THE EFFECT OF SERVANT LEADERSHIP EDUCATION AND PROVISION OF AN IMPLEMENTATION TOOLKIT ON NURSE MANAGER ENGAGEMENT INITIATIVES WITH STAFF

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By

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ABSTRACT

A review of the literature demonstrated that nurse managers are the vital link between senior management and staff nurses as the providers of care and have a pivotal role in creating an organizational culture of engaged employees. Transformational leadership has demonstrated value in having a positive impact on staff engagement compared to transactional and laisse-faire. However, research is limited regarding the impact of Servant Leadership practices by nurse managers and the engagement initiatives implemented with their staff. A pilot study with 60 nurse managers in an academic medical center was conducted to evaluate changes in Servant Leadership (SL) self-reported practices and measure implementation of staff engagement initiatives following education. The intervention included training on SL and evidence-based staff engagement initiatives with a toolkit for implementation followed with weekly coaching sessions for ten weeks. A SL self-assessment survey on leadership practices and staff engagement initiatives was administered pre-intervention and repeated twelve weeks post-intervention. A paired $t$ test was used to detect statistical differences between the means of nurse managers behaviors and practices and differences in pre and post project implementation of staff engagement initiatives. The post-project end of survey resulted in a 35% response rate. The majority of nurse managers identified a positive connection between the model of Servant Leadership and their role as a leader. Nurse managers identified focusing on the Servant
Leadership practices of accountability and empowerment as the two highest rated practices.

Following the education, nurse managers implemented a total of twenty-four staff engagement initiatives as a result of this project and 100% found the implementation toolkit helpful.

The pilot evaluation supports expanding this pilot program within the health care system with a larger population of nurse managers.
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With deep gratitude,

Kathy Barry
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Chapter I

Introduction

This chapter discusses the role of the nurse manager and the impact on clinical nursing staff to achieve outcomes in the delivery of care. The background and significance of the problem are detailed. The aims of the project are explained. An organizational needs assessment is discussed. The conceptual framework is provided and describes the phenomenon of interest.

Description and Statement of the Problem

In a 2017 Nursing Report, “the findings focused on the influence of unit nurse managers on patient and nurse outcomes within the nursing practice environment. Managers with engaged nursing workforces believed that establishing meaningful connections with staff is a key factor to success” (Dempsey & Assi, 2018, p. 282). The nurse manager role has a significant impact on the health care system with responsibilities of 24/7 accountability of inpatient units, Emergency Departments, managing multiple primary care, specialty clinics, or telehealth programs. Health care executive leaders need to provide supportive leadership development for nurse managers and strategies to create a highly engaged workforce.

Background and Significance of the Problem

The IOM Future of Nursing report 2010 (IOM, 2010), identifies the need for strong leadership to address health care issues and transform the health care system (Echevarria, Patterson, & Krouse, 2017). Nurse managers have a pivotal role in creating an organizational culture of engaged employees. They are the vital link between senior management, physician
colleagues, and staff nurses as providers of care. Nurse managers create structure, implement processes for nursing care, and facilitate job satisfaction for staff, positive quality outcomes for patients and families (How & Cummings, 2008).

The American Organization for Nurse Leadership (2015) defines nurse managers as: …nurse leaders with 24-hour accountability and responsibility for a direct care unit or units that provide the critical link between the administrative, strategic plan, and the point of care. The nurse manager is responsible for creating safe, healthy work environments that support the work of the health care team and contribute to patient engagement. The role is influential in creating a professional environment and fostering a culture where interdisciplinary team members can contribute to optimal patient outcomes and grow professionally (p. 3).

The nurse manager's leadership role is a 2eSousa2n that has a significant impact on clinical nursing staff to achieve outcomes in the delivery of care. Nurse managers impacts include establishing a healthy work environment, staff retention, sound fiscal management, patient safety, and quality-driven outcomes (Echevarria et al., 2017).

Nurse sensitive quality indicators have an impact on patient quality of care. Clinical examples of acute care indicators are patient falls, and hospital-acquired pressure injuries, catheter-associated urinary tract infections, ventilator-associated pneumonia, and central line bloodstream infections (Montalvo, 2007). Performance expectations for nurse managers are on the rise because hospital reimbursements are increasingly tied to patient outcomes (Warshawsky, Lake, & Brandford, 2013).

