland (Kanste, 2011), Ireland (Casey et al., 2010; Freeney & Tiernan, 2009), Japan (Suzuki et al., 2009), Sweden (Arman et al., 2009; Engstrom et al., 2010), Taiwan (Chang et al., 2008), as well as the United States (DeMarco et al., 2007; Garon, 2012; Gianfermi & Buchholz, 2011; Hartung & Miller, 2013; Mackoff et al., 2013; Maslach & Leiter, 2008; Pedaline et al., 2012; Shirey et al., 2013; Upenieks, 2003; Warshawsky et al., 2012). One study recruited participants from both Canada and the United States (Kath et al., 2013) and one identified study setting as North America (Maslach & Leiter, 2008). The remaining five studies did not disclose geographic location (DeMarco et al., 2005; Judkins et al., 2006; Parsons & Stonestreet, 2003; Rather, 1994; Sieloff & Bularzik, 2011).
Demonstrating that oppressive group behaviors are not limited to staff nurses, 25 of 33 studies reviewed included nurse managers (Arman et al., 2009; Casey et al., 2010; Clarke et al., 2012; Freeney & Tiernan, 2009; Garon, 2012; Gianfermi & Buchholz, 2011; Hartung & Miller, 2013; Judkins et al., 2006; Kanste, 2011; Kath et al., 2013; Lee et al., 2010; Leiter & Maslach, 2009; Mackoff et al., 2013; MacPhee et al., 2012; Paliadelis, 2013; Paliadelis et al., 2007; Pannowitz et al., 2009; Parsons & Stonestreet, 2003; Pedaline et al., 2012; Spence Laschinger et al., 2011; Shirey et al., 2013; Suzuki et al., 2009; Upenieks, 2003; Warshawsky et al., 2012). However, sample size was identified as a potential limitation. Arman et al. (2009) worked with 10 managers and Pannowitz et al. (2009) disclosed a sample size of eight nurse managers. While Kanste (2011) worked with a random sample of 435 nurses, only two percent were nurse managers; Hartung and Miller (2013) and Pedaline et al. (2012) worked with just six nurse managers. Garon (2012) and Kath et al. (2013) did not quantify how many of the nurse participants were managers, and DeMarco et al. (2007) identified that 47% of the 738 study participants with varying backgrounds were staff nurses without specifying the specific percentage of nurse managers.


Of the 25 studies including nurse managers, sample sizes varied most frequently between 17 and 33 nurse manager participants (Clarke et al., 2012; Freeney & Tiernan, 2009; Gianfermi & Buccholz, 2011; Leiter & Maslach, 2009; Mackoff et al., 2013; MacPhee et al., 2012; Paliadelis, 2013; Paliadelis et al., 2007; Parsons & Stonestreet, 2003; Shirey et al., 2013). Nurse manager participants represented urban, suburban, and public health systems; tenure in leadership role varied across research and was inconsistently reported.

**Intervention**

Nine studies included an intervention in their design. Six studies examined the effects of empowerment awareness and professional development through educational presentations (Chang et al., 2008; Clarke et al., 2012; Engstrom et al., 2010; Judkins et al., 2006; Lee et al., 2010; Mackoff et al., 2013). MacPhee et al. (2012) employed a combination intervention consisting of workshops with nurse manager mentoring and networking; Pedaline et al. (2012) assessed the effects of individual mentoring as an intervention with acute care nurse managers. DeMarco et al. (2005) explored reflective writing methodology in a facilitated group pilot aimed at creating a more positive professional identity, moving from powerless to empowered. While this study was not conducted in a work setting, upon completion of the experience, the graduate nursing student participants suggested that the intervention be made available to nurses in healthcare facilities (DeMarco et al., 2005).
**Measurement**

Thirteen studies employed more than one reliable measurement tool to evaluate outcomes (Casey et al., 2010; Chang et al., 2008; Engstrom et al., 2010; Gianfermi & Buchholz, 2011; Judkins et al., 2006; Kanste, 2011; Lee et al., 2010; Leiter & Maslach, 2009; Maslach & Leiter, 2008; Spence Laschinger et al., 2011; Suzuki et al., 2009; Warshawsky et al., 2012; Wong & Laschinger, 2013). In addition, Sieloff & Bularzik (2011) conducted their study to further refine and validate the Sieloff-King Group Power Assessment tool, while DeMarco et al. (2007) used one valid tool to determine the validity of another, known as the Silencing the Self Scale-Work (STSS-W) instrument. Pedaline et al. (2012) utilized one leadership practice inventory measure as a pre- and post-assessment, obtaining data from both study participants and identified participant observers.

