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Leadership Practices of Veterans Health Administration Nurse Executives:
An Exploration of Current Practices and Professional Development Needs

A dissertation
presented to
the faculty of the Department of Educational Leadership and Policy Analysis
East Tennessee State University

In partial fulfillment
of the requirements for the degree
Doctor of Education

by
Virginia Holt Bieber
December 2003

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Keywords: Nurse Leadership, Nurse Executive, Healthcare Administration, Professional Development, Leadership Practices Inventory, Transformational Leadership

ABSTRACT

Leadership Practices of Veterans Health Administration Nurse Executives:
An Exploration of Current Practices and Professional Development Needs

by

Virginia Holt Bieber

Transformational leadership has been linked to improved organizational performance and has been recognized as a possible solution to the challenges in Health Care. The role of Nurse Executives (NE) has become an influential leadership position in Health Care Organizations (HCO) and a factor in improving HCO. The purpose of this research was to explore self-reported leadership practices of Veterans Health Administration (VHA) Medical Center NEs, examine leadership strengths of the NEs, and report professional development needs of the NEs.

The study population consisted of NEs employed in the Veterans Affairs Medical Centers (VAMC's) throughout the United States. The Leadership Practices Inventory (LPI) Self-assessment by Kouzes and Posner (2001) was the survey instrument. A letter eliciting participation and a web page address containing the LPI was emailed to the NEs. The survey was completed via the web and submitted electronically. Seventy-seven (55%) of the NEs participated in the study.

The results indicate the VHA NEs in this study are using transformational leadership practices regularly. Self-reported leadership practices of this population of NEs indicate that they are engaged in the five leadership practices of challenging the process, inspiring a shared vision, enabling others to act, modeling the way, and encouraging the heart. The NE strengths are enabling others to act, modeling the way, and encouraging the heart. They scored slightly lower in challenging the process and inspiring a shared vision. The self-reported LPI scores of the NE

in this study were statistically significantly higher than the leaders in Kouzes and Posner's research (2002b).

The NEs were asked to identify the five most essential leadership skills of exemplary NE. The results indicate professional development for NE should include: transformational leadership skills, financial skills, organization skills, and personnel management skills. Incorporating these skills into a professional development program for NE could be a starting point to improving organizational performance of HCOs.

The results of this research provide insight into current NE leadership practices and the professional development needs of NEs, which may lead to the development of a model for professional leadership training for NEs.

DEDICATION

This work is dedicated to my mother, Judith A. Holt, and my late grandmother, Mayme F. Holt. From their vision, wisdom, humble spirit, noble character, and encouragement, I discovered at an early age that life is a journey in learning. Thanks to these inspiring women I have and will continue to pursue a life long learning journey.

This work would not have been possible without the support, encouragement, and wise counsel of Jeff Bieber, my husband. His humble spirit and kind heart have taught me much about life.

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CHAPTER 1

INTRODUCTION

Experts in the health care industry agree that health care systems in the United States are fraught with problems and are being faced with new challenges. The primary focus of the health care debate centers on cost, access, and quality of care (Sultz & Young, 2001). The major dilemma in health care has been an increased demand by consumers for quality health care services and an increase in the cost of providing quality health care services (Griffith, 1995). At the same time, health care organizations have been faced with the task of controlling cost while providing access to care (Dwore, Murray, Fosbinder, & Parsons, 2000). With the demand to provide more services and improve quality of care with fewer resources, hospitals have had to make drastic changes in managing and providing patient care (Nagaike, 1997). Health care organizations have been challenged to improve overall organizational performance, decrease costs of services provided, meet customer expectations of quality, demonstrate positive clinical outcomes, and indicate financial status (Plsek, 1995).

Health care is a business that impacts everyone. According to Sultz and Young (2001), health care “consumes almost 14 percent of the United State’s gross domestic product and now exceeds one trillion in costs” (p.1). Health care has become extremely complex. The major players include providers, policy makers, managed care organizations, and third-party payers.

“Change has been the one constant in health care in the United States in the 1990s” (Chow, Coffman, & Morjikian, 1999, p. 291). Just what to change has caused much philosophical and political debate. Questions on how to solve the universal health care dilemmas continue to go unanswered and may never be solved because of the complexity of providing health care. Meanwhile, health care organizations strive to stay current, reorganize, and compete in the health care market.

Health care institutions have been undergoing major transformations, and over the past decade these institutions have been impacted in numerous ways including restructuring, redesigning, and reorganizing (Beyers, 1999). Drivers in the restructuring of the health care industry include resource shifts, quality improvement initiatives, financing changes, development of new technology, and methods of communication (Beyers; Griffith, 1995). Another driver that has impacted the health care industry has been the investor-owned health care delivery organization. These are entities with a profit-seeking motive (Salmon, 1995). These drivers and others are changing the way health care organizations operate. Lutz, Grossman, and Bigalke (1998) noted that organizations must learn to manage capital, information, risk, and government regulations. When this management is done effectively, health care organizations can achieve operational efficiency and prevail in the health care market.

Lutz et al. (1998) suggested that there are two phases to the reorganization of health care. "The first is to consolidate providers to control markets, cost, and quality. The second, perhaps more crucial, phase is to make the delivery of patient care services work" (p.1). Major obstacles such as a lack of resources, a decrease in workforce, and an increasingly complex patient population must be overcome in order to deliver quality health care. To meet the needs of the patients and deal with the changes impacting health care, organizations have been revising the services offered to patients (Chow et al. 1999).

The health care industry has been changing and evolving since its inception, and it continues to reform. Morrison (2000) suggested that the lack of leadership was the largest issue facing health care organizations. The health care industry has been known for inadequate business principles such as a lack of communication, vision, and planning (Lutz et al., 1998). Health care organizations have changed their focus from management to leadership, modeling organizations in the business sector. The whole environment within health care organizations has changed. The health care industry has moved away from a traditional multi-layer hierarchy or bureaucracy to a horizontal organization (Alexander, 1997). In an attempt to improve, health care

organizations have implemented new approaches such as quality improvement and patient centered care. These approaches welcome and use employee involvement (Klakovich, 1994). At the same time, the new approaches create the need for leadership during health care reform. Morrison suggested that health care organizations are in need of leadership. As health care organizations strive to improve organizational performance much of the responsibility for redesign of the health care organization, leadership, and management responsibilities has fallen on the nurse (Brooks, 1999). The need for effective Nurse Executive leadership exists in health care systems (Dwore et al., 2000).

Along with the restructuring of health care organizations, the job titles and responsibilities of the Nurse Executive have emerged and evolved over the past two decades (Dwore et al., 2000). Traditionally, the Director of Nursing was responsible for the nursing department and reported to the senior management team. In many hospitals, that position has been eliminated and replaced with a Vice-President of Patient Care Services or Nurse Executive. This person reports directly to the Chief Executive Officer (CEO) and generally manages several departments (Alexander, 1997). The role of the Nurse Executive has become an influential role in health care organizations. "The environment which nurse administrators create and the way they relate to their workforce, [*sic*] are pivotal to organizational viability" (Perra, 2000, p.1). The American Nurses Association published the expectations of the Nurse Executive in 1995, stating that the Nurse Executive "participates in the administration of health care organizations as a full member of the executive team" (p.7). These duties may include activities such as strategic and long range planning, allocation of resources, leadership in critical thinking, and human resource development. The Nurse Executive position is complex, and the person who holds the position is a vital member of the hospital executive management team. Their responsibilities have included management of the nursing service and oversight for nursing clinical practice (Klakovich, 1994). Nurse Executives often have responsibilities for other departments within the hospital.

Nurse Executives have been charged with ensuring cost-effective quality patient care (Perra, 2000). As Klakovich (1994) pointed out, "The Nurse Executive, as the only member of senior management with both clinical and financial perspective, plays a pivotal role in the success of patient-centered care" (p.48). Dwore et al. (2000) found that Nurse Executives were "integrated into their top-level management team and heavily involved in their organization's decision-making process" (p.33). Perra suggested that the responsibility of organizing a successful health care work force, meeting both the needs of the patient and organization, has been given to Nurse Executives.

Fosbinder et al. (1999) conducted a study involving 40 Nurse Executives and 56 influential colleagues. The results of the study indicated that the Nurse Executives and their influential colleagues agreed: the most important quality for the Nurse Executive was leadership. Perra (2000) suggested, "style of leadership determines how Nurse Executives relate to their professional nurses and ultimately how successful their health care institutions will be" (p.1).

A growing consensus that nursing leaders need to be transformational leaders has been indicated in the literature (Chow et al. 1999; Dunham & Klafehn, 1990; McDaniel, 1993). "Transformational leadership theory provides a useful model for effective nursing leadership in modern health care settings" (McDaniel, p. 27). Al-Kandari (1993) suggested a transformational nursing leader was one who searches for opportunities and follows the Kouzes and Posner leadership model of challenging the process, inspiring a shared vision, enabling others to act, modeling the way, and encouraging the heart. Kouzes and Posner (2002a) suggested that the leadership practices could be learned and assessed.

Cook (1999) noted that there are few reported experimental and qualitative studies in leadership and nursing. Many of the articles on leadership and nursing were only opinion papers. He suggested, "There is a need for focused research into leadership in nursing" (p. 307).

Nurse Executives in the private sector and the public sector have experienced considerable change in organizations where they are employed and in their role within the

organization. Studies exploring the Nurse Executive role have been primarily conducted in the private sector of health care. This kind of selective study excludes nurses in the public sector such as those employed by the Department of Veterans Affairs (VA) (Jaco, Price, & Davidson, 1994).

Nurse Executives from the Veterans Health Administration (VHA) were selected as the population for this study for several reasons. Nurse Executives in the VHA have been employed by one of the largest and oldest health care systems in the world (Kizer, 2001). Therefore, they were one of the largest nursing services operating under one national health care organization. Nurse Executives within the VHA have been an important and significant part of the Nurse Executive population with their networking, competition, and peer associations on a national level (Jaco et al., 1994). The VHA facilities and daily operations are similar, thus the role of the Nurse Executive is reasonably consistent. Jaco et al. examined the responsibilities, activities, and characteristics of VHA Nurse Executives and concluded that they were a "cohesive group with minimal variation" (p. 62).

Statement of the Problem

As nurse leaders have evolved into executive positions in health care organizations, leadership has become a focal point in health care leadership literature. One conclusion that can be drawn from the literature on nursing leadership is that Nurse Executive leadership style has been associated with health care organization success (Perra, 2000; Stordeur, Vandenberghe, & D'hoore, 2000). If nursing leadership has been a factor in improving health care organizations, a review of current Nurse Executive leadership practices should be examined. By examining leadership practices of Nurse Executives, one can determine current leadership practices, leadership strengths, and professional development needs of a population of Nurse Executives.

The purpose of this research is to explore self-reported leadership practices of Veterans Health Administration (VHA) Medical Center Nurse Executives, examine leadership strengths of the Nurse Executives, and report professional development needs of the Nurse Executives.

Research Questions

1. What are the self-reported leadership practices of the Nurse Executives as measured by the Leadership Practices Inventory (LPI)?
2. Is there a difference between the self-reported leadership practices of Nurse Executives and effective leadership practices reported in the existing literature?
3. Does leadership training have an effect on leadership practices?
4. Are there differences between self-reported leadership practices of Nurse Executives serving on the Top Management Team (TMT) of the Medical Center compared to Nurse Executives not on the TMT?
5. What are the essential leadership skills identified by Nurse Executives?
6. Are there demographic characteristics of Nurse Executives (gender, age, educational level, and years of experience) that are related to differences in the self-reported leadership practices as measured by the LPI?

Significance of the Study

The study will explore self-reported Nurse Executive leadership practices, leadership strengths, areas for improvement in leadership practices, and reported needs for professional development training. The results will provide insight into current Nurse Executive leadership practices and the professional leadership development needs of Nurse Executives that may lead to the development of a model for professional leadership training for Nurse Executives. This study will also add to the body of research on Nurse Executive Leadership.

