PARTICIPATIVE CULTURE: IMPACT ON ORGANIZATIONAL COLLEAGUE COMMITMENT AND PRODUCTIVITY
A RESEARCH PAPER
SUBMITTED TO THE GRADUATE SCHOOL IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE MASTERS OF SCIENCE
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DECEMBER 2009
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ABSTRACT

Multiple challenges confront healthcare leaders, making it difficult to maintain a competitive advantage. Leadership and organizational culture are two important explanatory constructs influencing organizational performance. High performance and colleague commitment are increasingly important factors associated with a success of an organization. Healthcare organizations must have a strategic plan to ensure a foundation of highly committed and productive colleagues. The purpose of this descriptive correlational study is to explore the relationship between organizational participative culture perceptions and colleague commitment and productivity. A convenience sample of 100 nurses from a small community hospital will be recruited. An online survey will be conducted using an 18-item questionnaire designed to measure organizational climate. Commitment and productivity will be measured with employee customer service scores, one yes or no question to the participants about having ever made a significant medical error, Maslach’s Burnout Inventory, and Ross and Hulin’s Turnover Intentions Scale. Study results will provide information about the correlation between organizational culture perceptions and commitment and productivity. Healthcare leaders may be able to use this information in strategic planning to enhance colleague commitment and productivity and to improve quality of care.
Chapter I

Introduction

Participative management addresses the relationship between the organization and its colleagues. It examines fundamental issues of governance within an organization and the role of colleagues and external stakeholders in all levels of organization. Participative management is particularly well-suited for science-based organizations whose key colleagues are noted for their creativity, intrinsic motivation for work that interests them, stronger affiliation with their discipline, and sensitivity to directive management. Participative management is an open form of management where colleagues have a strong decision-making role. Leaders who actively seek a strong cooperative relationship with their colleagues develop participative management. The advantages of participative management include increased productivity, improved quality, and reduced costs. The numerous challenges facing the healthcare industry have made it essential for organizations to find creative ways to gain and sustain a competitive advantage. Angermeier, Dunford, Boss, & Boss, (2009). Human capital may be the greatest challenge in creating an environment that is producing excellent quality, patient satisfaction, and efficiency. The health care industry is a field is subject to undergo increasing scrutiny, greater demands and changes in the near future. Organizations need to identify management strategies that will allow their organizations to succeed in the friable environment.
Overview

Since its origin with Mayo’s *The Human Problems of a Industrial Civilization* (1933), and Lewin’s field theory *The Hawthorne Event*, (1947), a variety of literature has been written on participative management, which includes colleague involvement, industrial democracy and stakeholder involvement. Recently, the focus has been on participative management and its relationship to dramatically improved information and communication technology, and greater colleague involvement in organizational decision-making.

Lewin’s (1947) work had a profound impact on social psychology and on appreciation of experimental learning, and group dynamics. Lewin believed that behavior was determined by the totality of the individual’s situation. Individuals were seen to behave differently according to the way in which tensions between perceptions of self and environment were worked through.

Mayo’s (1933) research examined the impact of work conditions in colleague productivity through his famous Hawthorne Studies. Mayo started these experiments by examining physical and environmental influences of the workplace, and later, moved into the psychological aspects and their impact on colleague motivation as it applies to productivity. Mayo’s work showed an increase in worker productivity related to the psychological stimulus of being singled out, involved, and made to feel important.

The literature reflects a growing recognition in order for an organization to achieve high productivity and improved quality managers require new labor-management strategies, including ways to share gains, organize work, and utilize the skills,
knowledge, and motivation of the workforce. Creating this type of organizational culture change will require the support from all levels.

Statement of Problem

Multiple challenges confront health care leaders, making it difficult to maintain a competitive advantage. Leadership and organizational culture are two important constructs influencing organizational performance. Healthcare organizations must have a strategic plan to ensure a foundation of highly committed and productive colleagues.

Purpose of Study

The purpose of this descriptive correlational study was to explore the relationship between organizational participative culture perceptions and colleague commitment and productivity. This was a partial replication of Angermeier et al.’s (2009) study.

Research Questions

1. Does participative management reduce colleague turnover, levels of burnout, medical errors, and improve customer service ratings?
2. What is the impact of participative management on colleague productivity and commitment to an organization?

Theoretical Framework

Kanter’s (1993) colleague empowerment and Pierce, Rubinfield and Morgan’s (1991) Conceptual Model of Process and Effects will be used to guide this study. Kanter’s theory was based on research indicating when colleagues are empowered, they perform better, are more committed to the organization, and less likely to leave, which all influence the effectiveness of the organization. Pierce, et al. (1991) found that two colleague perceptions were fundamental to the success of participative management. The
leadership must provide a transparent flow of information to colleagues and allow input from colleagues to base decisions on the work environment. Also, colleagues must feel they have some control over work and decisions that affect their personal well-being.

**Definition of Terms**

*independent variable: participative management.*

Angermeier et al. (2009) referred to participative management as leadership strategies that endeavor to increase colleague productivity by rewarding performance, fostering colleague commitment, and decentralizing decision-making to give colleagues a voice in their work environment.

*dependent variables: customer service.*

Angermeier et al. (2009) defined customer satisfaction as “the likelihood of recommending services”. Angermeier et al. indicated when colleagues that are more engaged and satisfied with their jobs, they are motivated to go the extra mile for their patients.

*dependent variables: medical errors.*

Angermeier et al. (2009) defined medical errors as any error made by a nurse that reached the patient.