Notably, three studies used both the Maslach Burnout Inventory (MBI) measure and the Areas of Worklife Survey (AWS) to assess workplace culture, introducing the concept of an engagement-burnout continuum in an attempt to evaluate empowerment and predict burnout (Lee et al., 2010; Leiter & Maslach, 2009; Maslach & Leiter, 2008). While Suzuki et al. (2009) did not integrate the AWS into their study, data were collected using the Japanese version of the MBI. The remaining studies utilized multiple verbal communication strategies to measure outcomes, including open-ended and broad interviews (Daiski, 2004; DeMarco et al., 2005; Hartung & Miller, 2013; MacPhee et al., 2012; Paliadelis, 2013; Paliadelis et al., 2007; Parsons & Stonestreet, 2003; Rather, 1994; Shirey et al., 2013; Upenieks, 2003), semi-structured “critical conversations” (Pannowitz...
et al., 2009), focus groups (Freeney & Tiernan, 2009; Garon, 2012), or a combination of strategies (Clarke et al., 2012; Mackoff et al., 2013). Arman et al. (2009) conducted structured observation; Pannowitz et al. (2009) also conducted observations and used ethnographer field notes in data collection and measurement.

Findings

Empowerment, defined by Lee et al. (2010) and Maslach and Leiter (2008) as the positive opposite of burnout, was explored as a primary theme and identified as essential to effective practice for nurses at all levels (Arman et al., 2009; Casey et al., 2010; Chang et al., 2008; Clarke et al., 2012; Daiski, 2004; DeMarco et al., 2005; DeMarco et al., 2007; Engstrom et al., 2010; Freeney & Tiernan, 2009; Garon, 2012; Gianfermi & Buchholz, 2011; Kath et al., 2013; MacPhee et al., 2012; Maslach & Leiter, 2008; Paliadelis et al., 2007; Pannowitz et al., 2009; Pedaline et al., 2012; Sieloff & Bularzik, 2011; Shirey et al., 2013; Spence Laschinger et al., 2011; Suzuki et al., 2009; Upenieks, 2003; Wong & Laschinger, 2013), as well as a key factor in job satisfaction (Casey et al., 2010; Chang et al., 2008; Daiski, 2004; Engstrom et al., 2010; Garon, 2012; Gianfermi & Buchholz, 2011; Pannowitz et al., 2009; Parsons & Stonestreet, 2003). Self-silencing behaviors of disempowered nurses are evidenced by their inability to advocate for self or others (Daiski, 2004; DeMarco et al., 2007; Garon, 2012; Pannowitz et al., 2009; Rather, 1994), which negatively impacts self-esteem (Clarke et al., 2012; DeMarco et al., 2005; Paliadelis et al., 2007), and the open communication environment necessary to sustain a culture of safety (Garon, 2012; Hartung & Miller, 2013; Shirey et al., 2013; Sieloff &
Bularzik, 2011; Wong & Laschinger, 2013). Kanste (2012) and Warshawsky et al. (2012) linked work engagement and effect of demands with the engagement-burnout continuum. Effective leadership depends on effective leadership development and administrative systems (Arman et al., 2009; Clarke et al., 2012; Hartung & Miller, 2013; Kath et al., 2013; Mackoff et al., 2013; MacPhee et al., 2012; Parsons & Stonestreet, 2003; Shirey et al., 2013; Spence Laschinger et al., 2011; Wong & Laschinger, 2013). Significantly impacting leadership abilities, powerlessness is further manifest in lack of organizational respect and support for goal achievement (Casey et al., 2010; Clarke et al., 2012; Freeney & Tiernan, 2009; Gianfermi & Buchholz, 2011; Mackoff et al., 2013; MacPhee et al., 2012; Paliadelis et al., 2007; Parsons & Stonestreet, 2003; Sieloff & Bularzik, 2011; Upenieks, 2003), avoidance of confrontation by nurses (DeMarco et al., 2007; Pannowitz et al., 2009), and normalization of power inequities and domination (Daiski, 2004; DeMarco et al., 2005; Freeney & Tiernan, 2009; Garon, 2012; Lee et al., 2010; Pannowitz et al., 2009; Rather, 1994). Of the six worklife domains—workload, control, reward, community, fairness, and values—Maslach and Leiter (2008) found perception of fairness in the work environment to be the determinant of engagement when studied over time.

Findings also included the importance of peer support and social networking among nurses (Clarke et al., 2012; Daiski, 2004; DeMarco et al., 2005; Freeney & Tiernan, 2009; Garon, 2012; Gianfermi & Buchholz, 2011; Judkins et al., 2006; Lee et al., 2010; Mackoff et al., 2013; MacPhee et al., 2012; Paliadelis et al., 2007; Pannowitz et al., 2009). Finally, the need for self-awareness of negative behaviors resulting from oppressive conditions was identified as the first step on the path to empowerment (Casey
et al., 2010; Clarke et al., 2012; Daiski, 2004; DeMarco et al., 2005; DeMarco et al.,
2007; Kath et al., 2013; Lee et al., 2010; MacPhee et al., 2012; Paliadelis et al., 2007;
Pannowitz et al., 2009; Rather, 1994). When those subjugated acknowledge their
experience, empowerment is possible.