Assumptions, Limitations, and Delimitations

This study will assume that the leadership roles of the Nurse Executives are similar, as the facilities in which they work are similar. Self-reporting of the Nurse Executives is a limitation. Other limitations of the study are that the study is limited to 143 Nurse Executives employed by Veterans Health Administration, a division under the Department of Veterans Affairs, and that the reliability of the data will be dependent upon the cooperation, honesty, and perceptions of the participants.

Definitions of Terms

The following definitions are included for clarification:

1. Joint Commission on Accreditation of Healthcare Organizations (JCAHO): the Joint Commission evaluates and accredits health care organizations in the United States. JCAHO establishes standards for health care organizations and evaluates the compliance of organizations against the standards and benchmarks. JCAHO accreditation is nationally recognized as a measure of quality within health care (Joint Commission on Accreditation of Healthcare Organizations, 2002a).
2. Leadership practices: Kouzes and Posner (2002a) developed five leadership practices that include model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart. These five exemplary practices were found to be common when describing personal-best leadership experiences.
3. Nurse Executive: the nurse administrator in the top nursing management position in the medical center or health care system.
4. Professional development: additional skills and knowledge gained by participating in educational programs, conferences, workshops, and self-directed learning.
5. Top management team: executive level governing team of a medical center, includes the chief executive office and other key leadership executives.

6. Transformational Leader: a leader who creates a vision, inspires, and empowers followers to emulate the leader and excel to a higher level of achievement (Northouse, 1997).
7. Department of Veterans Affairs (VA): provides federal benefits to veterans and their dependents, includes nationwide programs in health care, financial assistance, and national cemeteries (Department of Veterans Affairs, 2002). VA is used loosely to refer to the Department of Veterans Affairs and its federal programs.
8. Veterans Affairs Medical Centers (VAMC): individual medical centers within the Veterans Health Administration health care system also referred to as VA Health Care Facilities.
9. Veterans Health Administration (VHA): one of the major operating units of the U.S. Department of Veterans Affairs (VA). The VHA refers to the veterans health care system. The VHA is composed of 21 Veterans Integrated Services Networks (VISN) (Department of Veterans Affairs, 2002; Kizer, 2001).
10. Veterans Integrated Service Networks (VISN): generally have 7 to 10 VA Medical Centers, numerous ambulatory care clinics, nursing homes, domiciliaries, and counseling centers within the network. Each network works as one health system from a basic budgetary and management perspective (Kizer, 2001).
11. *The Leadership Challenge*: (Kouzes and Posner, 2002a). It is a model of leadership that focuses on: challenging the process, inspiring a shared vision, modeling the way, enabling others to act, and encouraging the heart. This book was first published in the late 1980s.

Overview of the Study

The purpose of this research project is to explore self-reported leadership practices of Nurse Executives. Chapter 1 included the introduction and background information, problem statement, research questions, purpose of the study, assumptions, limitations, delimitations, and

definitions of terms. Chapter 2 contains a review of relevant literature and research. The review of literature will focus on transformational leadership, the Leadership Practices Inventory, an overview of the VHA transformation, Nurse Executive role, VHA Nurse Executive, Nurse Executive leadership best practices, self-reported leadership practices, educational requirements for Nurse Executives, and ongoing professional development of Nurse Executives. Chapter 3 contains methodology including the research design of this study. Chapter 4 contains the results of the data, statistical analysis, and relevant findings. Chapter 5 will contain a summary of the data, conclusions, and recommendations for practice and for further research.

CHAPTER 2

REVIEW OF LITERATURE

This literature review includes the following: (a) transformational leadership, (b) Leadership Practices Inventory, (c) overview of the Veterans Health Administration, (VHA) transformation, (d) Nurse Executive role, (e) VHA Nurse Executive, (f) Nurse Executive leadership best practices, (g) self-reported leadership practices in health care, (h) educational requirement for Nurse Executives, and (i) professional development of Nurse Executives.

Transformational Leadership

Transformational leadership has been recognized as a model of leadership since the mid-1980s. As its name implies, transformational leadership transforms individual attitudes and behaviors. A transformational leader motivates followers to do more than expected (Bass, 1985). Transformational leadership goes beyond and is an extension of transactional leadership. Transactional leadership focuses on the exchange that occurs between leaders and followers. This communication exchange or transaction is an expression of expectations and potential rewards (Avolio & Bass, 2002).

Transformational leadership embodies many aspects of leadership. Transformational leadership generally involves values, trust, integrity, fairness, ethics, vision, charisma, change agent, motivation, communication, goals, and clear standards (Avolio & Bass, 2002; Bass, 1985; Northouse, 1997). Transformational leadership focuses on the followers needs (Bass, 1985). As Bass noted, “It is the transformational leader who raises consciousness about higher considerations through articulation and role modeling” (1985, p. 15). Transformational leaders transform followers into leaders (Avolio & Bass).

Bass (1985) suggested that transformational leadership “can bring about the big differences and big changes in groups, organizations, and societies” (p.17). Bass (1996)

suggested that transformational leadership could make a difference in organizational performance. Positive correlations have been reported between transformational leadership practices and job satisfaction, employee productivity, commitment, and organizational effectiveness (Dunham-Taylor, 2000; McNeese-Smith, 1996; Taylor, 1996).

Use of transformational leadership practices is associated with employee commitment, job satisfaction, and role ambiguity (Niehoff, Enz & Grover, 1990). George et al. (2002) studied the design, implementation, and evaluation of a Shared Leadership Concepts Program. The program was evaluated using the Leadership Practices Inventory Self and Observer forms. Nurses who participated in the Shared Leadership Concepts Program improved transformational leadership behaviors, professional nursing practice autonomy, and a perceived improvement in patient satisfaction.

Barrick, Day, and Lord (1991) suggested that effective leadership in an organization could have a substantial financial impact on the organization, “an average estimate of over 25 million dollars (after taxes) throughout an executive’s average career span” (p.19). Maister also (2001) concluded that leadership impacted financial performance. He suggested, “Financial performance is driven by quality and client relationships. Quality and client relationships are driven by employee satisfaction. Employee satisfaction is driven by high standards, coaching, and empowerment” (p. 84).

Transformational leadership has been linked to improved organizational performance; therefore, transformational leadership practices should be used in healthcare organizations. Bass suggested transformational leadership training should be provided to all levels of an organization (1996). Transformational leadership can be taught and learned (Bass, 1996; Kouzes & Posner, 2002a). Bass went on to say that, “Transformational leadership and the philosophy that underlines it can become an integral part of an organization’s career development program” (1996, p.98).

Leadership Practices Inventory

Posner and Kouzes (1988) took what had been learned about transformational leadership and leadership and conducted a qualitative study to attempt to understand leadership. They asked managers who were attending management development seminars to describe, “a ‘personal best as a leader’ –an experience in which they got something extraordinary accomplished in an organization. This was an experience in which they felt they had lead, not managed, their project to plateaus beyond traditional expectations” (p.484). The personal best survey was 12 pages long and had a total of 37 open-ended questions, over 650 surveys were completed. Posner and Kouzes also developed a short form of the personal best survey and managers completed over 450 short form surveys. They also conducted 38 in-depth interviews with managers from a variety of public and private sector companies. This data were analyzed for content by Posner and Kouzes and validated by two outside raters.

Kouzes and Posner (1987) developed the Leadership Practices Inventory (LPI) using the personal best quantitative and qualitative research results. The results of their initial work revealed "the fundamental pattern of leadership behavior that emerges when people are accomplishing extraordinary things in organizations is best described by the following five practices..."challenging the process," "inspiring a shared vision," "enabling others to act," "modeling the way," and "encouraging the heart" (p. 310). "The Leadership Practices Inventory was developed to empirically measure the conceptual framework developed in the case studies of managers' personal best experiences as leaders-times when they had accomplished something extraordinary in an organization" (Posner & Kouzes 1988, p. 495).

The LPI was first used by 120 MBA students. The authors then completed a discussion of each item in the survey, consulting professionals in psychology, organizational behavior, and human resource management. The instrument was modified and revised to create the LPI (Posner & Kouzes, 1988). The LPI-Self Assessment is a 30-item questionnaire designed to measure five empirically developed leadership behaviors. Six statements have been designed to measure each

of the five leadership practices (Kouzes & Posner, 2002b). The LPI was reformulated in 1999 from a 5-point scale to a 10-point scale, however the basic structure of the LPI has not changed, except for a few editorial modifications and revisions (Kouzes & Posner, 2000). Kouzes and Posner noted that the instrument has been used extensively, with over 100,000 respondents (Kouzes & Posner, 2002b). Though Kouzes and Posner do not refer to the Leadership Practices Inventory as a transformational model, it clearly measures transformational leadership practices (Al-Kandari, 1993; Bass, 1985).

Kouzes and Posner (2002b) reported the results of their analysis of the LPI. Means and standard deviations for the LPI-Self are as follows: modeling the way mean=47.0, standard deviation 6.0; inspire a shared vision mean=40.6, standard deviation 8.8; challenging the process mean=43.9, standard deviation 6.8; enabling others to act mean=48.7, standard deviation 5.4; encouraging the heart mean=43.8, standard deviation 8.0. Kouzes and Posner (2002b) reported from their research the leadership skills most frequently practiced are enabling others to act and modeling the way, followed by encouraging the heart and challenging the process. Inspiring a shared vision was the least frequently practiced skill (Kouzes & Posner, 2002b).

The LPI has been used in various settings including: higher education, health care, banking, business, and the military. Kouzes and Posner (2002b) reported that LPI results generally have not been related to demographic or organizational variables such as age, years of experience, educational level, size of facility, staff position, or department. Generally, the authors have not found gender to be significantly different on the LPI- Self. Males and females reported engaging in each of the practices with similar frequencies. Encouraging the heart was the only practice that females have indicated engaging in more frequently than males (Kouzes & Posner, 2002b).

Positive correlations have been reported between the leadership practices and job satisfaction, employee productivity, and organizational commitment in health care (McNeese-Smith, 1996; Taylor, 1996). Gunter (1997) and Lowe (2000) found that Kouzes and Posner's

Leadership practices are all related to organizational commitment. Positive correlations have been found between all five of Kouzes and Posner's leadership practices and job satisfaction and organizational commitment in staff nurses (Taylor). This is a significant finding in the context of health care quality and costs. As Taylor suggested, the leadership practices could be used to improve job satisfaction and organizational commitment, which would decrease employee turnover rates and increase productivity. The use of the five leadership practices could improve organizational performance by improving job satisfaction, productivity, and commitment.

Overview of the Veterans Health Administration

The Department of Veterans Affairs (VA) was established in 1989 as a successor of the Veterans Administration. The task of the VA is to provide federal benefits to veterans and their dependents (Department of Veterans Affairs, 2002). The VA includes four major operating units, with one being the Veterans Health Administration (VHA) (Kizer, 2001). Over the past five years the VHA has integrated its health care facilities under 21 Veterans Integrated Service Networks (VISN) (Department of Veterans Affairs). The VHA has been the largest integrated health care system in the nation (VHA General Information, 2002). This federal system has been comprised of 163 medical centers located throughout the United States (Department of Veterans Affairs, 2002). Between 1995 and 1999 52 medical centers were merged into 25 local health care systems (Kizer). The medical centers provided a full spectrum of medical, surgical, and rehabilitative care (Department of Veterans Affairs). This system employed a staff of almost 200,000 including 55,000 nursing department employees of whom 36,000 were registered nurses (Valentine, 2000).

To keep up with changes in the delivery of health care, the VHA had to reorganize and change the government bureaucracy. The transformation of the VHA was inspired by outside organizations such as "Kiser Permanente and private health care groups" (Kizer, 1998, p.113). As Flynn, McGlynn, and Young, (1997) noted, "Managed care practices that were once confined

to ... HMOs have been adopted by most healthcare organizations in the United States, including VA" (p. 330). Some of the changes in the VHA that have also taken place in the private sector of health care include increase in primary care, use of teams, increase in providers that are nonphysician, and a focus and increase in outpatient and community care (Valentine, 1998).