Leadership development is essential for the success of a nurse manager. Nurse managers need to be provided with tools to help them “adopt, adapt or abandon” leadership behaviors that would either help or hurt positive changes within their facilities (Cadmus & Holmes, 2013, p. 46). Staff nurses follow the characteristics, both positive and negative, of their leader (Kerfoot, 2008); therefore, nurse managers must endeavor to influence their teams to achieve the outcomes
within their organizations successfully. “Nurse manager and staff nurse engagement should be closely aligned to reflect the synergy needed to facilitate desired outcomes” (Gray & Shirey, 2013, p. 343).

Nurse managers have frequently been described as “chief retention officers” for Registered Nurses (RN) staff, and studies note that nurses leave their manager, not their hospital (Burke, Flanagan, Ditomassi, & Hickey, 2017). Gallup research indicates that workers’ engagement behaviors are due to the environmental conditions created by managers, and only 15% of workers worldwide have managers that enable engagement behaviors (Royal, 2019).

The four primary leadership models noted in health care are transactional, adaptive, transformational and Servant Leadership (Trastek, Hamilton, Niles, 2014). A study conducted by McAlearney (2006) identified conflict within organizations on the best practices for leadership development and the lack of a specific model of leadership for health care.

The primary leadership styles cited in nursing literature are transactional, transformational, and laissez-faire (Failla & Stichler, 2008). Of these three styles, transformational leadership is identified as having the most positive impact on nurse manager outcomes related to staff satisfaction, staff retention, and patient outcomes (Spano-Szekely, Quinn Griffin, Clavelle, & Fitzpatrick, 2016). There is a dearth of research in the literature of the impact of Servant Leadership in nursing.

**Servant Leadership**

Historically, the concept of serving goes back thousands of years with references found in Eastern culture texts such as Hinduism, Chinese texts attributed to Lao-Tzu, Christian texts seen in the Gospel of Mark, Judaism, Muslim sacred text, and Western culture. In the modern
context, Servant Leadership utilizes a holistic approach to engage followers. Followers are involved from a relational, emotional, ethical, and spiritual connection and are encouraged to grow to their full potential (Eva, Robin, Sendjaya, van Dierendonck, & Liden, 2019).

The term "Servant Leadership" was coined by Robert K. Greenleaf in his 1970 essay, The Servant as Leader (Iarocci, 2020). The Robert K. Greenleaf Center for Servant Leadership (2016) notes the following:

A servant-leader focuses on the growth and well-being of people. While traditional leadership may involve the accumulation and exercise of power by one at the “top of the pyramid,” Servant Leadership is different. The servant-leader shares power, putting others’ needs first, and helps people develop and perform as highly as possible.

The literature identifies several advantages of Servant Leadership in creating better employee-leader relations, which can positively impact a company and improve employee satisfaction, customer service, and higher productivity. Decision-making is shared, and employees are encouraged to enhance innovation within the organization. Servant Leadership is also seen as promoting diversity and focuses on employee well-being and training (Luenendonk, 2016). Many businesses are known for Servant Leadership, such as The Container Store, Marriott, Starbucks, Nordstrom, Southwest Airlines, and Chik-Fil-A, (Lichtenwalner, 2020).

While health-care is seen as having an alignment of the values and principles of Servant Leadership (Rudnick, 2017), a review of the literature reveals a scarcity of research on Servant Leadership in nursing. Choudhary, Akhtar, and Zaheer (2013) asserted that transformational leadership is most commonly compared to Servant Leadership than any other leadership theory.

Servant Leadership is part of emerging theories following the previous academic focus on transformational and charismatic leadership. “Transformational leadership is defined as a leadership style with explicit attention to the development of followers through individualized
consideration, intellectual stimulation, and supportive behavior (van Dierendonck, 2011, p. 1235).” These elements are comparable and complementary to the definitions of Servant Leadership. Transformational leaders’ primary allegiance is to the organization. It fails to consider the importance of a moral compass, which is a crucial aspect of Servant Leadership, as noted by van Dierendonck, (2011).

Transformational leaders focus on organizational objectives; and inspire their followers to higher performance to achieve the organizational goals. “Servant-leaders focus more on concern for their followers by creating conditions that enhance followers’ well-being and functioning and thereby facilitate the realization of a shared vision; servant-leaders trust followers to do what is necessary for the organization (Stone, Russell, & Patterson, 2004).”