Among mitigating factors identified to support liberation, providing education
was identified as a key to overcoming oppression, whether offered in a group setting
(Clark et al., 2012; Chang et al., 2008; Engstrom et al., 2010; Judkins et al., 2006; Lee et
al., 2010; Mackoff et al., 2013), through individual mentoring encounters (Pedaline et al.,
2012), or a blended methodology using both group and individual support sessions
(DeMarco et al., 2005; MacPhee et al., 2012). Reflective writing has also been explored
as a facilitated group intervention aimed at creating a more positive professional identity
and moving from powerless to empowered (DeMarco et al., 2005). Most of the remaining
group or blended interventions reflected structured leadership education programs
primarily focused on empowerment (Chang et al., 2008; Clarke et al., 2012; Engstrom et
al., 2010; Judkins, et al., 2006; Lee et al., 2010; MacPhee et al., 2012).
CHAPTER 3. CAPSTONE PROJECT DESIGN

**Project Design and Description**

Following a leadership laboratory design (Mackoff et al., 2013), this project posited that nurse managers may overcome their current state of oppression through group exploration of perception and process changes (Freire, 2012). Upon approval from project site and academic institutional review boards, project information and voluntary consent documentation were provided to 22 eligible nurse managers and email follow-up was conducted to answer questions. Eleven nurse managers submitted signed consents; ten participated in all four monthly intervention groups with one nurse manager absent from both the third and final sessions.

A valid and reliable pre-assessment survey tool, de-identified to protect anonymity and confidentiality, was distributed to participants and non-participants. Using a human-centered design approach, nurse manager participants in this capstone project were engaged in co-creating group session schedules and content topic prioritization (Craig, 2012; Friess, 2010; Steen, 2012). Nurse managers met in a facilitated group session for 90 minutes monthly over a four month timeframe, scheduled in advance according to group consensus. Group sessions were held at the main medical center campus in the early afternoon, included refreshments and were agenda-driven with group activities, discussion and education materials. A formative evaluation was conducted at the end of each session; summative evaluation was completed by repeating the AWS pre-assessment survey three months after the final group session.
Rationale for Design Framework

Research related to nurse leader work life and satisfaction demonstrates that in addition to senior leader support, engagement of those affected by change is an important requirement for success. Using a theory-based model to guide the change process ensures inclusion and needs assessment of all identified participants and other key stakeholders. Additionally, addressing resistance and providing ongoing clear communication of progress and outcomes is essential to the sustainability of change.

Lippitt’s Change Theory

Providing effective assistance to nurse managers requires intentional and goal-directed planned change (Mitchell, 2013; Ziegler, 2005). Lippitt’s change theory guided development of structures and processes to support this capstone project’s goal and move nurse managers in a new direction (Gareis, 2010; Shanley, 2007; Stichler, 2013; Ziegler, 2005). Founded in a helping relationship, Lippitt’s model defines seven phases facilitated by an identified change agent that emphasize communication and feedback, group work, and emotional impact (Lehman, 2008; Mitchell, 2013; Shanley, 2007; Stichler, 2013; Ziegler, 2005). As needed, Lippitt’s theory allows freedom of movement back and forth between each of the following phases: diagnose problem, assess change capacity, assess change agent’s motivation and resources, develop objectives, define change agent role, maintain change, and terminate helping relationship (Mitchell, 2013; Ziegler, 2005).

Leadership Laboratory

A group setting is an effective vehicle for change when leaders successfully integrate interpersonal dynamics with group objectives and individual member needs.
(Bernard et al., 2008). Establishing group behavior expectations, a collaborative, facilitated process, assesses initial group dynamics and helps mitigate anxiety (Interaction Associates, 1997). The group will change over time, evolving as identified constituent needs are met and new issues may be discovered (Bernard et al., 2008). Time for individual reflection is also a therapeutic consideration for advancing positive self-image and empowerment.

Mackoff et al. (2013) developed a leadership laboratory to support nurse manager needs through perspectives of lived experiences and appreciative inquiry. In addition to elements of peer coaching, the intervention was grounded in adult learning principles and included participant input. Feedback from the study’s 33 nurse manager participants was incorporated in leadership laboratory design and development through action research methodology. The conceptual framework and format of Mackoff et al.’s evidence-based solution effectively addressed the capstone practice problem identified for this project and resonated with this writer.

**Human Centered Design**

Steen (2012) describes the core principles of human-centered design (HCD) as creating an atmosphere of user-centered appreciation to explore practices and needs through development of an inclusive team and organized approach to innovation. HCD requires group facilitator to acknowledge and mitigate inherent self/background biases, opening a connection to other (i.e., participants). This model supports creating a connection and understanding that encourages partnership in conducting research and the processes of discovery, innovation implementation and evaluation (Friess, 2010; Steen,
HCD applied to insider positionality of group facilitator as well as need for participant engagement in group sessions.