Although the VHA transformation is ongoing, the operational results have been unprecedented. By using integrated service networks the VA has improved services and lowered costs (Kizer, 1999). The results of the transformation have "demonstrated a 25% reduction in per patient costs, improved access to healthcare services, greater service satisfaction, and unequivocally higher quality of care" (Kizer, 2001, p. 95). The VHA and its transformation has served as an example of "best practices" to other health care organizations during this era of health care transformations (Young, 2000, p. 66). A recent report by Jha, Perlin, Kizer, and Dudley (2003) suggested that the quality of care in the VA health system had improved substantially from 1997 to 2000 after the systemwide transformation.

Most recently, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has recognized the VHA as a leader in patient safety and the VHA has received national and international interest in its progressive Patient Safety Program (Stalhandske, Bagian, & Gosbee, 2002). The VHA has also implemented a progressive pharmacy benefits management program that has had a substantial impact on the VA (Kizer, Ogden, & Ray, 1997). Although the VHA journey to improve continues, the VHA has emerged as a benchmark for other health care systems.

Nurse Executive Role in Health Care

Historically, the role of the Nurse Executive has been viewed as a vital leadership position for health care organizations in their pursuit of organizational goals (Clifford, 1998). The role of Nurse Executives has evolved over the last several years from a "focus on nursing services to a broader accountability for patient care services across the continuum"(Clifford, p.

129). There have been many reasons for the change in the role of the Nurse Executive. One significant factor was the expectation of the Joint Commission on Accreditation of Healthcare Organizations, which stated that the nurse leader at the executive level has had several functions, including "participating with the governing body, management, medical staff, and clinical leaders in the organization's decision-making structures and processes" (Joint Commission on Accreditation of Healthcare Organizations, 2002b, p. NR-4).

Nurse Executives have experienced changes in title, roles, and responsibilities (Clifford, 1998). Murray et al. (1998) noted, "Nurse executives (NEs) on hospital administrative teams currently are more involved in governing board responsibilities, strategic planning, budgeting decisions, medical staff interactions, and nursing department oversight than ever before" (p. 17). The Nurse Executive role has expanded in many cases to include forecasting health care trends, developing and implementing policies, initiating programs and systems, strategic planning, business plan construction, and design of services (Fosbinder et al., 1999; Klakovich, 1994).

As McDonagh (1998) noted, it was once rare to have a nurse or a woman in the boardroom. Currently, there are numerous opportunities for Nurse Executives to have input into health care organization management. Many Nurse Executives have become equal to senior administrators or are the senior administrators in health care organizations (Dwore et al., 1998). The Nurse Executive role has evolved and Nurse Executives have been integrated into the executive levels of administration in some health care organizations (Dwore et al., 2000).

A study of Nurse Executive (NE) integration into executive level administration in Utah's 53 acute care hospitals was completed. Triangulation was used to evaluate integration. The Nurse Executive and two influential professional colleagues were asked to complete a questionnaire dealing with integration and involvement. Qualitative data were collected by individually interviewing Nurse Executives. Dwore et al. (2000) concluded the following results:

NEs tend to perceive (1) acceptance as NEs by their CEOs; (2) greater involvement in hospital-wide activities and decisions over the last three years; (3) substantial interaction,

particularly as clinical experts, with their governing boards; and (4) increased participation, largely due to their own initiative, in hospital issues. Influential colleagues indicate that NEs are (1) integrated into their organization's top-level management team and (2) heavily involved in their organization's decision-making process. (p.33)

The major role of Nurse Executives centered on "ensuring cost-effective, high-quality patient care by designing, leading, and supporting professionally appropriate care delivery systems" (Clifford, 1998, p. 13). Fosbinder et al. (1999) noted that Nurse Executives cited the greatest advantage of being in their position was to improve health care and the well-being of patients. As the authors noted, this gives the health care organization a competitive edge by having a focus on excellent patient care. "More than any other health care professional, the nurse executive can bring the concerns of the patient to the forefront of the health care debate" (Alexander, 1997, p. 81).

Nurses comprised the largest percentage of health care employees providing both direct and indirect care to patients (Brooks, 1999; Cortes, 2001). As Kohles et al. (1995) implied, Nurse Executives are most affected among health care leaders by the changes that are occurring within healthcare organizations. Perra suggested that the "leadership style of nurse administrators contributes to the success of their organization" (Perra, 2000, p.1). Nurse Executives currently have more power, authority, and responsibility in health care organizations than ever before. Therefore, it is imperative that they have the skills to lead effectively.

VHA Nurse Executive

The role of nurse leaders in the Department of Veterans Affairs Medical Centers (VAMCs) has evolved over the last decade. Originally the VA chief nurse role was similar to a director of nursing, with the chief nurse reporting to a physician chief. In many of the VAMCs across the country, the nurse leader was the Associate Medical Center Director for Nursing or Patient Care (or equivalent title) with the nurse leader reporting directly to the medical center director and generally serving on the top management team (TMT) within the VAMC (Valentine, 2000). Although this change in nurse leadership has not occurred in each of the VAMCs across the country, much has been done to elevate the role of the nurse leader within the VAMCs. This nurse leader scenario has not been unique to the VA system, as the VAMC chief nurses used the private sector as a model for development (Valentine, 2000).

Nurse leaders in many institutions have been elevated to varying degrees of leadership and responsibility within medical centers and hospitals across the country, with a trend toward executive level responsibility. Assumption of title, however, has not universally carried the same meaning across the field of nursing or within health care systems. There has been a lack of consistency in Nurse Executive titles themselves. Differences have been found in title definitions, responsibilities, and executive-level function (Clifford, 1998).

The Nurse Executives from VHA have been employed by one of the largest and oldest health care systems in the world (Kizer, 2001). The VHA employed more nurses than any other health care organization (Kizer, 2000). With the recent transformation, the VHA has made functional and structural changes comparable to managed care organizations. Most VHA facilities and daily operations are similar, thus, the role of the Nurse Executive should be reasonably consistent. A study conducted by Jaco et al. (1994) examined the responsibilities, activities, and characteristics of VHA Nurse Executives and concluded that they were a "cohesive group with minimal variation" (p. 62).

Nurse Executive Leadership Best Practices

Bowles and Bowles (1999) indicated the need for strong nursing leadership. The nursing profession must be prepared to meet the changes that are occurring in the health care industry (Gilmartin, 1998). Nurse Executives have a unique role in health care organizations. They are generally responsible for the greatest percentage of full-time equivalents and thus their financial budget is one of the largest in the hospital. In addition, they often have oversight for other departments within the organization. Their leadership skills and abilities have become important as they manage numerous resources including finance, equipment, medications, and hospital staff. A balance must be maintained between human relations and operational strategy, while motivating staff, sharing a vision, and improving operational efficiency (Dixon, 1999).

Jobs and Steinbinder (1996) suggested that nurse leaders need different leadership characteristics than their predecessors. Nurse leaders need to inspire and encourage. They should be proactive, intuitive, and innovative, demonstrating compassion and credibility, and they should emphasize collaboration and teambuilding.

Dixon (1999) noted that health care leaders need transformational leadership behaviors to lead health care organizations in the 21st century. As Al-Kandari (1993) suggested, "A transformational nursing leader is one who challenges the process, searches for opportunities, inspires a shared vision, enables others to act, models the way, and encourages the heart" (p.110). Transformational leaders challenge and motivate others to achieve and excel above levels that were not thought possible (Bass & Avolio, 1994).

The leadership practices by Kouzes and Posner (2002a) were complementary to transformational leadership practices. "Modeling the way," "inspiring a shared vision," "challenging the process," "enabling others to act," and "encouraging the heart" are five practices that were found to be common among leaders who were "getting extraordinary things done in organizations..." (p.13).

Using Kouzes and Posner's, LPI instrument, McNeese-Smith (1996) conducted a study on effective leadership behavior for hospital managers. This study included 41 department managers in two suburban, not-for-profit hospitals in Seattle. Almost half of the group were nursing managers and half were non-nurses. The managers completed the LPI-Self and a demographic questionnaire. The results indicated the following:

Hospital managers can increase employee productivity, job satisfaction and employee involvement in the goals of their hospital through demonstrating certain leadership behaviors....Employees who felt their managers empowered the staff had high job satisfaction. Hospital workers who felt their employers were focused on change and new technology showed high organizational commitment. Employees who felt managers set high standards and behave according to the same values they set for their employees had high productivity. (p.160)

The results of this study demonstrated the importance of the five exemplary leadership practices as identified by Kouzes and Posner's (2002a). These five leadership practices have implications for health care executives, as they identify best practices and leadership skills needed to be successful in today's health care arena.

Self-Reported Leadership Practices in Health Care

McNeese-Smith (1991) conducted a study on effective leadership behavior for hospital managers using Kouzes and Posner's LPI instrument. Forty-one hospital department managers were studied. Approximately half of the managers were nurses and the other half were managers of other clinical and non-clinical departments. The study also included 471 followers who were responsible to the managers in the study. The managers completed the LPI-Self and the followers completed the LPI-Others. The results of this study were as follows with the first mean for the leader and the second mean for the follower: challenging process (4.01, 3.48); inspiring shared vision (3.77, 3.35); enabling others to act (4.34, 3.77); modeling the way (3.87, 3.57);

encouraging the heart (3.79, 3.59). Leaders and followers both rated "enabling others to act" as the highest and "inspiring a shared vision" as the lowest behavior. Both groups rated "modeling the way" as the third behavior. Leaders ranked "encouraging the heart" as the second lowest and followers placed it as the second highest. Overall, the leaders rated themselves higher (3.96) than did the followers (3.56). Murray et al. (1998) suggested that Nurse Executives tend to rate themselves higher in effectiveness of Nurse Executive's leadership skills than their influential colleagues.

Roundy (1991) used the LPI-Self to examine leadership practices of hospital administrators. The author concluded that the leadership practices of Kouzes and Posner support the transformational model of leadership. "Transformational executive leaders who pursues these specific leadership behaviors will discover a new organizational understanding" (p. 154).

Wells et al. (1999) compared how members of the top management perceived nurse executives' participation in strategic decision-making. Both chiefs of staff and facility directors generally agreed with the Nurse Executives' perceptions of their own involvement in strategic decision-making. Although not always in agreement with peer assessment, self-assessment of leadership behaviors can be used to determine leadership practices as a starting point for learning. As Senge, (1994) stated, "Organizations learn only through individuals who learn. Individual learning does not guarantee organizational learning. But without it no organizational learning occurs" (p.139).

Educational Requirements of Nurse Executives

The focus of nursing education has been clinical training. Leadership education has been limited during nurse education. Chow et al. (1999) noted:

Most nurses in leadership positions have been taught leadership only as a part of their basic nursing education. At that time, however, they have no professional experience upon which to reflect. They can only absorb general principles and observe the actions of

other nurses in leadership roles. As a consequence, many are unprepared for their later leadership roles and responsibilities. (p. 295)

The educational background of Nurse Executives varies widely. A registered nurse can have the following degrees: associate degree (two-year program generally at a community college), diploma (three-year program generally hospital based), baccalaureate degree, master's degree, and doctoral degree (Coffman, Blick, & Wong, 1998). Nursing baccalaureate and graduate programs generally promoted leadership development (Balik, 1998). The American Nurses Association (1995) noted its expectations of Nurse Executives; they need a baccalaureate and graduate degree as well as a certification in nursing administration. Nurses generally had an excellent clinical perspective of health care but were not as aware of the business aspects and organizational management operations of a health care organization (Chow et al., 1999). Clifford (1998) found that Nurse Executives indicated that an educational background rich in clinical and business skills was essential in enabling them to balance both clinical and administrative areas of health care. An administrative degree served to elevate the Nurse Executive to a higher level within organizations. Medical Center Directors valued the knowledge base of an administrative degree (Banaszak-Holl et al., 1999).