*dependent variables: burnout.*

Angermeier et al. (2009) defined burnout as the result of reduced decision-making authority, lack of resources to buffer stress, and lack of access to information.

*dependent variables: turnover intentions.*

Angermeier et al. (2009) defined turnover intentions as, “How likely an individual is to look for another position?” If colleagues, “often think about quitting”.
Limitations

The study’s focus on a single organization places constraints on the generalizability of its findings. The small size of the sample in comparison to other studies can make the findings questionable. Also, the study was primarily cross-sectional, although some measures were taken at different time periods. The study will be conducted over a two-week period. Further research should be conducted to investigate the importance of different dimensions of ownership across a broader spectrum of organizations.

Assumptions

This descriptive correlational study replication was grounded by the following assumptions.

1. External environment changes require organizational change.
2. Leadership is capable of leading organizational cultural change.
3. Leadership is interested in improving their organization.
Chapter II

Literature Review

Multiple challenges face healthcare workers in the current state of the economy. One challenge is separating the viable organizations from those that cannot withstand the multiple pressures to maintain and sustain a competitive advantage. Contemporary management challenges in the healthcare industry have many different variables, but there is increasing evidence that management’s greatest issue is organizational foundation or culture Angermeier et al. (2009).

The purpose of this descriptive correlational study was to explore the relationship between organizational participative culture perceptions and colleague commitment and productivity. The variables in the study were participative management, employee customer service, medical errors, burnout, and turnover intention.

Organization of Literature

The literature review covers selected studies associated with the four measures. Angermeier et al. (2009) examined customer service, medical errors-patient outcomes, burnout, & turnover intentions. In recent literature there was a focus to capture current evidence in practice at an organizational level. The supportive literature reviewed was discussed per article.
Organizational Culture

Participative culture and practices have existed for more than a century. Angermeier et al. (2009) examined the impact on an organization’s sustainability and growth potential, setting such an organization apart from others in the same market. Two colleague perceptions, fundamental to the success of a participative management organization, are free flowing information and employee perceived control of the work environment. Decisions are made in a bottom-up fashion with the thinking that the colleagues at the direct care or manufacturing level would see the correct process and have an effective way to improve processes. Angermeier et al. (2009) hypothesized those colleagues who reported higher participative-climate perceptions will be less likely to have intentions to leave the organization, would be less likely to commit medical errors, have lower levels of burnout, and have excellent customer service ratings.

The online survey participants were part of a large healthcare organization in southeastern part of the United States. The organization employed approximately 5000 colleagues with 312 departments. The Human Resources Department was integral in supplying the names and demographic information of the participants. The survey took place over a two-week period in June 2007. Colleagues were notified one week prior to the survey of its existence to promote increased participation. Responses were received from 3,757 colleagues, representing a 75% respondent rate. Manager, administration, and colleagues with no direct care with patients were excluded from the survey to give accuracy to the medical errors section of the survey. Colleague surveys were excluded if there was incomplete data or missing customer service evaluations. The final count for the study was 2,522 participants. The average age of participants was 42.4 years old,
and the mean organizational tenure was 8.8 years. The respondents were primarily female (84%) and Caucasian (74%). Over half of the respondents (59%) had some college education and a small percentage (7%) had a Masters degree or higher.

Participative management was measured using the Likert Profile, an 18-item questionnaire designed to measure organizational climate along six dimensions: leadership, motivation, communication, decision-making, goal setting, and control processes. Colleague customer service scores were taken from the 2007 performance evaluation conducted by the organization each year. Management rates colleagues based on performance standards annually. Medical errors were measured using a “yes” or “no” response to ever making a medical error. Burnout was measured using Maslach’s Burnout Inventory cited in Angermeier et al’s. (2009). The inventory was made up of a 23-item scale that measure three sub-dimensions of burnout, including depersonalization, personal accomplishment, and emotional exhaustion. Turnover intentions were measured using Rosse & Hulin’s scale cited in Angermeier et al’s. (2009). The scale included one question and two statements with respondents answering in a Likert style. No reliability was reported.

The results indicated that participative management was positively related to customer service (CS) performance and negatively related to medical errors, burnout, and turnover. ANOVA results were confirmed in that a significant difference existed between participative-management systems for dependent variables CS (F=35.75, p<.01), burnout (F=126.28, p<.01), and turnover intention (F=146.67, p<.01). The likelihood of colleagues committing a medical error was lowest among colleagues who rated the work climate as participative and highest when they rated the climate as
exploitive authoritarian. ANOVA and logistic regression results supported the hypothesis. Colleagues in highly participative work climates provided 14% better CS, committed 26% fewer medical errors, demonstrated 79% lower burnout, and felt 61% lower likelihood of leaving the organization than those in authoritarian work climates.

In conclusion, Angermeier’s et al. (2009) hypothesis was tested and proven to be significant. Participative management was a culture developed in an organization. The focus of participant management was on improving the commitment to the organizational vision, mission and productivity. Participative management was accomplished through colleague pay-for-performance, transparency, decentralization decision-making, and job enhancement. It could be assumed that having a participative management culture would be linked to a high level of performance and customer satisfaction. The findings suggested that organizations would benefit from enhancing the work climate to participative rather than authoritarian. This change in culture would bring many challenges to an organization; but as this study has indicated, the benefits were worth the effort.