**Facilitative Leadership**

Finally, while the initial configuration of group sessions remained loose to invite nurse manager input, Facilitative Leadership® (Interaction Associates, 1997) methodology provided structure to enhance group leader effectiveness, using tools and training designed to maximize participant involvement. Prospective subject matter would be decided collaboratively based on nurse manager input and consensus, consideration of unmet needs, group and individual goals. The key to successful implementation would be encouraging nurse managers to remain open to innovative possibilities and to translate these into their own lived experiences (Mackoff et al., 2013). Formative feedback is encouraged using a plus/delta debriefing format whereby participant input is used to reinforce what works as well as suggest change (Interaction Associates, 1997).

**Capstone Project Intervention**

Mackoff et al. (2013) employed an outside consultant to facilitate leadership laboratory group sessions; however, this writer is experienced with group facilitation. With a professional background in facilitating group therapy as a psychiatric nurse, years of experience providing group education for nurses at all levels as a clinical educator, training in Facilitative Leadership® (Interaction Associates, 1997) and nursing education focus in graduate school, this writer was both comfortable and competent to facilitate interventional group sessions with nurse managers.
Appreciative Inquiry

Structure and content of interventional groups was specific to lived experiences and unmet needs of participant nurse managers (Mackoff et al., 2013). Rather than contributing further to an already negative problem-focused culture, exploring change opportunities using an appreciative inquiry process established a positive mindset and encouraged engagement (Richer, Ritchie, & Marchionni, 2010). Throughout its four phases—discovery, dream, design, and destiny—appreciative inquiry shifts emphasis from restrictive limitations to the possibilities of change (Havens, Wood, & Leeman, 2006; Richer et al., 2010). Aligned with capstone project goals, this methodology focuses on collaboration and creating shared meaning through discovery and understanding of self and social culture (Benson & Dresdow, 2008).

Similar to the learning lab action research methodology piloted by Mackoff et al. (2013), appreciative inquiry is grounded in facilitator-participant partnership. In the discovery phase, capstone participant nurse managers were guided to reflect backward on past experiences, inward to explore meaning of those experiences, and forward to imagine innovative solutions built on past positive experiences (Benson & Dresdow, 2008; Havens et al., 2006). Participant activity and discussion included envisioning a future positive state (dream phase) and generating ideas to co-construct this desired future (design phase); the objective of destiny, then, is sustaining change through empowerment and continued reflection (Havens et al., 2006; Richer et al., 2010). Principles of appreciative inquiry were used to prompt channeling of nurse manager energy toward creating and sustaining a positive professional image (Benson & Dresdow, 2008; DeMarco et al., 2005; Tuckey, Bakker, & Dollard, 2012).
**Summary of Group Sessions**

Held on April 10, 2014, the first session focused on nurse manager understanding of capstone project as well as participant co-creation of group session structure and process. An overview of confidentiality ground rules, data triggering capstone project and a brief summary of evidence supporting group session intervention was presented. Activities included participant identification of concerns and challenges written on sticky notes and sorted by AWS categories on poster paper displayed around the conference room. Group discussion included defining hallmarks of oppression; connections to the literature included article and self-directed reflective exercise on identifying oppression (Dubrosky, 2013). Formative group feedback was positive and hopeful for creating actionable change through future group session activity and education.

The second 90 minute group session, held on May 15, 2014, opened with review of assigned reading and reflection from previous month. Information on appreciative inquiry principles and application were shared, including individual note cards with model components and prompts to support appreciation as a language of understanding (Richer et al., 2010). Next, participants prioritized challenges shared during first session. Using appreciative inquiry principles, discussion and group activity included describing the desired future of at least one identified challenge and envisioning a plan for structural or procedural change. Education included two articles linking nurse manager efficacy, engagement and role satisfaction to “finding voice” (Hudek, 2012; Warshawsky & Havens, 2014). Plus/delta group feedback did not elicit suggestions for change to group
format or process; group consensus indicated discussion, activities and education was “on track” with identified needs.

After reviewing articles from previous month, the third group session, held on June 12, 2014, centered on group members developing actionable plan around identified top priority. Aligned with HCD, a World Café format was used to guide activity and discussion—encouraging innovation and maximizing participant engagement (Burke & Sheldon, 2010). Three “café” topics focused on joy at work (Midddaugh, 2014), linking behavior to professional relationships (Frisina & Frisina, 2011), and accountability (O’Connor, Kotze, & Wright, 2011). Discussion centered on common themes of communication, relationships and accountability as nurse managers shared perceptions of self, senior leaders and organizational culture. Accountability and self-awareness were demonstrated through discussion and resulting action plan on priority challenge. Plus/delta feedback was conducted with no change suggested. No return response was received after email follow-up with absent participant.