Parsons, Fosbinder, Murray, and Dwore (1998) conducted a study of 40 Nurse Executives and 56 of their mentors. Seventy-eight percent (n = 31) of the Nurse Executives expressed the need for a graduate degree to accomplish the responsibilities of their job. Courses cited as being the most important were nursing administration (35%), business administration (30%), hospital administration (25%), and public administration (10%). The most important factors for effective job performance were having a mentor or role model (25%), formal education (20%), work experience (18%), and continuing education (18%). Of the 28 nurses who reported traditional or proactive career paths, 65% (n = 28) had a bachelor's or master's degree. They also reported having additional degrees such as an MBA or master's degree in nursing, or a Ph. D.

Nurse Executives need a broad knowledge and understanding of health care as a system. They also need an understanding of finance, organizational management, and human resources (Mahoney, 2001). Nursing education curricula need to include development of leadership knowledge and skills, management of financial resources, information resource management, strategic planning, and health care service delivery (Feldman, 2001). Nursing educators need to reevaluate nursing education programs to meet the needs of Nurse Executives. Furthermore, Nurse Executives need to be equipped with knowledge and skills in decision-making, finance and technology (Murray et al., 1998). Nurses gained knowledge and skills in leadership by attending programs, workshops, continuing education seminars, taking courses, or pursuing an advanced degree in nursing administration or an equivalent degree (Mahoney).

Professional Development of Nurse Executives

Alexander (1997) and Murray et al. (1998) suggested Nurse Executives must evaluate and develop effective leadership skills to be successful in the competitive health care market. As clinicians, nurses gained some experience in leadership as they care for patients and interact with staff. However, these learned leadership competencies have not been enough to prepare them for the challenges that health care has been facing (Chow et al., 1999). Agreement exists in the literature on the need for Nurse Executive leadership in health care. In a study conducted by Dwore et al. (1998), triangulation was used between Nurse Executives and their supporters and hinderers to determine areas for additional Nurse Executive professional self-development. Some of the themes that emerged from the qualitative data were; Nurse Executives generally sought professional development, had the ability for life long learning, recognized the benefits of a professional development program that is planned and used over time, and suggested the need to combine practice and theory.

Nurses used continuing education and formal leadership programs to develop leadership knowledge and skills (Brooks, 1999; Chow et al. 1999). Beyers (1999) noted that continuing

education for nurses was as vital as a nursing basic education program. Continuing education has changed as a result of new technology, which made it more palatable for many.

In reviewing the literature regarding Nurse Executive leadership skills and health administration competences, no universal Nurse Executive leadership skill set emerged. The themes from the literature indicated that Nurse Executives need leadership skills and health care administration skills, with the major emphasis on leadership.

According to Chow et al. (1999) nurses needed professional development in the following areas: system perspective, vision development, risk taking, innovation, and change management. Parsons et al. (1998) found that Nurse Executives reported additional self-development was needed in the following areas: "information technology, systems analysis, finance, long-range planning, and program evaluation" (p.12). This group of Nurse Executives also noted that professional organization memberships were important in improving their performance as an executive. Fedoruk and Pincombe, (2000) established a competency profile for the Nurse Executive that included commercial sensitivity, creativity and innovation, strategic planning, communication, enabling role, coalescing role, motivating role, flexibility and resilience, courage, commitment, and inter-personal sensitivity. Corning (2002) conducted a study to examine leadership style, motivation, and leadership skills required of Nurse Executives. Corning concluded that the top 10 competencies required in a Nurse Executive's job included "employee development/coaching," "teamwork," "self-management," "interpersonal skills," "empathy," "planning with flexibility," "decision making," "management," "futuristic thinking," and "negotiation" (p.374). Other competencies identified in the literature included: negotiation, technical skills, policy development, and strategic decision-making (Lett, 1999). Campbell (1995) concluded that VHA Nurse Executive development programs should include strategic planning, finance, marketing, and management.

It is important for nurses to "develop a foundation of leadership and management knowledge that they can build on through a planned program of continuing education" (Brooks,

1999, p. 120). Griffith, Warden, Neighbors, and Shim, (2002) suggested that for most individuals continuing education in health administration is unfocused and infrequent. The authors characterized continuing education as lacking in "intensity, structure, and integration into the workplace" (p.92).

To improve knowledge, skills, and abilities in leadership through continuing education Nurse Executives need to examine their leadership styles and develop characteristics of transformational leadership (Dunham & Klafehn, 1990). The five leadership behaviors developed by Kouzes and Posner (2002) can be used to develop positive leadership practices. The LPI, along with the five leadership practices, provide a "framework by which leadership may be defined, taught, learned and assessed" (Bowles & Bowles, 1999 p.4).

Summary

The purpose of this research project is to explore self-reported leadership practices of Nurse Executives, examine leadership strengths and report professional development needs of Nurse Executives. The literature review included an overview of Transformational Leadership and the Leadership Practices Inventory. A synopsis of the VHA transformation to its current status as a benchmark for other health care systems followed. The role of the Nurse Executive was explored, along with the role of the VHA Nurse Executive. Nurse Executive leadership best practices and self-reported leadership practices were identified. A presentation of educational requirements and professional development of Nurse Executives concluded the chapter.

Leadership has become central to the success of health care organizations as they strive to meet the challenges of delivering care. The literature reviewed provides the background for this study to assess self-reported leadership practices of nurse executives. A review of the literature indicates that Nurse Executive best practices include transformational leadership characteristics. Kouzes and Posner's LPI instrument has been used successfully in health care organizations to evaluate transformational leadership practices of health care administrators. Although there is an

inconsistency in nurse executive educational backgrounds and professional development requirements, there is agreement regarding the need to develop leadership skills of Nurse Executives to improve organizational performance.

CHAPTER 3

METHODOLOGY

This chapter consists of a description of the study, population, research design, instrumentation, data collection, and data analysis that was used in this study.

Description of the Study

The research design used in this study was intended to explore self-reported leadership practices, leadership strengths, and professional development needs of Nurse Executives within the VHA Medical Centers. The research questions developed to guide this study were as follows:

1. What are the self-reported leadership practices of the Nurse Executives as measured by the Leadership Practices Inventory (LPI)?
2. Is there a difference between the self-reported leadership practices of Nurse Executives and effective leadership practices reported in the existing literature?
3. Does leadership training have an effect on leadership practices?
4. Are there differences between self-reported leadership practices of Nurse Executives serving on the Top Management Team (TMT) of the Medical Center compared to Nurse Executives not on the TMT?
5. What are the essential leadership skills identified by Nurse Executives?
6. Are there demographic characteristics of Nurse Executives (gender, age, educational level, and years of experience) that are related to differences in the self-reported leadership practices as measured by the LPI?

Population

The population consisted of all 143 Nurse Executives employed in the Department of Veterans Affairs Medical Centers (VAMCs). Veterans Health Administration is an integrated

health care system with Medical Centers and Health Care Systems located throughout the United States. Each facility or Health Care System had a designated Nurse Executive who was asked to participate in this research project.

Research Design

This was a quantitative study designed to explore self-reported leadership practices and professional development needs of Nurse Executives employed in the Department of Veterans Affairs Medical Centers across the United States. Exploratory descriptive research methods were used. Descriptive statistics were used to organize, summarize, and report the data (Gall, Borg, & Gall, 1996).

Instrumentation

An established survey instrument, the Leadership Practices Inventory (LPI), was used to collect data on self-reported leadership practices from Nurse Executives (Lewis, 1995). Permission to use the LPI Self was granted by Barry Ponser (Appendix A). Demographic information was also collected. The general demographic questions are in Appendix B. The Leadership Practices Inventory (LPI)-Self Assessment form is in Appendix C. The LPI-Self Assessment is a 30-item questionnaire designed to measure five empirically developed leadership behaviors. Six statements were designed to measure each of the five leadership practices (Kouzes & Posner, 2002b).

A series of statements were developed describing each of the various leadership practices to create the LPI instrument. The five leadership behaviors were quantified by questions "Challenging the Process" (questions 1, 6, 11, 16, 21, 26); "Inspiring a Shared Vision" (questions 2, 7, 12, 17, 22, 27); "Enabling Others to Act" (questions 3, 8, 13, 18, 23, 28); "Modeling the Way" (questions 4, 9, 14, 19, 24, 29); "Encouraging the Heart" (questions 5, 10, 15, 20, 25, 30) (Kouzes & Posner, 2001). Each statement was scored on a 10-point scale, with the higher value

indicating a frequent use of a leader behavior; for example: (1) Almost never do what is described in the statement; (2) Rarely; (3) Seldom; (4) Once in a while; (5) Occasionally; (6) Sometimes; (7) Fairly Often; (8) Usually; (9) Very Frequently; and, (10) Almost always do what is described in the statement (Kouzes & Posner, 2002b). Self and Observer forms of the LPI have been developed; the LPI-Self Assessment will be used in this study (Kouzes & Posner, 2002a).

Means and standard deviations for the LPI-Self were as follows: modeling the way mean=47.0, standard deviation 6.0; inspire a shared vision mean=40.6, standard deviation 8.8; challenging the process mean=43.9, standard deviation 6.8; enabling others to act mean=48.7, standard deviation 5.4; encouraging the heart mean=43.8, standard deviation 8.0. The total sample size used in this LPI-Self analysis was 2,072 (Kouzes & Posner, 2000). Kouzes and Posner (2002b) reported from their research the leadership skills most frequently practiced are enabling others to act and modeling the way, followed by encouraging the heart and challenging the process. Inspiring a shared vision is the least frequently practiced skill (Kouzes & Posner, 2002b).

Kouzes and Posner have established internal reliability for the LPI instrument (2002b). Using the revised edition of the LPI, Kouzes and Posner (2000) reported consistent findings from results that were reported earlier from the first edition of the LPI. The total sample size used in the latest analysis (using the revised form) was 17,908, of which 2,072 were from the LPI-Self form. Measured by Cronbach's Alpha the, LPI-Self Assessment leadership practices were all above the .75 level. The leadership practice for the five scales of leadership were challenging the process .80, inspiring a shared vision .87, enabling others to act .75, modeling the way .77, and encouraging the heart .87 (Kouzes & Posner, 2002b). The internal reliability of the LPI-Self Assessment was strong, with .70 -.90 considered high positive by Hinkle, Wiersma, and Jurs (1998). Kouzes and Posner (2002b) noted that reliability coefficients from the LPI-Self (.75 - .87) have a tendency to be slightly lower than the LPI-Observer (.88 - .92).

Construct validity establishes that the instrument measures an established construct (Gall et al., 1996). Independent reviewer Leong (1995) noted the following:

In terms of construct validity of the LPI, a study examining the relationship between the LPI and managerial effectiveness found strong evidence for the discriminant validity of the LPI. Using a Leadership Effectiveness Scale developed for this study, it was found the five practices were significantly related to subordinates' rating of managerial effectiveness....The coefficient alpha for the Leadership Effectiveness Scale was .98 and a test-retest reliability based on 57 MBA students was .96. Using a multiple regression the five component practices of the LPI significantly predicted the Leadership Effectiveness Scale ($F = 318.9, p < .0001$ adjusted $R^2 = .756$). (p. 555)

Kouzes and Posner (2002b) noted that test-retest reliability for the five leadership practices has been consistently strong, usually with high correlations ($r=0.90$). They have compared the LPI scores every two years since 1987 and the scores on the LPI have been relatively stable over time.

Comparisons Between Self and Observers

Kouzes and Posner (2000) noted that there were no statistically significant differences ($p < 0.001$) between leaders using the LPI-Self form and their constituents using the LPI-Observer form in the area of challenging and modeling. However, there were statistically significant differences between leaders and their constituents in the areas of inspiring, enabling, and encouraging. Though statistically significant, these differences may have little practical significance, except to note that constituents view the leaders as slightly more inspiring and encouraging and slightly less enabling than the leaders view themselves.