A study conducted by Jenkins and Stewart (2010) examined the Impact of the nurses’ perceptions of nurse managers’ Servant Leadership orientation on nurse job satisfaction. The findings provided evidence that the behaviors and attitudes of the nurse manager do impact employee job satisfaction. Departments, where staff perceived that managers had higher Servant Leadership orientation, demonstrated a significant positive impact on individual employee job satisfaction. Ehrhart (2004) showed Servant Leadership accounts for an additional commitment (5%), job satisfaction (7%), perceived supervisor support (4%), and procedural justice (8%) over and above transformational leadership.

The health care facility in this pilot project is an academic medical center in the Mid-Atlantic region and is part of a large integrated health care system. In 2013, the health care system endorsed Servant Leadership as its leadership model. The health care system has the following set of guiding principles for leadership:
• Focus on the mission and personal character: Leaders work to gain self-awareness, seek feedback, actively lead by example and stay true to their personal values to serve them

• Focus on others: Leaders create a culture of continuous learning and development, inspire service-focused environments, and provide opportunities for others to achieve their highest potential.

• Focus on organizational results: Leaders make timely decisions, hold self and others accountable and are committed to providing superior service and care.

Once the initial introduction and roll-out of Servant Leadership were completed in 2013 across the health care system, it was an expectation this model would be sustained. However, there is no standardized process for sustaining the Servant Leadership model as changes in executive leadership occur, or new employees join the organization. This approach results in a wide variation of the implementation and practices of Servant Leadership within the health care system. The facility for this pilot project does not have a structured process to introduce new employees and leadership to Servant Leadership. Lack of a formal process to add Servant Leadership serves as a missed opportunity for employees to be aware of this leadership model and how the theory focuses on supporting the employee and achieving organizational objectives. The value of providing nurse managers with training on Servant Leadership may positively impact nurse manager engagement with their staff, improve staff engagement, and staff satisfaction.
Organizational Needs Assessment

Health Care System Structure

The health care system is an extensive integrated health system in the United States (US). The corporate structure is one of centralization regarding system policies and procedures for administrative, personnel, and clinical programs related to the major disciplines of surgical services, medical services, primary care, specialty care, behavioral health, and geriatrics. The corporate Chief Operating Officer (COO) oversees regional Executive Directors for the health care system. Each regional Executive Director oversees the CEO of each facility located within the designated region. Facility executive leaders and Clinical Program Directors collaborate with respective regional and corporate office leaders. Communication was primarily top-down throughout the organization. The system’s governance model is being restructured to provide regional Executive Directors greater participation in decision-making of corporate policies and strategic planning.

The Office of Nursing Service (ONS) at the corporate level of the health care system has responsibility for nursing policy development, overall oversight of nursing practice, and collaboration with clinical program offices at the national level. ONS has no direct oversight of facility Chief Nursing Officers (CNO). Each CNO has direct accountability to the CEO of their respective facility. The role ONS serves is one of representing the voice of the nursing profession as a member of interprofessional teams within program offices such as Acute Care, Primary Care, Behavioral Health, and Geriatrics at the national level. ONS provides expertise regarding the clinical scope of practice to ensure quality and standardization of practice.
ONS serves the CNOs of each facility to align the work of nursing to achieve the health care system’s strategic plan. The communication between ONS and CNOs is collaborative and consists of monthly CNO calls to cascade administrative and clinical program information from the corporate level. There are quarterly face to face meetings with ONS and the regional CNO representatives and an annual two-day face to face meeting for all CNOs in the health care system. CNOs are lead members of regional or health care system-level committees. ONS has established clinical Field Advisory Committees (FAC) with subject matter experts (SME) that guide evidence-based practice across the health care system. Nursing SME also contribute to interprofessional teams designing and implementing health care system-level program initiatives.

**Nurse Manager Orientation**

A review of nurse manager orientation was conducted in 2017-2018 across the health care system by ONS and found variable formats of structure and content design at the facility level. There is no standardized or consistent model for developing nurse managers regarding leadership principles, leadership competencies, or providing education and training on Servant Leadership. The format and content of nurse manager leadership development are determined at the local facility level. There is no formal data available to measure how many leaders across the health care system have participated in or completed Servant Leadership training.

**Facility Organizational Needs Assessment**

The medical center participating in this pilot project is located in one of the state’s urban cities in the Mid-Atlantic region. The campus is surrounded by other city businesses and physically blends in with the environment.
The facility has an open feel due to high ceilings and an abundance of natural lighting. Facility décor is noted to have framed photography of health system executives, current facility executive leadership, and local geographic landmarks. The signage is nondescript in terminology and design. Paint colors are consistent throughout the facility. There are framed photographs in the main corridor of hospital staff and patients interacting. Most of the pictures are images of smiling patients and staff, many showing physical touch levels such as a handshake, embrace, or arms wrapped around shoulders.