The final group session was held on July 17, 2014. Success of the action plan developed in sessions two and three was described by three nurse manager participants accountable for implementation, reinforcing appreciative inquiry principles and empowerment. A self-reflective activity focused participants on self-identification of strengths using What I Do Best cards (Gallup, 2008). Discussion included review of thematic World Café responses from previous session, overview of challenges identified in session one, connection between appreciative inquiry approach and perceptions of finding voice for self and other advocacy. Rath and Harter’s (2010) Five Essential Elements of Wellbeing was presented as a final educational element to support thriving
both professionally and personally. The concluding formative feedback indicated consensus desire to continue group sessions in the future. Participants suggested opening including all nurse managers in professional development to resolve challenges, improve the leadership culture and role satisfaction.

**Assessment Tool**

Engagement encompasses the multifaceted dimensions of job satisfaction, commitment, and involvement (Maslach & Leiter, 2008). Improvement through change is possible when individuals’ concerning issues are recognized and confronted with willingness to explore alternatives (Lippitt & Schmidt, 1967; Ziegler, 2005). The summative evaluation, designed to measure impact of change related to a completed program on participants or an organization (Wilson, Crockett, & Curtis, 2002), was conducted using a valid and reliable tool, the Areas of Worklife Survey (AWS) (Leiter & Maslach, 2011). This survey is a tested strategy for targeting intervention structures and processes (Maslach, Leiter, & Jackson, 2012). Overall, the six dimensions assessed through the survey provide data reflecting participant perception of professional autonomy, empowerment, recognition, fairness, educational opportunities, trust, working relationships, respect, and input into decisions (Lee et al., 2010; Leiter & Maslach, 2000; Maslach & Leiter, 2008; Maslach et al., 2012).

The AWS has been used with nurse managers in health care settings; licensing and necessary permission were purchased from the survey publisher, Mind Garden (Leiter & Maslach, 2000). For this capstone project, a paper survey requiring handwritten responses was distributed prior to group session initiation and three months after final
group was conducted. Anonymity was protected through creation of a unique code known only to individual survey respondents. Participant surveys were also color coded to distinguish from non-participants as well as pre- and post-assessments. Raw data from pre- and post-assessment surveys were transcribed to a spreadsheet and converted to “adjusted scores” according to reverse scoring key provided by survey vendor. Adjusted scores were then used in data analysis.

Statistically, the AWS was developed to assess job-person fit (match versus mismatch) based on the six dimensions measured (Leiter & Maslach, 2000). Survey respondents are asked to rate their perception of job congruence with regards to workload, control, reward, community, fairness and values. The expected outcome of this capstone project would be evidenced by improved AWS scores when comparing pre- and post-intervention survey results.

Other Evaluative Strategies

A formative evaluation process was also employed to collect participant feedback at the conclusion of each group session. Facilitative Leadership® encourages a plus/delta debriefing methodology to identify specific positives and opportunities for change to improve the next group experience (Interaction Associates, 1997). This process is a brief cooperative exercise of verbal exchange among the participants with the group facilitator functioning as both guide and scribe. Project modifications were implemented based on nurse manager feedback, ensuring continuous improvement and focus on high impact issues. Participant feedback was positive overall, including expressions of appreciation for refreshments, which ranged from beverages, fruit, and snacks provided at each group session.
session to the full lunch served at final session. Participants, individually and as a group, shared feelings of perceived organizational support based on capstone project focus and intervention depth and breadth.
Results

Data in this report were compiled from the pre- and post-AWS surveys. This study sampled 21 nurse managers from a rural California health system. Of the sample population, 11 voluntarily consented to participate in a monthly group session intervention over four months; one participant did not return the post-intervention survey. Ten non-participant nurse managers completed both the pre- and the post-assessment survey. In order to preserve confidentiality of small sample population and participant group, nurse manager characteristics and demographics were intentionally omitted.

Descriptive Statistics

Table 1 displays the descriptive statistics for the capstone pre- and post-AWS dimension scores by subscale. Each dimension has a range of 4.00, from 1.00 (Extreme Mismatch) to 5.00 (Extreme Match), with a midpoint of 3.00 (Leiter & Maslach, 2011). Using the AWS to assess nurse manager (n=86) perceptions before and after a leadership development initiative, Lee et al. (2010) found mean scores across all six worklife dimensions showed a slight downward trend, but no statistical significant change was demonstrated. Both pre-and post-intervention, AWS mean scores for congruence of Values were closest to a complete Match and Workload scores were closest to a complete Mismatch (Lee et al., 2010).

Notably, as illustrated in Figure 1, the capstone pre-AWS mean scores for Workload and Fairness are towards the Mismatch end of the scale. Control, Reward, Community and Values are toward the Match end of the scale. The mean of Values is
closest to a complete Match, and Workload is closest to a complete Mismatch. The mean of Reward is closest to the midpoint. In post-AWS mean scores, there is a slight upward trend for Workload, Control, Community and Fairness, while Reward and Values demonstrate a slight downward trend. Reward shifts towards the Mismatch end of the scale and remains closest to the midpoint; all other subscale summaries remain essentially the same.