Kouzes and Posner (2002b) reported that the LPI has sound psychometric properties. An independent assessment of the LPI had similar findings (Lewis, 1995):

The LPI is one of the most extensively researched management development tools I have encountered. It is a model of sound research design from its initial development and refinement through subsequent concurrent validity studies. The instrument and instructions are easy to read and follow, and the trainer's guide is logical and clear. I highly recommend it as a developmental tool for new and experienced managers. (p. 557)

Data Collection

A letter (Appendix D) eliciting participation in the research project was e-mailed nationwide to 143 Nurse Executives employed throughout the Veterans Health Administration System. Following the initial introductory letter, a letter (Appendix E) explaining the details of the project with a web page address and link were e-mailed to the Nurse Executives. The web page <http://www.visn9.us/lpi> contained the Leadership Practices Inventory and demographic questions. The Nurse Executives were asked to complete online an questionnaire and submit electronically. Participants were asked to respond within 10 days. The survey was completed electronically and automatically returned to the researcher. A follow-up letter (Appendix E) was e-mailed to the Nurse Executives who did not respond to the first questionnaire after the initial 10-day period. The Nurse Executives who did not respond after the second 10-day period were e-mailed again and given an additional four days to respond.

An incentive was offered to the Nurse Executives to encourage completion of the survey. At the conclusion of the study, a drawing was held in which each participant who completed the survey had two chances to win \$250 that was donated to their facility's nursing education department. The donation could be used for texts, training, or any form of nursing education at the discretion of the Nurse Executive. Notification that the winning facilities had been selected and notified was e-mailed to all the participants of the study; no individual names or facilities were disclosed.

Confidentiality was protected by restricting access of the returned surveys to the researcher and the web page designer. Every attempt was made to maintain respondents anonymity. The Nurse Executive's name was used solely for the purpose of follow-up to those who had not responded by the deadline and selection of winners for the incentive awards. Each individual who participated received his or her own individual LPI results for personal use after he or she completed the survey and submitted the results. All statistical analyses were presented in summary form (no specific person or facility was identified). At the conclusion of this research project, a letter of appreciation for participation (Appendix F) was e-mailed to each Nurse Executive who completed a survey. An abstract of the study was e-mailed to each participant at the conclusion of the study and forwarded to VHA Central office of Nurse Administration.

Data Analysis

The findings of this research were analyzed using the Statistical Package for Social Sciences (SPSS) software program, which is used to analyze and display data (Gall et al., 1996). Descriptive statistics were used to describe the demographics of the sample. The demographics included in the analysis were gender, age, education, experience, and current position.

Research Question 1: What are the self-reported leadership practices of the Nurse Executives as measured by the Leadership Practices Inventory (LPI)? To examine Nurse Executive leadership practices, descriptive statistics in the form of mean and standard deviation were used to describe the sample.

Research Question 2: Is there a difference between the self-reported leadership practices of Nurse Executives and effective leadership practices reported in the existing literature? The mean and standard deviations of the five LPI scores from previous research were compared to those found in the current study.

Research Question 3: Does leadership training have an effect on leadership practices? To answer this research question, a Pearson r was used to determine the direction and magnitude of the relationship between the independent variable leadership training (Gall et al., 1996). The dependent variable was scores on the LPI scale.

Research Question 4: Are there differences between self-reported leadership practices of Nurse Executives serving on the Top Management Team (TMT) of the Medical Center compared to Nurse Executives not on the TMT? A t -test for independent means was used to determine if the observed differences between the mean LPI scores of the two groups was statistically significant (Gall et al., 1996).

Research Question 5: What are the essential leadership skills identified by Nurse Executives? Descriptive statistics were used to determine the essential leadership skills as identified by the Nurse Executives.

Research Question 6: Are there demographic characteristics of Nurse Executives (gender, age, educational level, or years of experience) that are related to differences in the self-reported leadership practices as measured by the LPI? A t -test for independent samples was used to determine gender differences. Pearson correlation was used to determine differences in age and differences in years of experience. A t -test for independent samples was used to determine the differences in education levels.

Summary

This chapter included a description of the study, population, research design, instrumentation, data collection procedures, and methods of data analysis. It is a quantitative study designed to explore self-reported leadership practices, leadership strengths, and professional development needs of Nurse Executives within the Department of Veterans Affairs Medical Centers. Chapter 4 is a representation of the results of the data, statistical analysis, and

relevant findings. Chapter 5 contains a summary of the data, conclusions, and recommendations for practice and for further research.

CHAPTER 4

RESULTS

Introduction

The purpose of this research was to explore self-reported leadership practices of Veterans Health Administration (VHA) Medical Center Nurse Executives, examine leadership strengths of the Nurse Executives, and report professional development needs of the Nurse Executives. The Leadership Practices Inventory Self-assessment by Kouzes and Posner (2001) was used as the survey instrument. The purpose of this chapter is to report the results of the research as they relate to the demographic questions and specific research questions. Demographic data are presented first and the findings are presented as responses to individual research questions.

The study population consisted of Nurse Executives employed in the Department of Veterans Affairs Medical Centers (VAMC's) throughout the United States. One hundred forty-three Nurse Executives were invited to participate in the study. Due to the inability to contact two of the Nurse Executives, 141 Nurse Executives (98.6%) constituted the population.

Seventy-seven (55%) of the Nurse Executives participated in the study. Sixty-eight (88.3%) were females and nine (11.7%) were males. Their ages ranged from 39 to 61 years ($M=51.84$).

The highest degree obtained for the majority of the Nurse Executives was a master's degree, with 89.6% ($N = 69$) of the Nurse Executives reporting having a master's degree. A doctorate degree was the highest degree reported by 9.1% ($N = 7$) of the Nurse Executives. A bachelor's degree was reported by 1.2% ($N = 1$) of the Nurse Executives. The highest degrees obtained by the Nurse Executives were categorized into fields of study: nursing/nursing specialty degrees, administrative/management/leadership degrees, and health education/nursing education degrees. Forty-six percent ($N= 35$) of the Nurse Executives had a nursing/nursing specialty degree, 30% ($N=23$) had an administrative/management/leadership degree, 9% ($N=7$) had health

education/nursing education degrees, and 16% ($N=12$) did not report the degree discipline. Eight (9%) of the Nurse Executives reported that they were currently working on a degree.

The Nurse Executives reported having approximately 18 years' ($M = 17.74$) experience as an administrative nurse with a range of 2 to 33 years. They had about 11 years experience as a Clinical Nurse ($M = 11.46$) a range of 2 to 39 years.

Titles of the Nurse Executives varied. Slightly more than half (50.6%) ($N = 39$) of the Nurse Executives reported having the title of Associate Medical Center Director for Nursing (or Patient Care), and 35.1% ($N = 27$) reported having other titles. Some of the titles included: Associate Director of Operations, Associate Chief of Staff, Associate Chief of Staff/Patient Care Support Program/Nurse Executive, Executive Chief Nurse, and Associate Director of Patient Care Services. The title of Chief, Nursing Service was reported by 10.4% ($N = 8$) of the Nurse Executives. Three (3.9%) Nurse Executives did not report a title.

Research Question 1

What are the self-reported leadership practices of the Nurse Executives as measured by the Leadership Practices Inventory (LPI)?

This first research question addressed the self-reported leadership practices of the Nurse Executives as measured by the Leadership Practices Inventory results are shown in Table 1. The Nurse Executives scored highest in enabling others to act (52.97), modeling the way (51.34), and encouraging the heart (49.29). They scored slightly lower in challenging the process (48.28) and inspiring a shared vision (47.73).

To explain the differences in N , 77 Nurse Executives completed the demographic section of the survey; however, four Nurse Executives did not complete the LPI portion of the survey. Of the 73 who completed the LPI, one Nurse Executive did not answer one question in the scale of encouraging the heart. Therefore, the numbers for N vary slightly.

Table 1

Self-Reported Leadership Practices of Nurse Executives

LPI Scales	N^a	Mean	Median	Std. Dev.
Challenging the Process	73	48.2877	50	5.9802
Inspiring a Shared Vision	73	47.7397	49	6.3443
Enabling Others to Act	73	52.9726	53	3.9930
Modeling the Way	73	51.3425	52	4.2954
Encouraging the Heart	72	49.2917	50	5.7859

^a N= 73 in each scale, except for the scale of encouraging the heart, one participant did not complete all questions in this scale (missed one question), therefore N=72 for the scale of encouraging the heart.

The reliability analysis (Cronbach Alpha) for the LPI scales of the Nurse Executive data and Kouzes and Posner's data is shown in Table 2. The reliability for each of the LPI scales for the Nurse Executives is .70 or above for challenging the process, inspiring a shared vision, enabling others to act, and encouraging the heart. The LPI scale of modeling the way (alpha = .60) is below .70. Kouzes and Posner's (2002b) reliability analysis (Cronbach Alpha) for the LPI scales were all above .70 for each of the scales. The Nurse Executives' reliability for the scale of modeling the way (.60) is lower than Kouzes and Posner's reliability for that scale (.77). The inconsistency in this scale cannot be explained. The scale was analyzed in its original form and no questions were deleted from the scale to maintain the integrity of the LPI instrument.

Table 2

Reliability Analysis (Cronbach Alpha) for the LPI Scales, Nurse Executive Data and Kouzes and Posner Data (2002b)

LPI Scales	Nurse Executive		Kouzes & Posner
	Alpha	N^a	Alpha (N=2,072)
Challenging the Process	.78	73	.80
Inspiring a Shared Vision	.84	73	.87
Enabling Others to Act	.71	73	.75
Modeling the Way	.60	73	.77
Encouraging the Heart	.86	72	.87

^a N= 73 in each scale, except for the scale of encouraging the heart, one participant did not complete all questions in this scale (missed one question), therefore N=72 for the scale of encouraging the heart.

Research Question 2

Is there a difference between the self-reported leadership practices of Nurse Executives and effective leadership practices reported in the existing literature?

This question addresses the differences between the self-reported leadership practices of Nurse Executives and Kouzes and Posner’s (2002b) research. See Table 1 for the Self-Reported Leadership Practices of the Nurse Executives. Table 3 is a comparison of the Nurse Executives in this study and Kouzes and Posner’s (2002b) research. The self-reported means of the Nurse Executives are all higher than the means in Kouzes and Posner’s research.

Table 3

Comparison of Means and Standard Deviations of Nurse Executive Data and Kouzes and Posner (2002b) Data

LPI Scales	Nurse Executive Data		Kouzes and Posner Data	
	Mean	Std. Dev.	Mean	Std. Dev.
Challenging the Process	48.3	6.0	43.9	6.8
Inspiring a Shared Vision	47.7	6.3	40.6	8.8
Enabling Others to Act	53.0	4.0	48.7	5.4
Modeling the Way	51.3	4.3	47.0	6.0
Encouraging the Heart	49.3	5.8	43.8	8.0

To determine if the differences between the means of the Nurse Executives in this study and Kouzes and Posner's (2002b) research were statistically significant, an SPSS-matrix input file was created which included the mean, standard deviation, and sample size for each of the two groups. The ONEWAY procedure in SPSS, which reads matrix input files, was used to test the difference between the two means. See Table 4 for the results. There was a statistically significant difference at ($p < .0005$ level) between the Nurse Executives and Kouzes and Posner's means for each of the Leadership Practices (2002b).

Table 4

Differences Between LPI Means of Nurse Executives and Kouzes and Posner Research (2002b)

	Sum of Squares	DF	Mean Square	F	Significance of F
Challenging the Process	1357.560	1	1357.560	29.584	< .0005
Inspiring a Shared Vision	3594.556	1	3594.556	47.179	< .0005
Enabling Others to Act	1287.270	1	1287.270	44.828	< .0005
Modeling the Way	1329.735	1	1329.735	37.553	< .0005
Encouraging the Heart	2098.510	1	2098.510	33.316	< .0005

Research Question 3

Does leadership training have an effect on leadership practices?

To answer Research Question 3, Nurse Executives were asked to indicate specific training in leadership and/or management (courses, workshops, seminars, certifications or other training that they had attended). There were 10 opportunities to list training. There were 224 leadership-training sessions attended as reported by the Nurse Executives. Some of the most common training types included: Health Care Leadership Institute, Leadership VA, Federal Executive Institute, American Organization of Nurse Executives Conferences, Advanced Nursing Administration, and American Nurses Credentialing Center Conferences and Certification.