Casida and Pinto-Zipp (2008) examined the relationship of leadership style and organizational culture as the driving force of success or failure in an organization. This study was based in an acute care hospital, which achieved excellence in customer satisfaction scores. Casida and Pinto-Zipp (2008) explored the management styles and their impact on the organizational culture, thus producing excellent patient satisfaction scores. Casida and Pinto-Zipp (2008) conducted a study that described how first line leaders lead in a transformational manner was more effective than those with alternative styles of leadership. The leader must create and implement a vision of what could be
accomplished at work and empower colleagues to use the vision as the foundation. The leader must develop a motivating work-climate molding colleagues to achieve more with less and taking accountability beyond own self-interests for the good of the organization.

The setting of Casida and Pinto-Zipp’s (2008) study was four acute care hospitals in the largest health care system in New Jersey. A convenience sample of nurse managers and staff registered nurses was drawn from all four hospitals with the assumption that all four hospitals in the system shared the same philosophy, mission, and core values. All participants worked in units that had good performance ratings on quality of care and patient satisfaction exceeding the health care systems benchmarks during the first and second quarter of 2006. Inclusion criteria included: (a) A nurse manager must have been in her position for at least 6 months, (b) The nursing unit is staffed by 15 or more staff nurses; and (c) A full-time day shift nurse who has worked and reported to the same nurse manager for 6 months or more. The only exclusion criterion was being a night shift staff nurse due to the assumption of minimal contact with the nurse manager.

Thirty-seven nurse managers qualified and agreed to participate in the study. One hundred staff nurses from each of the four hospitals participated. The nurse managers were primarily Caucasian, females with the mean age of 45.7 years old. The staff nurses were also primarily Caucasian females with the mean age of 40.9 years old. All of the participants were experienced in their roles.

A survey was used as the study instrument, which had to be completed by the participants within 30 days of distribution of the survey packet. The survey was a multi-factor leadership questionnaire (MLQ) measuring three types of leadership styles:
transformational, transactional, and non-transactional Laissez-faire. The MLQ was determined to be a reliable and a valid instrument used extensively in multiple organizations. Denison’s Organizational Culture Model (2005) was used as a conceptual framework examining adaptability, mission, involvement, and consistency in an organization.

The analysis of data in Casida and Pinto-Zipp’s (2008) study demonstrated statistically significant correlations between leadership and organizational culture variables. Transformational leadership (TF) showed a strong correlation with a positive organizational culture (M=3.6, SD=0.58). Non-Transactional Laissez-faire leadership showed a negative correlation with organizational culture (r= -0.34, p=0.000). Organizational effectiveness was connected to transformational leadership due to the high positive correlation of the traits on the nursing units. There was a strong positive correlation between transformational leadership and positive organizational culture. There was a negative correlation between Laissez-faire leadership and positive organizational culture.

The findings suggested that when nurse managers frequently display TF leadership behavior with colleagues there is likely to be a positive, desirable, and flexible nursing unit organizational culture in which the mission and adaptability culture traits dominate. Nursing unit managers have many challenges in the litigious health care climate. Developing a solid, empowering foundation would enable the organization to meet the demands of the consumers. A nurse manager’s leadership style shapes the unit that the person oversees.
Amos and Weatherton (2008) examined the fit or match between person and an organization using the Person-Organization (P-O) Fit Theory. The concept of P-O fit was ideal in an organization because it suggested that the individual who fits well with in the organization was likely to display positive attitudes and behaviors thus display improved job satisfaction. The author analyzed value congruence across seven dimensions and its relationship to: (a) job satisfaction, (b) organizational commitment, (c) satisfaction with the organization as a whole, and (d) turnover intentions. The author hypothesized that employees who have high levels of congruence on these seven dimensions will also report higher levels of job and organizational satisfaction and organizational commitment. These particular colleagues will also have lower turnover rates. The colleagues will become more empowered to feel ownership to the end product or outcomes.

The participants in Amos and Weatherton (2008) study were 151 undergraduate and graduate students from a mid-sized university in southern United States. Two-thirds of the participants were women with a mean age of 23 years old. Ninety-five percent of the students had part-time jobs. The participants were primarily Caucasian (70%). The response rate for the questionnaire that was completed during a class period was 92%. Incomplete questionnaires were not used in the data analysis. There were five instruments used in the study:

1. Value congruence was measured using the Seven Values of Excellence Scale. Each participant used a Likert-type scale to rate seven values, which included: superior quality and service, innovation, importance of people as individuals,
importance of details of execution, profit orientation, goal accomplishment, and communication. The reliability coefficient for this instrument was .75.

2. Job satisfaction was measured using the Overall Job Satisfaction Scale. The scale consisted of 18 statements using a Likert-type scale rating. Reliability coefficient = .87.

3. Organizational satisfaction was measured using a modified Warr and Routledge scale. A Likert-type scale was used for scoring. Reliability coefficient was = .84.

4. Organizational commitment was measured using Affective Commitment Scale (ACS), Normative Commitment Scale (NCS), and Continuance Commitment Scale (CCS). Each scale consists of eight questions with Likert-type rating scale. Reliability coefficient was = .85, .69, and .68 respectively.

5. Turnover intentions were measured by using the Mobley, Griffeth, Hand, and Meglino scale. A Likert-type scale was used for rating. Reliability coefficient was = .86 (cited in Amos and Weatherton 2008).