Table 1.

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Workload</td>
<td>2.160</td>
<td>.505</td>
</tr>
<tr>
<td>Control</td>
<td>3.539</td>
<td>.732</td>
</tr>
<tr>
<td>Reward</td>
<td>3.012</td>
<td>.864</td>
</tr>
<tr>
<td>Community</td>
<td>3.370</td>
<td>.714</td>
</tr>
<tr>
<td>Fairness</td>
<td>2.666</td>
<td>.686</td>
</tr>
<tr>
<td>Values</td>
<td>4.250</td>
<td>.550</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Workload</td>
<td>2.270</td>
<td>.751</td>
</tr>
<tr>
<td>Control</td>
<td>3.776</td>
<td>.996</td>
</tr>
<tr>
<td>Reward</td>
<td>2.912</td>
<td>.844</td>
</tr>
<tr>
<td>Community</td>
<td>3.550</td>
<td>.722</td>
</tr>
<tr>
<td>Fairness</td>
<td>2.908</td>
<td>.854</td>
</tr>
<tr>
<td>Values</td>
<td>4.200</td>
<td>.582</td>
</tr>
</tbody>
</table>

*Note. M=mean, SD=standard deviation.*
Figure 1. Pre- and Post-Intervention Mean Subscale Score for the AWS.

Compared with the normative sample of over 22,000 respondents (Leiter & Maslach, 2011), the positive correlation among pre-AWS subscales for Control and Reward, Control and Fairness, Control and Values, Reward and Fairness is stronger among capstone project nurse managers. Table 2 shows the pre-AWS correlation matrix. Post-AWS positive correlations among the subscales for nurse manager capstone participants are stronger than the normative sample in all five Workload subscales, Reward and Community, Community and Fairness, Community and Values, and Fairness and Values (Leiter & Maslach, 2011). Table 3 shows the post-AWS correlation matrix. Notably, there are stronger significant correlations between the subscale dimensions on the post-intervention correlation matrix.
Table 2.

*Pre-Intervention Correlation between AWS Subscales (N = 20)*

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Workload</th>
<th>Control</th>
<th>Reward</th>
<th>Community</th>
<th>Fairness</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workload</td>
<td>.091</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>.538*</td>
<td>.015</td>
<td>.038</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reward</td>
<td>.090</td>
<td>.538*</td>
<td>.496*</td>
<td>.274</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>.279</td>
<td>.015</td>
<td>.038</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fairness</td>
<td>.164</td>
<td>.572**</td>
<td>.496*</td>
<td>.274</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Values</td>
<td>.440</td>
<td>.368</td>
<td>.236</td>
<td>.263</td>
<td>.305</td>
<td></td>
</tr>
</tbody>
</table>

**p < .01, two-tailed  
*p < .05, two-tailed

Table 3.

*Post-Intervention Correlation between AWS Subscales (N = 20)*

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Workload</th>
<th>Control</th>
<th>Reward</th>
<th>Community</th>
<th>Fairness</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workload</td>
<td>.455</td>
<td>.330</td>
<td>.299</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>.433</td>
<td>.605**</td>
<td>.500*</td>
<td>.572**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reward</td>
<td>.817**</td>
<td>.640**</td>
<td>.408</td>
<td>.473*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>.259</td>
<td>.673**</td>
<td>.408</td>
<td>.473*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fairness</td>
<td>.231</td>
<td>.605**</td>
<td>-.009</td>
<td>.500*</td>
<td>.572**</td>
<td></td>
</tr>
</tbody>
</table>

**p < .01, two-tailed  
*p < .05, two-tailed

Inferential Statistics

Ten of the 11 consented nurse managers completed all four monthly group sessions as the capstone project supportive and educational intervention. One participant nurse manager did not attend the final two sessions; one participant did not complete a post-AWS survey.
Is there a statistically significant difference on the workload dimension of the AWS between pre-and post-intervention session?

A paired samples $t$ test was conducted to determine a significant difference on the worklife dimension between pre-and post-intervention session. A paired samples $t$ test indicated no significant difference on the worklife dimension between pre- ($M = 2.160$, $SD = .505$) and post-intervention session ($M = 2.270$, $SD = .751$), $t(19) = .614$, $p = .547$.

Is there a statistically significant difference on the control dimension of the AWS between pre-and post-intervention session?

A paired samples $t$ test was conducted to determine a significant difference on the control dimension between pre-and post-intervention session. A paired samples $t$ test indicated no significant difference on the control dimension between pre- ($M = 3.539$, $SD = .732$) and post-intervention session ($M = 3.776$, $SD = .996$), $t(18) = 1.295$, $p = .212$.

Is there a statistically significant difference on the reward dimension of the AWS between pre-and post-intervention session?