To analyze Research Question 3, the leadership training variables were analyzed using descriptive statistics, frequency table, and Pearson χ^2 . The descriptive statistics for leadership training were as follows: (the number of training types ranged from 0 to 10 ($M=2.91$, $SD=2.03$). For frequencies of the number of leadership training types see Table 5. Three leadership/management training types were listed by 18.2% of the Nurse Executives, 15.6% of the Nurse Executives listed four, and 13% listed only one training type. Data were collected for the length of each training type, but these data were incomplete and, therefore, unusable. Data

were also collected on the value of the training. All of the training was noted to be valuable, except for 2 cases, which indicated that the training was not valuable.

Table 5

Number of Leadership Training Types

Number training types	Frequency reporting	Percent
0	9	11.7
1	10	13.0
2	17	22.1
3	14	18.2
4	12	15.6
5	7	9.1
6	5	6.5
7	1	1.3
8	1	1.3
10	1	1.3
Total	77	100.0

The Pearson r was calculated to determine the relationship between the number of leadership training types and leadership practices (see Table 6). The table shows the Pearson r , two-tailed probability and the number of cases on which the correlation was based. Modeling the way had a correlation of .136 and a significance of $p = .251$. Encouraging the heart had a correlation of .153 and a significance of $p = .200$. Modeling the way and encouraging the heart had the highest correlations, but they were still weak. None were statistically significant at the .05 level.

Table 6

Pearson r for Leadership Training and Leadership Practices

	N	Pearson Correlation	Significance (2-tailed)
Challenging the Process	73	.044	.714
Inspiring a Shared Vision	73	.035	.767
Enabling Others to Act	73	-.023	.850
Modeling the Way	73	.136	.251
Encouraging the Heart	72	.153	.200

Research Question 4

Are there differences between self-reported leadership practices of Nurse Executives serving on the Top Management Team (TMT) of the Medical Center compared to Nurse Executives not on the TMT?

To analyze the differences between self-reported leadership practices of Nurse Executives serving on the Top Management Team (TMT) of the Medical Center compared to Nurse Executives not on the TMT, a t -test for two independent samples was used. The descriptive statistics for this question are in Table 7. The t -test results for Nurse Executives serving on the Top Management Team versus those not on the TMT of the medical center are in Table 8.

Table 7

Descriptive Statistics for Nurse Executives Serving on the Top Management Team vs. Those Not on the TMT of the Medical Center

	Serve on TMT	N^a	Mean	Std. Deviation
Challenging the Process	No	10	45.4000	7.5895
	Yes	60	48.7000	5.7440
Inspiring a Shared Vision	No	10	43.0000	9.6839
	Yes	60	48.5667	5.4629
Enabling Others to Act	No	10	52.9000	3.2813
	Yes	60	53.0333	4.1618
Modeling the Way	No	10	51.2000	4.6380
	Yes	60	51.4500	4.2999
Encouraging the Heart	No	10	49.0000	4.6904
	Yes	59	49.4576	5.9228

^aA total of sixty-two Nurse Executives reported serving on the TMT. Of these, only 60 completed the LPI and were included in this analysis. Twelve of the Nurse Executives reported not serving on the TMT, and of these, 10 completed the LPI. Three Nurse Executives did not indicate if they served on the TMT. One Nurse Executive did not answer a question in the encouraging the heart scale, which is why N=59.

Table 8

t-test for Nurse Executives Serving on the Top Management Team vs. Those Not on the TMT of the Medical Center

		Levene's Test of		t-test for Equality of Means		
		Equality of Variances		T	df	Significance (2-tailed)
		F	Sig.			
Challenging the Process	Equal variances assumed	1.314	.256	-1.605	68	.113
Inspiring a Shared Vision	Equal variances not assumed	10.667	.002	-1.771	10 ^a	.107
Enabling Others to Act	Equal variances assumed	.958	.331	-.096	68	.924
Modeling the Way	Equal variances assumed	.610	.437	-.168	68	.867
Encouraging the Heart	Equal variances assumed	.973	.328	-.232	67	.817

^aNote that the Levene's test for equal variances for Inspiring a shared vision indicated that the *t*-test which does not assume equal variances was the appropriate test. Degrees of freedom is 10 because equal variances were not assumed.

A Levene's test for Equality of Variances was used to evaluate the *t*-test assumption of homogeneity of variance (Sall, Lehman, & Creighton, 2001). The results of this test indicated which of the two *t*-tests was used: *t*-test which assumes equal variances or the *t*-test which does not assume equal variances. The results of the Levene's Test for Equality of Variances indicated that the *t*-test that assumes equal variances was appropriate for challenging the process ($p=.256$); enabling others to act ($p=.331$); modeling the way ($p=.437$); and encouraging the heart ($p=.328$). A *t*-test which does not assume equal variances was used for inspiring a shared vision ($p=.002$). None of the leadership practices showed a statistically significant difference between the means of the Nurse Executives serving on the TMT and those not on the TMT of the medical center (see table 8): challenging the process ($p=.113$); inspiring a shared vision ($p=.107$); enabling others to act ($p=.924$); modeling the way ($p=.867$); and encouraging the heart ($p=.817$). Although there was not a statistically significant difference between the means of the Nurse Executives

serving on the TMT and those not on the TMT of the Medical Center, the means (Table 7) for challenging the process and inspiring a shared vision for those serving on the TMT are higher than the means of those not on the TMT.

Research Question 5

What are the essential leadership skills identified by Nurse Executives?

Descriptive statistics were used to determine the essential leadership skills as identified by the Nurse Executives. The Nurse Executives identified 359 essential leadership skills. The leadership skills were classified into 25 categories (see Table 9). Three independent reviewers reviewed the categories and the items within in each category and concurred with the category labels and items within the categories. Communication skills were listed as an essential leadership skill by 66.7% of the Nurse Executives. The top 10 essential leadership skills identified by the Nurse Executives included: communication skills (66.7%); interpersonal skills (41.7%); integrity (38.9%); visionary skills (31.9%); coaching-mentoring skills (26.4%); conflict-negotiation skills (26.4%); systems thinking skills (25.0%), personal mastery (23.6%); financial skills (23.6%); organization skills (20.8%).

Table 9

Essential Leadership Skills Identified by Nurse Executives

	Count	Percent of Responses	Percent of Cases
Communication Skills	48	13.4	66.7
Interpersonal Skills	30	8.4	41.7
Integrity	28	7.8	38.9
Visionary Skills	23	6.4	31.9
Coaching-Mentoring Skills	19	5.3	26.4
Conflict-Negotiation Skills	19	5.3	26.4
Systems Thinking Skills	18	5.0	25.0
Personal Mastery	17	4.7	23.6
Financial Skills	17	4.7	23.6
Organization Skills	15	4.2	20.8
Flexibility	14	3.9	19.4
Nursing Knowledge	14	3.9	19.4
Collaboration Skills	13	3.6	18.1
Analytical-Critical Thinking Skills	12	3.3	16.7
Strategic Planning Skills	11	3.1	15.3
Personnel Management	11	3.1	15.3
Innovation Skills	11	3.1	15.3
Change Agent	9	2.5	12.5
Facilitation Skills	7	1.9	9.7
Enabling Skills	6	1.7	8.3
Decision Making Skills	6	1.7	8.3
Employee-Customer Focus	4	1.1	5.6
Leadership Skills	3	.8	4.2
Sense of Humor	2	.6	2.8
Results Oriented	2	.6	2.8
Total responses	359	100.0	

Research Question 6

Are there demographic characteristics of Nurse Executives (gender, age, years of experience, and educational level) that are related to differences in the self-reported leadership practices as measured by the LPI?

Descriptive statistics were calculated for gender and LPI results (Table 10). There were 64 females and 9 males in the study who completed the LPI portion of the survey. To determine

gender differences, a t-test for independent samples was used, see Table 11 for the results. There were no significance differences for gender and the LPI scales at the .05 level of significance. The means (Table 10) for challenging the process, inspiring a shared vision, and encouraging the heart were higher for the females than the males. The remaining scale means were similar.

Table 10

Gender and Leadership Practices

	Gender	N	Mean	Standard Deviation
Challenging the Process	Female	64	48.5	5.5
	Male	9	46.6	8.7
Inspiring a Shared Vision	Female	64	48.0	6.3
	Male	9	45.9	6.5
Enabling Others to Act	Female	64	53.0	3.9
	Male	9	53.4	4.7
Modeling the Way	Female	64	51.4	4.3
	Male	9	52.8	4.1
Encouraging the Heart	Female	63	49.6	5.5
	Male	9	47.3	7.5

Table 11

t-test for Gender Differences and Leadership Practices

	Variances	t	df	Significance (2-tailed)
Challenging the Process	Equal variances not assumed	.661	9	.525
Inspiring a Shared Vision	Equal variances assumed	.934	71	.354
Enabling Others to Act	Equal variances assumed	.376	71	.708
Modeling the Way	Equal variances assumed	1.072	71	.287
Encouraging the Heart	Equal variances assumed	1.087	70	.281

The descriptive statistics for age and years experience is in Table 12. Mean age is 52. The Nurse Executives reported 18 years' experience as an administrative nurse. To determine the differences in self-reported leadership practices by age and total years experience, a Pearson Correlation was calculated (see table 13). There was no statistically significant difference between self-reported leadership practices and age or total years of experience at .05 level of significance.

Table 12

Descriptive Statistics for Age and Years Experience

	N	Mean	SD
Age	76	52	4.9
Yrs exp. Clinical nurse	72	11.5	8.3
Years exp. Administrative Nurse	73	17.7	7.1

Table 13

Correlations for Leadership Practices with Age and Total Years of Experience

		Age	Total years of experience
Challenging the Process	Pearson r	.021	.009
	Sig. (2-tailed)	.864	.942
	N ^a	72	66
Inspiring a Shared Vision	Pearson r	-.026	.032
	Sig. (2-tailed)	.829	.796
	N	72	66
Enabling Others to Act	Pearson r	.138	.205
	Sig. (2-tailed)	.246	.098
	N	72	66
Modeling the Way	Pearson r	.136	.108
	Sig. (2-tailed)	.255	.388
	N	72	.66
Encouraging the Heart	Pearson r	-.117	.058
	Sig. (2-tailed)	.333	.645
	N	71	65

^aNote that N=66 for total years of experience because 10 cases were not included in the analysis due to total years of experience for the 10 individuals was too close to age or exceeded age. Therefore, accuracy of years experience was questioned. One NE did not report age. N=72 for age, four individuals did not complete the LPI and one did not report age.

To determine differences in education levels a t-test for independent samples was used. First the types of degrees were categorized into two groups see Table 14. Nurse Executives reported holding a master's degree as the highest degree 89.6%, while 9.1% had a doctorate degree, and 1.3% reported having a bachelor's degree as the highest degree. Table 15 contains the descriptive statistics for education levels and Leadership Practices. Means for the Nurse Executives with doctorate degrees were slightly higher for each of the LPI scales than the means of the Nurse Executives with a master's degree.

Table 14

Highest Degree Obtained

	f	%
Bachelor's	1	1.3
Master's	69	89.6
Doctorate	7	9.1
Total	77	100

Table 15

Education and Leadership Practices Descriptive Statistics

	Highest Degree	N^a	Mean	SD
Challenging the Process	Master's	66	47.8788	6.0625
	Doctorate	6	52.3333	3.7238
Inspiring a Shared Vision	Master's	66	47.4697	6.4741
	Doctorate	6	50.1667	4.9565
Enabling Others to Act	Master's	66	52.7121	4.0259
	Doctorate	6	55.3333	3.0768
Modeling the Way	Master's	66	51.2121	4.3906
	Doctorate	6	52.8333	3.4881
Encouraging the Heart	Master's	65	48.9846	5.7350
	Doctorate	6	51.5000	6.1887

^aNote N = 66 for Master's degree and N = 6 for Doctorate degree, four individuals did not complete the LPI and one had a bachelor's degree and was not included in this analysis.