Nursing artifacts such as photographs of staff with patients are in the general public areas, and other artifacts can be seen in patient care units. Some units have a plaque to recognize nurses who have received certifications in the unit’s clinical specialty. Some have various staff photos, some have performance boards, and some have bulletin boards with announcements of hospital events, nursing education offerings, or Shared Governance updates. Employees are friendly, acknowledge each other, and willingly stop to assist visitors in reaching their destination.

The CEO and CNO have been together as a team for six years and have enjoyed a strong, cohesive relationship. The facility executive leadership team has identified an opportunity to improve employee engagement and patient satisfaction throughout the organization. The facility CNO recognized nursing staff engagement scores were below the national average. Nurse turnover rates were slightly above the national average, as reflected in the health care system’s All Employee Survey (AES). An analysis was conducted using multiple linear regression to determine the relative strength of the Nursing Work Index-Practice Environment Scales (NWIPES) (independent variables) as predictors of overall job satisfaction (dependent variable). The
primary predictors of total satisfaction were the rating of the RN manager and staffing. The CNO is committed to implementing change to improve these metrics.

As a member of the executive leadership team, the CNO endorses the Servant Leadership model and articulates the importance of the nurse manager role as servant leaders, impacting the nursing turnover rate and increasing employee engagement. The CNO has selected the principles of The Studer Group to increase staff engagement. The Studer Group is a global advisory firm that partners with health-care organizations to implement effective strategies and solutions to align leadership teams, attract, retain and promote talent and improve organizational culture (The Studer Group, 2019, para. 1). The CNO purchased The Handbook for Nurse Managers (Studer Group, 2011) for the nursing leadership staff as an educational format to link the importance of nurse manager engagement with staff to achieve the highest staff engagement outcomes. The CNO requested a process to reinforce how the characteristics of Servant Leadership link with staff engagement activities.

**Conceptual Framework**

The conceptual framework selected for this project is the eight dimensions of the leader-follower relationship in Servant Leadership based on van Dierendonck and Nuitjen’s work (2011). The eight dimensions are:

- **Empowerment**: empowering and encouraging the development of followers;
- **Accountability**: holding individuals and teams responsible for the outcomes in their control
- **Standing back**: supporting the interest of others and directing recognition for accomplishments to those who deserve the credit;
• Humility: the leader’s ability to acknowledge his or her limitations and seek the contributions of others to overcome those limitations;
• Authenticity: accurately representing, both privately and publicly, one’s true self;
• Courage: challenging accepted models and daring to take risks to find new solutions;
• Forgiveness: (interpersonal acceptance): the ability to understand where others are coming from and practice forgiveness when confronted with offenses, arguments, and mistakes;
• Stewardship: the ability to act as caretaker and role model in accepting responsibility for the larger organization.

Figure 1. Conceptual Model of Servant Leadership, van Dierendonck (2011)

Definition of Terms

Nurse Manager – defined as “responsible for creating safe, healthy work environments that
support the work of the health care team and contribute to patient engagement. The role is influential in creating a professional environment and fostering a culture where interdisciplinary team members are able to contribute to optimal patient outcomes and grow professionally” (AONE, 2015, p. 3). A nurse manager within the health care system is a Master’s prepared nurse manager with six months or more of experience as a nurse manager, has 24/7 responsibility for an inpatient unit, emergency department, ambulatory clinic, or procedural area, works full time and has direct supervision of nursing staff in the unit, clinic or procedural area.

**Servant Leadership** – this project’s definition is congruent with the eight dimensions of Servant Leadership framework developed by van Dierendonck and Nuitjen (2011). The eight dimensions are empowerment, accountability, standing back, humility, authenticity, courage, forgiveness and, stewardship.

**Servant Leadership initiatives to increase staff engagement** – these initiatives are defined as action(s) implemented to impact all staff within the unit or department and are designed to be an ongoing process. Leadership practices may be related to any of the dimensions in van Dierendonck and Nuitjen’s Servant Leadership framework. Staff engagement initiatives may be practices referenced in *The Studer Group Handbook for Nurse Managers*, recommended staff engagement practices referenced by nursing professional organizations or initiatives developed by the health care system’s Organizational Development program.

**Research Question**
The question guiding this pilot project is – “What are the effects of Servant Leadership education and the provision of an implementation toolkit on nurse manager engagement initiatives with staff?”