The results supported the authors’ hypothesis. Total value congruence had a statistically significant positive correlation with job satisfaction (r = .41), organizational satisfaction (r = .41), affective communication (r = .36), and normative commitment (r = .34). Value congruence did not correlate significantly with continuance commitment. Congruence with value dimension was also calculated. Superior quality and service had a statistically significant positive correlation with job satisfaction (r = .24), organizational satisfaction (r = .33), affective commitment, (r = .30). normative commitment (r = .28), and turnover intent (r = .-17).
Amos and Weatherton (2008) study examined the relation between value congruence dimensions and employee attitudes. The superior quality and service, and importance of people value dimensions most predicted colleagues’ attitudes. The importance of people as individual’s value positively related to job satisfaction. The study demonstrated a positive correlation between colleagues’ values matching their organization, higher levels of job satisfaction and commitment, and lower levels of turnover. The P-O fit was essential to have a truly effective organization and productivity.

As leaders, it is important to display value-centered behaviors to engage colleagues to move toward the organizational goals. This study identified the importance of values and organizational fit to the effectiveness of an organization. The organizational culture must portray this image in order to achieve congruence.

Carney (2006) examined the extent to which organizational culture influenced strategic involvement. It was crucial for the strategic management of health care that the cultural dimensions affecting health service organizations were developed and understood. Carney emphasized the power of organizational culture and the importance of middle management involvement in the strategic development of health care delivery. Strategy was defined as the pattern or plan that integrates an organization’s major goals, policies, and action sequences into a cohesive whole. The on-going decision-making process required involvement at all levels of an organization. The development of strategy was an important component of the health services industry. Culture played a powerful role in shaping the life of an organization.
Carney (2006) proposed two hypotheses. The first hypothesis was strong organization culture positively influences strategic involvement. The second hypothesis was professional clinicians were more strategically involved than non-clinicians, and the relationship was dependent on a strong organizational culture.

A descriptive study design was used. Quantitative data were generated through a questionnaire. The sample was derived from a total of 860 middle managers in non-for-profit organizations in the Republic of Ireland. The study was conducted in 60 acute care hospitals and eight regional health boards. The total response rate after exclusions was 42%. The sample was comprised of 234 professional clinicians and 118 non-clinicians. The participants ranged in the age group from 31-45 years and 65% were females. Sixty-six percent of the respondents were professional clinicians.

The questionnaire used to collect data was designed to elicit middle manager views on strategic involvement and organizational culture. The research tool was divided into 3 sections: (a) Strategic Involvement – SI, (b) Organizational Culture – OC, and (c) Biographical and Demographical – BD. Likert-type rating scales were used in each of the sections. Cronbach’s reliability analysis was used to test the reliability sections 1 & 2. The reliability coefficients were: SI (r=0.91), OC (r = .69). Quantitative data from the study instruments were analyzed using the Statistical Package for Social Science.

Carney’s (2006) findings were separated into two categories: (a) strong organizational culture positively influences middle manager strategic involvement, and (b) professional clinicians are more strategically involved than non-clinicians. This relationship was dependent on a strong organizational culture.
1. Strong organizational culture: The hypothesis was supported using regression analysis (p= .0001).

2. Professional clinicians VS non-clinicians: Regression analysis indicated that culture made a unique contribution to the prediction of the involvement in both groups. The second hypothesis was not supported by the research.

The results supported middle managers remaining strategically involved in proposing, shaping, and developing new organizational strategic initiatives; thereby, being key partners in shaping the organizational culture. Carney’s (2006) study emphasized the importance of colleague involvement because it was the organizational culture. The respondents predicted strong organizational culture as professionalism and commitment to the delivery of high quality care.

Manojlovich (2007) examined the impact of structural empowerment on professional work environment factors that lead to nursing job satisfaction. This view brought an interesting dynamic to the evaluation of correlation between work climate and the classic structure-process-outcome paradigm. Manojlovich chose to research the concept of building a supportive environment for nursing, which would improve patient outcomes and nurses’ job satisfaction. The Nursing Worklife Model was developed by Leiter and Laschinger (2006) to explain how organizational and nursing unit influences affect nurses’ lives in the workplace by either contributing to success or accelerating turnover. Manojlovich found literature to support the inclusion of nursing job satisfaction and empowerment in the Nursing Worklife Model and its seven domains.

Kanter’s Theory addresses the nurse leader’s role to access empowerment structures and to be able to use their influence to facilitate staff access to information,
support, resources, and opportunities. Nurses who perceive greater support and empowerment would in turn be more satisfied with their jobs.

The purpose of this study was to test a modification of Leiter and Laschinger’s Nursing Worklife Model (2006) in two different manners: (a) Does the Nursing Worklife Model explain nursing job satisfaction? (b) Does adding structural empowerment to the Nursing Worklife Model help explain additional variance in nursing job satisfaction? The study used a cross-sectional survey design to query a random sample of 500 acute care nurses in Michigan, during the summer of 2004. The study had a 66.4% return with a final number of 276 nurses. Surveys with incomplete data were excluded from the analysis. The nurses were selected from the Michigan Nurses Association. The average age of the participants was 42.9 years old. The nurses had unusually long tenure in current position with an average of 13 years of employment and an average of 17 years in nursing. The sample of nurses was primarily female (95%) and Caucasian (91%).

Instruments used in the study were the Conditions of Work Effectiveness Questionnaire-II (CWEQ-II), the Practice Environment Scale of Nursing Work Index (PES-NWI), and the Index of Work Satisfaction (IWS) (cited in Manojlovich, 2007).