A paired samples $t$ test was conducted to determine a significant difference on the reward dimension between pre-and post-intervention session. A paired samples $t$ test indicated no significant difference on the reward dimension between pre- ($M = 3.012$, $SD = .864$) and post-intervention session ($M = 2.912$, $SD = .844$), $t(19) = -.441$, $p = .664$. 
Is there a statistically significant difference on the community dimension of the AWS between pre-and post-intervention session?

A paired samples t test was conducted to determine a significant difference on the community dimension between pre-and post-intervention session. A paired samples t test indicated no significant difference on the community dimension between pre- ($M = 3.370, SD = .714$) and post-intervention session ($M = 3.550, SD = .722$), $t(19) = 1.060, p = .302$.

Is there a statistically significant difference on the fairness dimension of the AWS between pre-and post-intervention session?

A paired samples t test was conducted to determine a significant difference on the fairness dimension between pre-and post-intervention session. A paired samples t test indicated no significant difference on the fairness dimension between pre- ($M = 2.666, SD = .686$) and post-intervention session ($M = 2.908, SD = .854$), $t(19) = 1.902, p = .073$.

Is there a statistically significant difference on the values dimension of the AWS between pre- and post-intervention session?

A paired samples t test was conducted to determine a significant difference on the values dimension between pre-and post-intervention session. A paired samples t test indicated no significant difference on the values dimension between pre- ($M = 4.250, SD = .550$) and post-intervention session ($M = 4.200, SD = .582$), $t(19) = -.444, p = .662$.

Of the convenience sample of 22 eligible nurse managers offered an opportunity to participate in the capstone intervention group sessions, 11 voluntarily consented to
become participants and attend 90 minute group sessions once monthly over four months. One participant did not return a post-AWS survey.

**Is there a statistically significant difference on the workload dimension of the AWS between intervention participants and non-participants?**

An independent samples $t$ test was conducted to determine a significant difference on the workload dimension between intervention participants and non-participants. An independent groups $t$ test indicated no significant difference on the workload dimension between intervention participants ($M = 2.342, SD = .529$) and non-participants ($M = 2.090, SD = .529$), $t(39) = 1.301, p = .201$.

**Is there a statistically significant difference on the control dimension of the AWS between intervention participants and non-participants?**

An independent samples $t$ test was conducted to determine a significant difference on the control dimension between intervention participants and non-participants. An independent groups $t$ test indicated no significant difference on the control dimension between intervention participants ($M = 3.462, SD = .791$) and non-participants ($M = 3.787, SD = .929$), $t(38) = -1.191, p = .241$.

**Is there a statistically significant difference on the reward dimension of the AWS between intervention participants and non-participants?**

An independent samples $t$ test was conducted to determine a significant difference on the reward dimension between intervention participants and non-participants. An independent groups $t$ test indicated no significant difference on the reward dimension
between intervention participants ($M = 3.023, SD = .865$) and non-participants ($M = 2.875, SD = .821$), $t(39) = .564, p = .576$.

Is there a statistically significant difference on the community dimension of the AWS between intervention participants and non-participants?

An independent samples $t$ test was conducted to determine a significant difference on the community dimension between intervention participants and non-participants. An independent groups $t$ test using the homogeneity of variances correction indicated no significant difference on the community dimension between intervention participants ($M = 3.600, SD = .489$) and non-participants ($M = 3.320, SD = .869$), $t(29.65) = 1.262, p = .217$.

Is there a statistically significant difference on the fairness dimension of the AWS between intervention participants and non-participants?

An independent samples $t$ test was conducted to determine a significant difference on the fairness dimension between intervention participants and non-participants. An independent groups $t$ test indicated no significant difference on the fairness dimension between intervention participants ($M = 2.873, SD = .752$) and non-participants ($M = 2.708, SD = .788$), $t(39) = .684, p = .498$.

Is there a statistically significant difference on the values dimension of the AWS between intervention participants and non-participants?

An independent samples $t$ test was conducted to determine a significant difference on the values dimension between intervention participants and non-participants. An
independent groups $t$ test using the homogeneity of variances correction indicated no significant difference on the values dimension between intervention participants ($M = 4.202, SD = .400$) and non-participants ($M = 4.275, SD = .697$), $t(29.98) = -.406, p = .687$.

**Summary**

There were no significant differences on AWS dimensions between pre- and post-intervention session. There were no significant differences on AWS dimensions between participants and non-participants.
CHAPTER 5. IMPLICATIONS AND CONCLUSIONS

Implications for Practice

A key practice implication was identified by nurse managers through the formative evaluation process—participants requested inclusion of nurse manager peers from across the organization in a continuation of facilitated group sessions. As evidenced by consistent group attendance, active engagement and action plan success, the capstone intervention structure and process was well-received and successful in providing organizational support to mid-level nursing leaders. In addition to sustaining nurse manager group sessions, senior and executive organizational leaders should be made aware of nurse manager perceptions and experiences related to normalization of oppression through capstone project overview and findings.