The study question was formulated with the PICOT framework. Using an intervention (I) consisting of education, a toolkit for implementation of strategies for staff engagement, weekly coaching calls (optional), and comparison (C) of assessment tools conducted before and after the education intervention. Outcomes (O) compared nurse managers’ self-assessment ratings of their Servant Leadership practices before the educational session, and a post-self-assessment rating of their Servant Leadership practices three months after the educational session. Outcomes included data on the staff engagement initiatives implemented by nurse managers as a result of the educational session, implementation toolkit, and coaching calls. The third outcome evaluated the educational session's value, toolkit, and weekly coaching calls. The assessment informed the decision to expand the pilot project to other facilities within the mid-Atlantic region as an element of a standardized nurse manager leadership development program within the health care system. Longer-term outcomes may evaluate the impact on staff engagement as measured through the All Employee Survey (AES), nurse-sensitive quality outcomes, patient satisfaction, staff turnover and, nurse manager turnover.
Chapter II

Review of the Literature

Recent literature findings emphasize that nurse managers are the critical link between senior management and staff nurses as providers of care and have an essential role in creating an organizational culture of engaged employees. Nurse manager and staff nurse engagement should be more closely aligned to reflect the interaction needed to facilitate desired outcomes (Gray & Shirey, 2013; How & Cummings, 2008). This chapter details the literature review to appraise the impact of Servant Leadership on the role of nurse manager leadership practices and the level of engagement of the nurse manager and level of engagement of the staff nurse. This chapter identifies themes noted in the retained articles. A critique and synthesis of the retained literature is provided. This chapter closes with a rationale for the project.

Introduction to Search Strategy

The search strategy involved Boolean search techniques for empirical studies on Servant Leadership. Electronic databases searched include PubMed, Cumulative Index Nursing Allied Health Literature (CINAHL), JSTOR, Management, and Organizational Studies, Embase, and Emerald Intelligence. Inclusion criteria included a) Servant Leadership, b) nurse managers, c) employee engagement. D) English language; e) peer-reviewed, f) no year restrictions for publication, g) full text available, and h) empirical research.

Search terms included: “Servant Leadership” in the title with keywords, “Nurse Managers”, “Nurse Management”, “employee engagement”, “staff engagement”, “nurse manager engagement” and “nurse manager satisfaction”. Search terms were combined as
follows using Boolean operators: “Servant Leadership” AND “Nurse Managers”, Servant Leadership” AND Nurse Management”, “Servant Leadership” AND “employee engagement” OR “staff engagement” and “Servant Leadership” AND “Nurse Manager engagement” were applied to each database. Articles were filtered that addressed the manager’s impact of Servant Leadership on employee outcomes with empirical outcomes.

**Summary of Database Search**

The Management and Organizational Studies database search yielded 38 articles. Of these articles, there were two studies with empirical outcomes specific to SL characteristics or impact of SL on employee outcomes (Beck, 2014; Van Dierendonck, 2011). The Emerald Intelligence database search yielded 54 articles, with one article related to the inclusion criteria., Bao & Shao (2018). The Journal Storage (JSTOR) database review yielded 32 articles with two articles meeting the inclusion criteria (Parris & Peachey, 2013, Rivkin, et al., 2014). The Embase database search yielded 60 articles with one article meeting inclusion criteria (Hanse et al., 2015). The PubMed database yielded 81 articles with four articles retained that met inclusion criteria (Luk, 2018, Jenkins & Stewart, 2010, Garber, Madigan, Click, & Fitzpatrick, 2009, Aij & Rapsaniotis, 2017).

Nine articles were retained for further review: one narrative systematic review by Aij & Rapsaniotis, (2017), one qualitative and quantitative systematic review by Parris & Peachey, (2013), one synthesis of the literature by Van Dierendonck (2011) and five cross-sectional studies; Bao & Shao, (2018), Hanse, Harlin, Jarebrandt, Ulin, & Winkel (2015), Luk (2018) and, Jenkins & Stewart (2010), Rivkin, Diestel, & Schmidt, (2014) and, a descriptive study by 15eSousa and van Dierendonck, (2014).
The themes noted within the retained literature were psychological health and a sense of well-being (Rivkin et al., 2014, Parris & Peachey 2013), work engagement (Bao & Zhao, 2018), job satisfaction (Jenkins & Stewart, 2010), team effectiveness (Van Dierendonck, 2011), and empowerment (Aij & Rapsaniotis, 2017, DeSousa & van Dierendonck, 2014, Hanse et al., 2015, Luk, 2018).