The CWEQ-II questionnaire consisted of 19 items in six subscales based on Kanter’s theory of structural empowerment. The six subscales were; opportunity, information, support, resources, job activities, and organizational relationships. The tool used a 5-point Likert type scale for scoring. The reliability coefficient was 0.90.

The PES-NWI was used as a more focused measure of practice environment. A four-point Likert-type scale was used in scoring. There were 5 subsets within this measurement tool to assess the hospital environment that supported nursing practice;
nurse participation in hospital affairs, use of a nursing model as a basis of care on the unit, nurse manager ability, leadership and support of nurses, staffing and adequacy of resources and collegial nurse-physician relationships.

The IWS used a 7-point Likert-type rating scale and consisted of 41 items embedded in 7 subscales. The subscales measured the nurse’s satisfaction with autonomy, pay, and professional status, interaction with nurses, interactions with physicians, task requirements, and organizational policies. Reliability coefficient was 0.92.

Results of this study were described in two separate parts, hypothesis 1 and 2. All variables of the Worklife Model were statistically significant in explaining nurses’ job satisfaction, (P<1.01) supported hypothesis 1. Hypothesis 2 was supported as statistically significant for structured empowerment and its importance as an addition to the model.

In this study, nursing leadership functioned as a driving force behind practice domain factors. The configuration of the practice domain suggested there were points at which empowered nursing leaders could intervene to improve nurses’ job satisfaction. Nursing leaders could make a difference in the work place by changing the culture to a positive, engaging environment, thus improving job satisfaction and the ability to implement best practice and high quality.

Janssen (2004) examined the relationship between colleague empowerment and organizational commitment related to leadership support. The author proposed conflict with organizational leadership had a barrier affect in a positive relationship between colleague empowerment and organizational commitment. Leadership established goals
and the colleagues were supposed to support the goals. There was a disconnect between the desire and knowledge of the goals that the organization was pursuing. Conflicts with the leadership on goal attainment were due to lack of involvement, which might hinder colleagues empowered in developing or maintaining high levels of organizational commitment and reduce their engagement. This disconnect can cause higher rates of turnover and decreased quality of outcomes.

Janssen (2004) believed that enhanced competition and organizational change required colleagues commitment to maintaining and improving work processes, products, and customer service. The positive relationship between colleagues and their leaders was important, since leaders were the most salient agents of the organization who primarily determine the job products of subordinate colleagues.

The participants were teachers and educational executives. The teachers and executives were from primary and secondary schools. Forty-four percent (n = 91) of the teachers and executives responded to the survey. The survey completion was voluntary. The gender of the respondents was split evenly with 51% females with the average age of 43 years old and a mean tenure of 11 years in the system.

Three questionnaires were used in the survey. Empowerment was measured using a 12-item empowerment questionnaire to assess cognitions and feelings of empowerment. A 7-point Likert-type rating system was used. The reliability coefficient was (r=. 82). Interpersonal conflict with leaders was measured using several open-ended questions related to conflict with leaders, such as: (a) Do tensions occur between you and the executive staff? (b) Do you think the executive staff dislikes you? A 7-point Likert-type scale was used for scoring. The reliability coefficient was (r=. 85). Organizational
commitment was measured using a 9-item Organizational commitment Questionnaire. A 7-point Likert-type scale was used in scoring statements, such as I find that my values and the organizations values are very similar. The reliability coefficient was (r=. 92). Gender, age, and tenure were entered as covariates during analysis to control for the possibility of demographic differences in the predictor and outcome variables (cited in Janssen, 2004).

The findings of the study suggested that empowerment in interaction with higher levels of conflict with leaders did not significantly relate to organizational commitment. However, empowerment in interaction with lower levels of such conflict was significantly correlated with organizational commitment (p=<. 001). The results of the survey indeed indicate that a positive relationship between empowerment and organizational commitment disappears when colleagues are faced with higher levels of conflict with leaders. Empowered colleagues actively taking initiatives in work roles and leaders that resist those initiatives due to feeling threatened or simply not wanting to empower colleagues to advance in professional mission might obstruct a committed environment. The interpersonal conflict was found to be a salient job stressor. The study explored the relationship between improving these key factors with some additional requirements, and measurable high performance standards.

Meade (2005) examined how seven health care facilities evolved through an organizational change process with assistance of the Studer Group to become high performing organizations. A research study was conducted with the purpose of highlighting key factors that make an organization successful. Many organizations fail to realize the importance of colleague values and involvement, which must be in-line with
leadership. Meade (2005) discussed five factors that make organizations low performers of quality, and patient and colleague satisfaction: (a) colleagues aren’t held accountable (b) leadership team is not engaged, nor willing to model behaviors expected by colleagues, (c) leadership is not valued, (d) organization does not celebrate successes, and (e) inadequate communication regarding organizational goals.

Meades’ (2005) research utilized seven “high performing” hospitals which are defined by these measures: (a) patient satisfaction (>90%), (b) colleague satisfaction scores (>90%), (c) minimal colleague turnover (<12%), (d) market share dominance (8% growth in three years), financial returns or growth indicators (6.9% surplus or operating margin), and (e) quality improvements indicated by each facility as successful.

A total of 47-indepth personal interviews were conducted with all senior level administrators in each of the facilities using a standard questionnaire. The questions were open-ended and respondents were guaranteed anonymity. The average time for each interview was 24 minutes, conducted over a 3-week interval in the fall of 2005. The findings were summarized using content analysis. No reliability was reported.