Other practice implications are reflective of the benefits of a global educational intervention to support leaders at all levels developing high-level skills related to inspiring shared vision, and empowering and encouraging subordinates and peers (Selcer, Goodman, & Decker, 2012). Aligning leadership teams using new mental models for strategic challenges may assist complex systems approach change (Stevenson, 2012). Rather than a problem-focused approach applied to challenges and solution-seeking, appreciative inquiry adapts a positive psychology approach to explore what works well in the present and has been successful in the past (Billings & Kowalski, 2008; Seligman & Csikszentmihalyi, 2000). Transformational leaders focus on maximizing individual and group strengths, creating opportunities for synergy and collaboration to enhance overall performance and outcomes of systems and processes. Hosting an appreciative inquiry
workshop for the entire organizational leadership team would create an opportunity for enhancing individual skills, team building, and creative solution-seeking.

**Summary of Outcomes as Related to Evidence-Based Practice**

While no statistical significance was demonstrated in pre- and post-assessment survey scores, either between participants and non-participants or within the participant group, the impact of intervention sessions allowed respondents to see connection between the worklife dimensions assessed. Similar to the findings of Lee et al. (2010) and Mackoff et al. (2013), capstone group sessions provided a safe and supportive forum for nurse managers to strengthen peer relationships and apply positive leadership principles to worklife concerns. Based on formal and informal participant feedback, the value of recognizing characteristics of oppressive leadership normalization and broadening from a local to global perspective, through shared literature review related to disempowerment and self-silencing in nursing around the world, should not be underestimated (Garon, 2012; Paliadelis et al., 2007; Pannowitz et al., 2009).

Notably, significant and unforeseen organizational events may have confounded project outcomes. Between project inception and conclusion, the CNO unexpectedly retired, two other members of the executive team retired and resigned, and physician feedback to the board of directors and executive team identified dissatisfaction with nursing leadership.

**Conclusions**

Every leader is responsible for the organizational culture and creating a healthy work environment starts at the top, with senior leaders (Hartung & Miller, 2013; Spence
Laschinger et al., 2011). Nurse managers identified poor communication as a significant barrier to achieving professional goals and role responsibilities. Feeling disempowered, nurse managers silenced themselves to avoid conflict. Creating an ideal work environment, a cornerstone goal established by the board of directors and executive team, must be applied equitably throughout the organization—not just to staff, but to leaders as well.

Through an evidence-based practice project intervention, appreciative inquiry was introduced as a new way of looking at the same old problems—Vuja De (Kelley & Littman, 2005). Involving a paradigm shift away from the traditional problem-oriented perspective, appreciative inquiry compels leaders to envision the transformation of what is to what may be possible (Cooperrider & Srivastva, 1987). While the project intervention group sessions fostered a supportive community for learning and discussion, there were no significant differences between pre- and post-intervention assessment across AWS dimensions and no significant differences on AWS dimensions between participants and non-participants. Ultimately, as the initial data trigger for this capstone project, results from the biennial employee partnership survey in May 2015 will provide nurse manager work group comparison data for further study.
REFERENCES


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APPENDIX A. STATEMENT OF ORIGINAL WORK

Academic Honesty Policy

Capella University’s Academic Honesty Policy (3.01.01) holds learners accountable for the integrity of work they submit, which includes but is not limited to discussion postings, assignments, comprehensive exams, and the dissertation or capstone project.

Established in the Policy are the expectations for original work, rationale for the policy, definition of terms that pertain to academic honesty and original work, and disciplinary consequences of academic dishonesty. Also stated in the Policy is the expectation that learners will follow APA rules for citing another person’s ideas or works.

The following standards for original work and definition of plagiarism are discussed in the Policy:

Learners are expected to be the sole authors of their work and to acknowledge the authorship of others’ work through proper citation and reference. Use of another person’s ideas, including another learner’s, without proper reference or citation constitutes plagiarism and academic dishonesty and is prohibited conduct. (p. 1)

Plagiarism is one example of academic dishonesty. Plagiarism is presenting someone else’s ideas or work as your own. Plagiarism also includes copying verbatim or rephrasing ideas without properly acknowledging the source by author, date, and publication medium. (p. 2)

Capella University’s Research Misconduct Policy (3.03.06) holds learners accountable for research integrity. What constitutes research misconduct is discussed in the Policy:

Research misconduct includes but is not limited to falsification, fabrication, plagiarism, misappropriation, or other practices that seriously deviate from those that are commonly accepted within the academic community for proposing, conducting, or reviewing research, or in reporting research results. (p. 1)

Learners failing to abide by these policies are subject to consequences, including but not limited to dismissal or revocation of the degree.
Statement of Original Work and Signature

I have read, understood, and abided by Capella University’s Academic Honesty Policy (3.01.01) and Research Misconduct Policy (3.03.06), including the Policy Statements, Rationale, and Definitions.

I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the APA *Publication Manual.*

Learner name and date

Mary Laufer / November 14, 2014

Mentor name and school

Dr. JoAnn Manty, Capella University