The *t*-test for independent samples of education and Leadership Practices results are in Table 16. Because the probabilities for Levene’s test for equality of variances were all greater than .05 for all five leadership practices, the *t*-test that assumes equal variances was used. There were no statistically significant differences between education levels and leadership practices ($p > .05$).

Table 16

t-test for Education and Leadership Practices

		Levene’s test for equality of variances		t-test for equality of means		
		F	Significance		df	Significance (2-tailed)
Challenging the Process	Equal variances assumed	.963	.330	1.763	70	.082
Inspiring a Shared Vision	Equal variances assumed	.332	.566	.992	70	.325
Enabling Others to Act	Equal variances assumed	.354	.554	1.550	70	.126
Modeling the Way	Equal variances assumed	.845	.361	.878	70	.383
Encouraging the Heart	Equal variances assumed	.096	.757	1.022	69	.310

Chapter 5 includes a summary of the data, conclusions, and recommendations for practice and for further research.

CHAPTER 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter consists of a summary of the findings, conclusions, and recommendations for practice and for further research. The purpose of this research was to explore self-reported leadership practices of Veterans Health Administration (VHA) Medical Center Nurse Executives, examine leadership strengths of the Nurse Executives, and report professional development needs of the Nurse Executives.

Summary of Findings

The results of this study indicate that this population of Nurse Executives is practicing transformational leadership behaviors; however, there are several areas in which further training and investigation are needed. The summary of findings includes demographic data, and the findings are presented as responses to individual research questions.

Demographic Data

Seventy-seven Nurse Executives employed in the Department of Veterans Affairs Medical Centers throughout the United States participated in this study, a response rate of 55%. The Nurse Executives that participated in the study were 88% female and 12% were males. A large majority of the Nurse Executives (89.9%) held a master's degree but 9.1% reported having a doctorate as their highest degree. Forty-five percent of the Nurse Executives had a nursing/nursing specialty degree, 29.9% had an administrative/management/leadership degree, and 9.1% had a health education/nursing education degree as their field of study for highest degree earned. The Nurse Executives reported approximately 18 years ($\underline{M} = 17.7$) years experience as an administrative nurse and a mean of 11.5 years' experience as a clinical nurse.

Overall the Nurse Executives were a highly educated group with several years of experience in nursing administration and clinical nursing.

The majority of the Nurse Executives (50.6%) reported their title as Associate Medical Center Director for Nursing (or Patient Care) and 35.1% reported having other similar titles. The title of Chief, Nursing Service was reported by 10.4% of the Nurse Executives. There is a lack of consistency in Nurse Executive titles within the VA, which mirrors the private sector as reported by Clifford (1998).

Research Question 1

What are the self-reported leadership practices of the Nurse Executives as measured by the Leadership Practices Inventory (LPI)?

The self-reported leadership practices of the Nurse Executives as measured by the Leadership Practices Inventory were higher than those reported in previous research (Kouzes & Posner, 2002b). Using mean scores, with the range of 0 to 60, the Nurse Executives scored highest in enabling others to act (52.97), modeling the way (51.34), and encouraging the heart (49.29). They scored slightly lower in challenging the process (48.28) and inspiring a shared vision (47.73). The findings indicate that the respondents reported engaging in enabling others to act, modeling the way, and encouraging the heart very frequently. They reported engaging in challenging the process and inspiring a shared vision, slightly less than the other three behaviors.

The reliability analysis (Cronbach Alpha) for this study was consistently high and supported the results for Kouzes and Posner (2002b) for challenging the process, inspiring a shared vision, enabling others to act, and encouraging the heart. The scale of modeling the way had a reliability of .60 alpha compared to Kouzes and Posner's reported reliability of .77 alpha. This unexplained deficit in reliability should be explored in future research.

Research Question 2

Is there a difference between self-reported leadership practices of Nurse Executives and effective leadership practices reported in the existing literature?

To analyze the differences between self-reported leadership practices of Nurse Executives and other effective leadership practices reported in the existing literature, Kouzes and Posner's research data (2002b) was used. The self-reported means of the Nurse Executives were all higher than the means in Kouzes and Posner's research. The rank order of the leadership scales was very similar (Table 17). Enabling others to act and modeling the way, were the most frequently practiced skills for both groups. Inspiring a shared vision was the least practiced skill for both groups. Encouraging the heart was third, and challenging the process was fourth for the Nurse Executives, and the rank order for these two scales were reversed in Kouzes and Posner's data. The Nurse Executives report very similar leadership practices as Kouzes and Posner's population of 2,072 leaders. The results of this research question indicate that the Nurse Executives in this population practice these leadership behaviors more often than the leaders in Kouzes and Posner's research.

Table 17

Mean Score Comparisons and Rank Order of Nurse Executives and Kouzes and Posner's Research (2002b)

	Rank order	Kouzes and Posner	Rank order	Nurse Executives
	Kouzes & Posner	Mean	Nurse Executives	Mean
Enabling others to act	1	48.7	1	52.9
Modeling the way	2	47.0	2	51.3
Challenging the process	3	43.8	4	49.2
Encouraging the heart	4	43.9	3	48.2
Inspiring a shared vision	5	40.6	5	47.7

To determine if the differences between the means of the Nurse Executives in this study and Kouzes and Posner's research were statistically significant, a ONEWAY ANOVA procedure was used. The analysis resulted in a statistically significant difference at the $p=.0005$ level of significance for each of the leadership practices. This serendipitous finding indicated that the self-reported leadership practices of the Nurse Executives were statistically significantly higher than the self-reported leadership practices of the leaders in Kouzes and Posner's research. This finding suggests that the Nurse Executives in this study engage in the leadership practices more frequently than the leaders in Kouzes and Posner's research. These results support a study by Troutt (1994) in which the author found that top administrative individuals (all nurses) of a Home Health Care agency practiced transformational leadership behaviors more often than leaders in Kouzes and Posner's data. Note that these are self-reported leadership practices and observer data was not collected for this study. More accurate assessment of leadership practices could be obtained if the LPI- Self scores could be compared to LPI-Observer scores.

Research Question 3

Does leadership training have an effect on leadership practices?

Reported leadership training did not have an effect on leadership practices in this study. There were no statistically significant differences between leadership practices and number of training types. Leadership training was relatively high for this population, with 88% of the Nurse Executives having reported attending at least one leadership training type, while 75% of the Nurse Executives reported attending two or more training types. Because of the diversity of training types and high number of training types attended by the Nurse Executives, this population appears to be well trained in leadership.

This question had 10 possible options to complete for training types, with a description of the training, length of training, and value of training for each training event. Therefore, the question may have been too cumbersome to fully complete. The author analyzed only the

number of training types reported by the Nurse Executives. Because of the diversity in the actual training types reported by the Nurse Executives it was difficult to analyze the types of training. For future research this question should be modified to improve data collection for specific training types.

Research Question 4

Are there differences between self-reported leadership practices of Nurse Executives serving on the Top Management Team (TMT) of the Medical Center compared to Nurse Executives not on the TMT?

There were 62 (80.5%) Nurse Executives who reported serving on the TMT of their Medical Center and 12 (15.5%) Nurse Executives who reported not serving on the TMT of the Medical Center. Nurse Executives have been elevated to the TMT in 80.5% of this population of Nurse Executives, which is encouraging. This finding supports the conclusions of (Dwore et al., 2000). There were no significant differences in leadership practices reported between the Nurse Executives serving on the TMT and those not on the TMT. Although the differences between those serving on the TMT and those not on the TMT were not statistically significant, the means for challenging the process and inspiring a shared vision were higher for the Nurse Executives serving on the TMT. This indicates that the Nurse Executives on the TMT more frequently engage in challenging the process and inspiring a shared vision than Nurse Executives who are not on the TMT. If there are no significant differences between these two groups, this raises questions as to why the Nurse Executives who are not on the TMT have not been promoted to the TMT if they are practicing similar leadership behaviors.

Research Question 5

What are the essential leadership skills identified by Nurse Executives?

The Nurse Executives identified a number of leadership skills; of these, four categories were actually more administrative/management than leadership skills. The administrative/management skills identified were financial skills, organization skills, personnel management, and results oriented tasks. Nursing knowledge skills were also identified as essential skills that were not directly leadership skills. The remaining 20 categories were all leadership skills. The majority of the skill categories could be classified as transformational leadership characteristics. The skill categories that could be linked directly or indirectly to transformational leadership include: communication skills, interpersonal skills, integrity, visionary skills, coaching-mentoring, conflict-negotiation skills, systems thinking skills, personal mastery, flexibility, collaboration skills, analytical-critical thinking skills, strategic planning skills, innovation skills, change agent, facilitation skills, enabling skills, decision making skills, employee-customer focus, and leadership skills. This leadership skills set identifies the essential leadership skills needed by Nurse Executives as reported by the Nurse Executives in this study. Evaluation of this skills set should be a starting point for development of professional development training for Nurse Executives. Based on the reported skills identified by the Nurse Executives in this study, professional development for Nurse Executives should include transformational leadership skills, financial skills, organization skills, and personnel management skills.

Research Question 6

Are there demographic characteristics of Nurse Executives (gender, age, years of experience, and education level) that are related to differences in the self-reported leadership practices as measured by the LPI?

There were no significant differences at the .05 level of significance in gender, age, years of experience, and education level that were related to differences in the LPI results. These findings support the research of Kouzes and Posner (2002b), which has found that the LPI scores

are generally unrelated to demographic characteristics of age, gender, years of experience, and education level.

Conclusions

In *Critical Issues in Global Health* (2002) Filerman and Pearson suggested that transformational leadership must be used to reengineer the national health system. The VHA Nurse Executives in this group report that they are using transformational leadership practices regularly. Overall the self-reported leadership practices of this population of Nurse Executives indicate that the Nurse Executives are engaged in the five leadership practices of challenging the process, inspiring a shared vision, enabling others to act, modeling the way, and encouraging the heart. The Nurse Executive strengths are in enabling others to act, modeling the way, and encouraging the heart. They scored slightly lower in challenging the process and inspiring a shared vision. The self-reported LPI scores of the Nurse Executives in this study were statistically significantly higher than the leaders in Kouzes and Posner's research (2002b). The high response rate of this study indicates that the Nurse Executives are interested in their leadership abilities. Within this group of Nurse Executives, four fifths are serving on the Top Management Team of their medical center, which is an elevated and prominent position within the medical center.

Based on the reported skills identified by the Nurse Executives in this study, professional development for Nurse Executives should include: transformational leadership skills, financial skills, organization skills, and personnel management skills. Incorporating these skills into an organized professional development program for Nurse Executives and nurse leaders could be a starting point to improving health care organizations. Transformational leadership skills, as the primary focus of a professional development program for Nurse Executives, could make a difference in overall organizational performance of health care organizations by improving job satisfaction, productivity, and organizational commitment of employees.

Practice Recommendations

The Leadership Practices Inventory and the Leadership Challenge model of leadership by Kouzes and Posner (2002a) provided a framework for leadership development and analysis. As a result of this study, the following recommendations are proposed to promote leadership development.

1. As the demands on healthcare continue to increase, transformational leadership should be a focus of Nurse Executive training.
2. Processes should be in place to provide transformational leadership training to new Nurse Executives and to nurse leaders at all levels within each of the Medical Centers.
3. A leadership needs assessment should be conducted to address transformational leadership training needs of Nurse Executives.
4. The Leadership Practices Inventory is a model that can and should be used to assess nurse leadership practices at all levels of leadership within nursing.
5. Evaluating leadership practices, implementation of a leadership training program, and reevaluation of leadership practices would be helpful in determining the effects of a leadership-training program on Nurse Executive leadership practices.
6. Based on the findings of this research, professional development of Nurse Executives and Nurse leaders should include: transformational leadership skills (especially skills in challenging the process, and inspiring a shared vision), financial skills, organization skills, and personnel management skills.

Recommendations for Further Research

From the results and conclusions of this study, the following recommendations for additional research are indicated.