The interviewers found five factors after the data was analyzed that were essential to “high performing” health care organizations. The data were as follows:

1. Executive and senior leadership commitment: 91% of the respondents agreed that passion; mission, vision, and commitment of top leaders in an organization must be evident to meet the measured success.

2. Leadership evaluation & accountability: 43% of respondents agreed that behavior standards of colleagues and leaders must be outlined and all individuals must be accountable for these behaviors. A “no excuses”
environment & performance evaluations are essential. Seventy-five percent of the top organizations tie compensation to performance and achievement goals. It was also important to deal with poor performers quickly due to the negative impact they can have on an organization.

3. Leadership development institutes and training: 34% of senior leaders discussed the lack of skills that middle management had before starting an improvement process and change in culture. The organizations then started leadership learning programs within the organization to achieve a sense of “unity” of knowledge, which in-turn can move the colleagues in a different direction toward success and productivity.

4. Communication and colleague transparency: 21% of the respondents agreed that transparency of results and successes of colleagues is critical. The respondents expressed the importance of the colleagues’ involvement in the organizational processes, providing them with the ability to strive toward the same goals.

5. Patient care #1: 21% of the respondents agreed that focusing on the patient as the #1 driving forces in the decisions they make each day is necessary for successful organizations. Placing patient care in the pivotal point in the vision was a goal of each of the organizations.

Meade’s’ (2005) research emphasized the relationship between key factors of successful organizations with proven measurable outcomes for the organizations. It is apparent that leadership needs to create a foundation for the cultural change in order for the change to be successful. Changing the way “we always have done things” is always a
monumental task. It is leadership’s responsibility to be supportive and transparent of the changes and make sure that all of the colleagues that refuse to “get on the bus” find another place to fulfill their mission if the organization isn’t a good professional fit.

Wolfe and Zwick (2008) examined the relationship between colleague organizational involvement and organizational productivity. The researcher emphasized the main principle behind all initiatives for increasing involvement of workers was to get the direct care colleagues involved in the decision-making and work processes. Getting individuals involved must be accompanied by greater autonomy and control over assigned job tasks and methods of work. The question Wolfe and Zwick (2008) wanted to answer was: Does increased colleague involvement raise organizational productivity?

The research was done by conducting interviews with 18,824 organizational executives over a four-year period. The interviews were done using a standardized questionnaire. The questionnaire covered turnover, number of colleagues, personnel problems, coverage by works councils, collective bargaining, training, investments, innovations, and business strategies. Three questions addressed colleague involvement: (a) shift of responsibility and decisions to lower levels of hierarchy, (b) introduction of team work/self-responsible teams, and (c) introduction of units with own costs/result determination. Insurance companies, banks, and organizations with no colleagues other than the owner were excluded. No reliability was reported.

The findings indicated exporters, firms with investments in information technology and modern equipment, and organizations with higher shares of qualified colleagues, were more productive. Wolfe and Zwick (2008) found that increasing colleague involvement and financial incentives seem to increase the productivity of the
organization in the cross-sectional analysis. The authors concluded, if leaders of organizations desire to increase productivity and efficiency, colleagues should be involved in the decision-making and strategy development of the organization.

Patrick and Spence-Laschinger (2006) examined the necessary restructuring in today’s health care environment and how it has affected nursing leadership. The authors of this study proposed the restructuring has disempowered nurse managers, which has negatively influenced manager’s ability to create a positive work climate, mentor potential nurse leaders, and gain satisfaction in their leadership role. Patrick and Spence-Laschinger stated, “this phenomenon can threaten the culture of nursing work environment and nursing retention in today’s chaotic health care setting.”(p.13)

The purpose of the study was to examine the relationship between structural empowerment and perceived organizational support and the effect of these factors on the role satisfaction of middle level managers. When colleagues have access to formal and informal power, they have greater access to information, support, and resources required to do the job well as well as grow and learn in the process. Two hypotheses were tested: (a) Structural empowerment is positively related to middle level nurse managers’ perceptions of organizational support and (b) Structural empowerment and perceived organizational support are positively related to middle level managers’ role satisfaction.

The participants of this study were derived from a larger study of nurse managers. Middle managers (n = 126) were randomly selected from a registry list of acute care hospitals. A survey was mailed to the selected participants. A total of 84 nurse managers responded with a mean age of 49 years old. Sixty percent of the respondents worked in
community hospitals with the mean bed number of 517. Most of the respondents were Master’s prepared.

Structural empowerment was measured using the Conditions for Work Effectiveness Questionnaire-II (CWEQ-II). Items were rated on a 5-point Likert type scale. The reliability coefficient was (r=0.56).

Perceived organizational support was measured using the short-form version of Eisenberg’s Perceived Organizational Support Survey (1990). The survey asked questions related to the organization’s valuation of the colleague and actions it would be likely to take in situations that affect the colleague’s well being. The scale consisted of 13 items that were rated on a 7-point Likert-type scale. The reliability coefficient was (r=. 90).

Role satisfaction was measured by the Alienation from Work scale. Aiken & Hage (1966) defined role dissatisfaction as alienation from work, manifested by feeling of disappointment with career and professional development, as well as disappointment over the inability to fulfill professional norms. The scale consisted of 6 items, which were rated on a 5-point Likert type scale. The reliability coefficient was (r=. 85).

The findings indicated a positive relationship between structural empowerment and perceived organizational support ((p = 0.0001). Data provided strong support for hypothesis 1. Hypothesis 2, structural empowerment and perceived organizational support together, explained a significant amount of variance in the role satisfaction of nurse managers (p = 0.0001).