1. Additional research in this field is needed to assess not only self-reported leadership practices but also observer (including follower, peer, and supervisor) assessment of leader practices, which would provide a more complete understanding of leadership practices.
2. As a result of the literature review indicating support for the use of transformational leadership by Nurse Executives and the results of this study, additional research is warranted to determine specific aspects of transformational leadership training needs of Nurse Executives.
3. Additional research is needed to assess specific training needs of Nurse Executives in the areas of financial skills, organization skills, and personnel management skills.
4. Additional research is needed to investigate the possible implications of the implementation of the Leadership Challenge model (Kouzes & Posner, 2002a) on leadership practices of Nurse Executives.
5. Evaluating leadership practices, implementation of a leadership training program, and reevaluation of leadership practices would be beneficial in order to determine the effects of a leadership training program on Nurse Executives leadership practices.
6. Comparisons of Nurse Executive LPI results with other management positions within the VA medical centers would provide a more complete understanding of VHA Nurse Executive leadership in relationship to other leaders within the medical centers.
7. As a result of the high LPI mean scores of the Nurse Executive, it would be informative and insightful to assess and compare Nurse Executive aptitude and the LPI.
8. Further research is needed to determine if improved Nurse Executive leadership leads to improved patient care, health outcomes, and patient satisfaction.

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APPENDICES

APPENDIX A

Approval letter to use LPI

KOUZES POSNER INTERNATIONAL

15419 Banyan Lane
Monte Sereno, California 95030
Phone/FAX: (408) 354-9170

November 14, 2002

Ms. Virginia H. Bieber
3985 Wabaska Drive #3
San Diego, California 92107

Dear Virginia:

Thank you for your request to use the Leadership Practices Inventory (LPI) in your dissertation. We are willing to allow you to reproduce the instrument as outlined in your letter, at no charge, with the following understandings:

- (1) That the LPI is used only for research purposes and is not sold or used in conjunction with any compensated management development activities;
- (2) That copyright of the LPI, or any derivation of the instrument, is retained by Kouzes Posner International, and that the following copyright statement be included on all copies of the instrument: "Copyright ©1997 James M. Kouzes and Barry Z. Posner. All rights reserved. Used with permission.";
- (3) That one (1) **bound** copy of your dissertation and one (1) copy of all papers, reports, articles, and the like which make use of the LPI data be sent promptly to our attention; and,
- (4) That you agree to allow us to include an abstract of your thesis and any other published papers utilizing the LPI on our various websites.

If the terms outlined above are acceptable, would you indicate so by signing one (1) copy of this letter and returning it to us. Best wishes for every success with your research project.

Cordially,



Barry Z. Posner, Ph.D.
Managing Partner

I understand and agree to abide by these conditions:

(Signed) Virginia Bieber Date: November 24, 2002

APPENDIX B

Demographic Questions

**Please answer the following questions about yourself.
These questions are for statistical purposes only and are optional.**

Thank you for your help. Your participation is greatly appreciated.

Directions: Please indicate the answer that best describes your situation by marking the response in the space provided or entering text in the provided text box.

1. What is your gender? Male Female
2. What is your age? _____
3. Please indicate all degrees earned and list specific degree: (type in degree content area, example, Master's degree: Master's degree of Public Health).
 - No degree
 - Diploma (3 year program)
 - Associate degree Associate type
 - Bachelor's degree Bachelor type
 - Master's degree Masters type
 - Doctorate Doctorate type
 - Please list additional degrees you may have Additional degrees
4. Are you currently working on a degree or enrolled in an educational program? If yes, please list specific degree you are pursuing or educational program you are enrolled in.
 - Yes, Degree or educational program
 - No

7. Have you had specialty training in **leadership and or management**, (courses, workshops, seminars, certifications)? If yes, please list titles, brief description of training, and length of training. Please indicate if the training was valuable or not valuable. Describe length of training as number of hours, days, weeks, months or years (Ex: 4 weeks)

Select

None

	Name:	Description:	Length:	Was this valuable?	
<input type="checkbox"/> Certification	a.			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b.			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Course	a.			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b.			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Workshop	a.			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b.			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Seminars	a.			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b.			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Other	a.			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b.			<input type="checkbox"/> Yes	<input type="checkbox"/> No

6. Please indicate total number of years experience as an

Clinical Nurse _____yrs

Administrative Nurse _____yrs

Other professional experience, please list (with total years of other professional experience) _____ yrs

7. What is your current title?

Chief, Nursing Service

Associate Medical Center Director for Nursing (or Patient Care)

Other, please list _____

8. Do you serve on the Top Management Team (or Senior Management Team) of the Medical Center?

No

Yes

9. From your experience, please list what you believe to be the 5 most essential leadership skills of exemplary Nurse Executives.

1. _____

2. _____

3. _____

4. _____

5. _____

APPENDIX C

Leadership Practices Inventory [LPI]

Self

Please enter your complete name: _____

Instructions

Below there are thirty statements describing various leadership behaviors. Please read each carefully. Then look at the rating scale and decide how frequently you engage in the behavior described.

**All questions on the LPI questionnaire must be answered to obtain a complete score.
Here is the rating scale that you will be using:**

1 = Almost Never	6 = Sometimes
2 = Rarely	7 = Fairly Often
3 = Seldom	8 = Usually
4 = Once in a while	9 = Very Frequently
5 = Occasionally	10 = Almost Always

In selecting each response, please be realistic about the extent to which you actually engage in the behavior. Do not answer in terms of how you would like to see yourself or in terms of what you should be doing. Answer in terms of how you typically behave – on most days, on most projects, and with most people.

For each statement, decide on a rating and record it in the drop-box provided to the left of the statement. Do not leave any statement incomplete. Please remember that all statements are applicable. If you feel that any statement does not apply to you, in all likelihood it is because you do not frequently engage in the behavior. In this case, assign a rating of 3 or lower.

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Leadership Practices Inventory [LPI]

Self

To what extent do you typically engage in the following behaviors? Choose the number that best applies to each statement from the drop-box provided to the left of the statement. If you feel that any statement does not apply to you in all likelihood it is because you do not frequently engage in the behavior. In this case assign a rating of 3 or lower.

Response Guide

1 = Almost Never	6 = Sometimes
2 = Rarely	7 = Fairly Often
3 = Seldom	8 = Usually
4 = Once in a while	9 = Very Frequently
5 = Occasionally	10 = Almost Always

- __1. I seek out challenging opportunities that test my own skills and abilities.
- __2. I talk about future trends that will influence how our work gets done.
- __3. I develop cooperative relationships among the people I work with.
- __4. I set a personal example of what I expect from others.
- __5. I praise people for a job well done.
- __6. I challenge people to try out new and innovative approaches to their work.
- __7. I describe a compelling image of what our future could be like.
- __8. I actively listen to diverse points of view.
- __9. I spend time and energy on making certain that people I work with adhere to the principles and standards that we have agreed on.
- __10. I make it a point to know about my confidence in their abilities.
- __11. I search outside the formal boundaries of my organization for innovative ways to improve what we do.
- __12. I appeal to others to share an exciting dream of the future.
- __13. I treat others with dignity and respect.

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- __14. I follow through on the promises and commitments that I make.
- __15. I make sure that people are creatively rewarded for their contributions to the success of our projects.
- __16. I ask “What can we learn?” when things do not go as expected.
- __17. I show others how their long-term interests can be realized by enlisting in a common vision.
- __18. I support the decisions that people make on their own.
- __19. I am clear about my philosophy of leadership.
- __20. I publicly recognize people who exemplify commitment to shared values.
- __21. I experiment and take risks even when there is a chance of failure.
- __22. I am contagiously enthusiastic and positive about future possibilities.
- __23. I give people a great deal of freedom and choice in deciding how to do their work.
- __24. I make certain that we set achievable goals, make concrete plans, and establish measurable milestones for the projects and programs that we work on.
- __25. I find ways to celebrate accomplishments.
- __26. I take the initiative to overcome obstacles even when outcomes are uncertain.
- __27. I speak with genuine conviction about the higher meaning and purpose of our work.
- __28. I ensure that people grow in their jobs by learning new skills and developing themselves.
- __29. I make progress toward goals one step at a time.
- __30. I give the members of the team lots of appreciation and support for their contributions.

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APPENDIX D

Letter eliciting participation

Dear Colleague:

As mentioned in the March 2003 Nursing Conference Call, Virginia Bieber, a doctoral student from East Tennessee State University (ETSU), will be sending an e-mail to each nurse executive asking for participation in her doctoral dissertation research project. Her project is titled, "Self Reported Leadership Practices of Nurse Executives". The purpose of the project is to explore self reported leadership practices of VA nurse executives, examine leadership strengths, and report professional development needs of nurse executives. Incentives will be available within the survey.

Your participation in this project is voluntary and that only Nurse Executives complete the survey. Your time, participation and support of Ms. Bieber's efforts are, however, much appreciated. If you have questions please contact Ms. Bieber at (619) 795-0199 in San Diego or you may contact me. Thanking you in advance.

Sincerely,

Juan A. Morales, RN, MSN

Associate Director Patient/Nursing Services

James H. Quillen VAMC

423-926-1171, ext. 7213

423-979-3412 (fax)

APPENDIX E

Letter to Nurse Executives

Dear Nurse Executive,

I am a graduate student pursuing a doctorate degree in Educational Leadership at East Tennessee State University, Johnson City, Tennessee. My dissertation research centers on Nurse Executive leadership. As nurse leaders have evolved into executive positions in health care organizations, issues of leadership have become a focal point in health care literature. Nurse Executive leadership style has been associated with health care organization success. The purpose of this research is to explore self-reported leadership practices of Veterans Health Administration (VHA) Medical Center Nurse Executives, examine leadership strengths of the Nurse Executives, and report professional development needs of the Nurse Executives.

I am requesting that you complete the online Leadership Practices Inventory questionnaire and demographics questionnaire and submit electronically. Each individual who participates will receive his or her own individual results of the Leadership Practices Inventory for personal use. Leadership Practices Inventory by Kouzes and Posner is a highly respected model in the field of Leadership.

I know that you have a lot of demands on your time and you may not be interested in completing a survey for someone whom you do not know. Although I cannot compensate you individually for your time, at the conclusion of the study, a drawing will be held in which each participant who completes the survey will have two chances to win \$250.00 that will be donated to your facility's nursing education department. You may use the donation for texts, training, or any form of nursing education that you choose.

Your participation is voluntary and you may elect not to answer any questions that make you feel uncomfortable. Every attempt will be made to maintain confidentiality. The Nurse Executive's name will be used solely for the purpose of follow-up on those who have not responded by the deadline of May 5, 2003, individual self-assessment scores, and selection of winners of the incentive awards. All statistical analysis will be in summary form (no specific person or facility will be identified). The abstract of the study will be e-mailed to each participant at the conclusion of the study.

Thank you for your time and participation. If you have any questions do not hesitate to contact me at 619-795-0199 (please note that I live in the Pacific time zone). Please connect to the following web page to complete the survey <http://www.visn9.us/lpi>.

Sincerely,

Virginia H. Bieber

Graduate Student

East Tennessee State University

APPENDIX F

Thank you letter for participation

Dear Nurse Executive,

Thank you to those who participated in my research project on Leadership Practices of Nurse Executives. I am truly grateful for your participation. The purpose of this research was to explore self-reported leadership practices of Veterans Health Administration (VHA) Medical Center Nurse Executives, examine leadership strengths of the Nurse Executives, and report professional development needs of the Nurse Executives. An abstract of the results of the study is attached.

For those who participated in this research project a drawing has been held in which each participant who completed the survey had two chances to win \$250.00 that was donated to their facility's nursing education department. The two facilities were selected and received the \$250.00 incentive awards. To protect anonymity I am not be able to disclose the names of the facilities that were selected.

Thank you again for your time and participation in this research project. If you have any questions do not hesitate to contact me at 619-795-0199 (please note that I live in the Pacific time zone).

Sincerely,

Virginia H. Bieber

Graduate Student

East Tennessee State University

VITA

VIRGINIA HOLT BIEBER

- Personal Data: Date of Birth: March 15, 1967
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Clinical Nutrition, M.S., 1993
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