The results were consistent with Kanter’s theory contention that work environments have a strong impact on the colleagues’ ability to feel empowered; and
therefore, work effectively. Job satisfaction of middle managers will have a downward effect on colleagues in the units. Empowered leaders with the skills to create positive environments can have an overall effect on an organization. Middle managers were expected to inspire others with vision of what can be accomplished and to empower colleagues to operationalize this vision. The nurse manager was more satisfied and more likely to support and mentor subordinates.

Harmon and Scotti (2003) examined how high-involvement work systems (HIWS) can improve colleague satisfaction and service costs. HIWS represented a holistic approach to the work design that includes interrelated core features such as involvement, empowerment, development, trust, openness, teamwork, and performance-based rewards. HIWS has been linked to increased productivity, colleague and patient satisfaction, and positive financial contributions. This study indicated organizations with a culture of HIWS will have more expenses related to this approach, but the costs were offset by more satisfied customers, colleagues, less organizational turmoil, and lower service delivery costs, which could have a substantial financial impact on an organization.

The purpose of Harmon and Scotti’s (2003) research was to evaluate the effects HIWS had on colleague satisfaction and service costs in 146 Veteran Health Administration centers. The authors proposed that part of the cost-reducing effects of HIWS would occur through colleague satisfaction.

The study was part of an ongoing action-research project with the department of Veterans Affairs (VA) that is focused on how changes in the work environment affect quality and cost of service. The data was obtained from multiple sources including: (a)
colleague surveys, (b) existing internal quality and cost measures, and (c) other archival data. Performance data were used from all 146 healthcare facilities along with responses of 112,360 colleagues to a 133-item colleague survey. The survey was confidential and averaged individual data from the responses then aggregated the data. A 5-point Likert scale was used for rating questions. The reliability coefficient was \( r = 0.86 \). The average service delivery cost was measured using cost per unit patient by utilizing the end of the fiscal year data from each of the 146 facilities.

The findings supported the hypothesis that HIWS was associated with lower costs and that part of this relationship is mediated by satisfaction. HIWS was associated with lower costs \( (p = -0.13) \); this indicated that there has been improvement in costs 1 standard deviation difference since adoption of the work system. The VA facilities were saving $51.50 per patient. Each facility treats on average of 23,360 patients annually, which would equate to $1,203,040 in general health care costs for each organization. In reviewing the VA system as a whole, the savings would be $175.6 million annually.

HIWS designs generally receive minimal executive support because the challenge of creating this culture is huge. Reviewing the above cost benefits would potentially get the attention of many executives in today’s economic times. Not only has the VA saving money, colleague and patient satisfaction was improved which brings ongoing positive rewards to the organization, such as reduced turnover, reduced stress, benefit costs, and violence claims.

Marchionni and Ritchie (2008) examined the relationship between nursing adoption of best practice and the organizational variables that can influence such adoption. Two variables were thought to play a crucial role in the adoption of best
practice; organizational culture and leadership. Guideline driven care use to improve patient care and organizations. Organizations evaluating ways to implement guideline driven changes to the clinical practice. For guidelines to have impact on patient care, the guidelines must be created and evaluated before being disseminated to healthcare providers and implemented in daily practice. Interventions in the health care practices must be done with a change in behavior. Marchionni and Ritchie explored the relationship between leadership and culture of the organization and successful implementation of guideline driven care. Best practices were implementation of quality improvement initiatives to improve care and patient outcomes. The organization must be committed to make changes and support the providers in the change before the process can be effective. Key individuals must also be leading the change for the support to carry weight with the colleagues.

In this study, the units were selected by convenience in a large-university affiliated healthcare center. The study sought to determine whether culture of learning and transformational leadership was present on these units and whether these factors could differentiate between units with different degrees of best practice guideline implementation. Descriptive survey design was used with self-report questionnaires. The nurses’ perceptions of unit culture and leadership were assessed 6 months after the termination of the 12-week introductory period for guideline implementation. A total of 90 surveys were completed. The demographics of the respondents were similar.

The Organizational Learning Survey (OLS) and the Multifactor Leadership Questionnaire (MLQ) was used to collect the data.
1. OLS: This tool was a 21-item measure that assesses the presence of features encouraging organizational learning. A 7-point Likert type scale was used for scoring the questions. The reliability coefficient was (r= .90).

2. MLQ: This tool was a 45-item questionnaire that evaluates leadership behaviors. A 4-point Likert type scale was used for scoring questions. The reliability coefficient was (r= .55-.85) respectively (cited in Marchionni and Ritchie, 2008).

The results suggested that nurses report the presence of a culture of learning with moderately high scores on the OLS on units that have implemented best practice guidelines. The authors indicated the small size of the study was a limiting factor when reviewing the results and the impact of the findings. Further research is needed on this topic to validate the results.
Chapter III

Methods and Procedures

The phenomena of leadership and organizational culture have been defined as a driving force in the success or failure of an organization. Challenges in today’s healthcare industry have forced many organizations to look closely at the dynamics and organization culture in relationship to quality indicators and satisfaction of customers. Many variables contribute to the challenges in healthcare restructuring, but there is growing awareness among practitioners and scholars that the greatest obstacles have organizational, rather than clinical or financial, roots. Healthcare leaders must respond to these challenges through implementing new management strategies that will allow them to optimize investments in human capital in order to achieve the competitive edge in the market.

This study was a partial replication of Angermeier et al. (2009) study. The purpose of this descriptive correlational study was to examine the relationship between organizational participative culture perceptions and colleague commitment and productivity. Participative management strategies were an endeavor to increase colleague productivity by rewarding performance, fostering colleague commitment, and decentralizing decision making to give colleagues a voice in work decisions. The hypothesis predicted colleagues who report higher participative-climate perceptions
will be less likely to have intentions to leave the organization, less likely to commit medical errors, have lower levels of burnout, and have excellent customer service ratings.

Research questions

1. Does participative management reduce colleague turnover, levels of burnout, medical errors, and improve customer service ratings?

2. What is the impact of participative management on colleague productivity and commitment to an organization?

Population, Sample, and Setting

A convenience sample of 100 nurses from a small community non-for-profit health care system will be recruited. The health system employs just over 600 registered nurses. Colleagues must be registered nurses licensed in the state of Indiana and be employed by the current organization for one year. All registered nurses that do not meet these requirements will be excluded from the study. Multiple sources of data will be used to for this project, including colleague-opinion surveys and other archival data.

Colleague personal records will be obtained through the human resources department. Records will provide information on individual performance ratings, demographic variables (age and gender), length of employment at the current organization, e-mail addresses, and colleague identification numbers.

Protection of Human Subjects:

This study will be submitted to the institutional review boards at Goshen Health System (IRB) for approval prior to conduction. Ethical consideration will be given attention for this study and presented to the IRB as the organization’s intent is to adhere to ethical principles for research. Evaluating risks of the study and benefits to patients
will be done prior to the initiation of the study. Selection of patients will be fair with risks and benefits fairly distributed. Benefits of the study will include potential leadership process changes that could improve the quality of care and satisfaction of the customer and colleagues. No risks have been identified with this study, as the participants will be filling out a computer questionnaire. Voluntary participation with the right to refuse will be verbalized to the patient when getting consent. Full disclosure of the study will be given to the patient in the form of a written cover letter. All data will be anonymous in this study.

**Procedure**

The survey will be administered online over a two-week period of time. All registered nurses employed and meeting the study criteria by the organization will solicited for participation. One week prior to the survey a “pre-notice” e-mail will be sent to all registered nurses. The e-mail will be from the Chief Nursing Officer (CNO) briefly explaining the upcoming study, encouraging colleagues to participate. The e-mail will note that the research’s purposes are to better understand colleague opinions and improve the quality of work-life. The e-mail will also inform the colleagues the information is confidential and it will go directly to the researchers. No one else in or outside the health system will not have access to the individual information. One week later, the e-mail with the link to the survey will be mailed to all registered nurses via their work-email. The colleagues will be given two weeks to take the survey. Over the next two weeks, three reminder e-mails will be sent.
**Instrumentation, Reliability and Validity**

An online survey will be conducted measuring the independent variable, participative management using an 18-item Likert profile, questionnaire designed to measure organizational climate along six dimensions: leadership, motivation, communication, decision making, goal setting, and control processes. The possible scores on each measurement will range from 0-20. Score will be averaged across all measures. Angermeier, et al. (2009) reliability coefficient was ($r= .97$).

The dependent variables of colleague customer service scores, medical errors, burnout, and turnover will each be different instruments to collect the data for the study. Commitment and productivity will be measured with colleague customer service scores, using the previous years score. Participants leadership uses a series of performance standards to rate colleagues. Performance standards for customer service are interrelated to values in the organization: compassion, accountability, respect, and excellence. Each of these values will be rated 1-10 with 10 being “exceeds performance”.

Medical errors will be measured using a single question from the Joint Commission: “Have you ever made a significant medical error?” Participants will answer the question yes or no.

Burnout will be assessed using Maslach’s Burnout Inventory, a 23-item scale that measures three subdimensions of burnout, including depersonalization, personal accomplishment, and emotional exhaustion. These subdimensions will be combined to produce burnout phases 1-8 with 8 being (high burnout). Angermeier, et al. (2009), reliability coefficient was ($r= .78$).
Turnover intentions will be measured using Rosse and Hulin’s Turnover Intentions Scale. The scale includes one question and two statements. Responses to these three items will be summed to create a total score ranging from 3-21, with a higher score suggesting a greater intention to quit (r=. 88).

Data Analysis

Descriptive statistics will be used to analyze study variables and determine if participative management has an impact on colleagues’ organizational commitment and productivity. The relationship between participative management and each dependent variable will be determined with correlational analysis. Pearson Correlation will be used to determine the degree of any relationship between participative management and dependent variables of (customer service, burnout, medical errors, and turnover) each dependent variable. Additional evaluation will be conducted using analysis of variance and binary logistic regression analysis.

Summary

In this chapter, the methods and procedures to be used for this partially replicated Angermeier, et al. (2009), study is described. The specific variables examined are participative management organizational culture and its relationship to colleague commitment and productivity. A descriptive correlational design will be used with the anticipated sample numbering minimum of 100 registered nurse participants. Data will be collected through an online survey using an 18-item questionnaire designed to measure organizational climate. Commitment and productivity will be measured with employee customer service scores, one yes or no question to the participants about having ever made a significant medical error, Maslach’s Burnout Inventory, and Ross and
Hulin’s Turnover Intentions Scale. Study results will provide information about the correlation between organizational culture perceptions and commitment and productivity. This study will attempt to validate previous findings while providing additional valuable information, which healthcare leaders may be able to use in strategic planning to enhance colleague commitment and productivity and to improve quality of care.
References