**Psychological health and sense of well-being.** Rivkin et al., (2014) tested the positive relationship between Servant Leadership and employee’s psychological health via two studies conducted: examining emotional exhaustion and depersonalization as long-term indicators of strain, and short term indicators of job strain examined ego depletion and need for recovery.
“The multimethod approach provided a reasonably strong basis for concluding that the relationship of Servant Leadership and employee’s psychological health is stable, robust, generalizable and invariant when examining different indicators of strain, different employee specific work conditions and different level of analysis (Rivkin et al., 2014, p. 67).” The authors concluded previous research along with their findings show that Servant Leadership improves job attitudes and performance, but may also benefit employees’ health.

Parris & Peachey (2013) conducted a systematic literature review of Servant Leadership theory. The review systematically examined and organized the current body of research literature that quantitatively or qualitatively explored Servant Leadership theory in a given organizational setting highlighting 39 studies: 11 qualitative studies, 27 quantitative studies, and one mixed-method study. The studies occurred in multiple sectors including leadership (n=9), education (n=7), business (n=6), psychology (n=6), nursing (n=3), sales management (n=2), ethics (n=1), recreations and parks administration (n=1), services marketing (n=1) and sports (n=1). The review demonstrated Servant Leadership theory is applicable in a variety of cultures, contexts, and organizational settings. The studies confirm the applicability of the model’s leader to follower and follower to leader of trust, empowerment, vision, altruism, intrinsic motivation, commitment, and service by creating a positive work environment, which increase employee job satisfaction. The review validated Servant Leadership as a viable and valuable theory that helps organizations and the well-being of followers.

**Empowerment.** A study by Hanse et al. (2015) found significant positive correlations between the five primary dimensions of Servant Leadership: Empowerment, Accountability, Servitude, Humility and Stewardship, and the Leader-member Exchange (LMX), noting that a
Servant Leadership style positively influences high-quality LMX among health-care professionals.

Aij and Rapsaniotis (2017) conducted a systematic narrative review of published articles about Lean and Servant Leadership to identify different aspects of Servant and Lean leadership in health-care. Results noted Lean and Servant leaders focus on enabling employees to work more effectively, to be successful, and to feel responsible for their work. However, servant leaders approach their work with an explicit spiritual, moral, and ethical base. Findings suggest that strategic use of Servant Leadership may strengthen Lean implementation in the health care setting.

Luk (2018) evaluated the effectiveness of a one-year leadership enhancement program in an acute general hospital to enhance senior nursing managers’ ability to be caring leaders so they can nurture their teams to be holistic care providers. One questionnaire was a general measure of Servant Leadership, and the second questionnaire measured well-being in the workplace (WWQ). This program introduced the philosophy and practice of Servant Leadership and encouraged managers to act in the best interest of their followers. There was an overall improvement in Servant Leadership, particularly in empowering subordinates, behaving ethically, having conceptual skills, and creating values for those outside of the organization. During the year of implementation, the study noted a culture to serve and care was much more reinforced, which helped participants in the program put theory into practice.

DeSousa and van Dierendonck (2013) studied the merger of two financial organizations in Portugal using the Servant Leadership Survey (SLS). They found Servant Leadership has a higher effect on employee engagement through its ability to create a sense of empowerment
during times of high uncertainty. The findings support the view that “Servant Leadership seems to focus more on the needs of the individual than on the organization” (19eSousa & van Diernendonck, 2014 p. 892).

**Work engagement.** Bao & Zhao (2018) conducted a study within the Chinese culture using a cross sectional survey of employees in the public and private sector using seven items from Liden SL measurements, seven items from Leader-Member Exchange (LMX), sixteen items from Kim to measure public service motivation, and nine items of Utrecht Work Engagement Scale. The findings indicate Servant Leadership is positively related to work engagement, after taking into the effects of control variables but there is no substantial evidence to confirm followers’ motivation to emulate their Servant leaders whether in the public or private sector to serve to others, which is assumed a strength and unique component of Servant Leadership theory.

**Job satisfaction.** Jenkins & Stewart (2010) conducted a study empirically testing the impact of nurse managers’ Servant Leadership orientation on nurse job satisfaction. The study generally found there is a strong positive correlation between commitment to serve and job satisfaction and role inversion behaviors and nurse job satisfaction. When nurse managers are perceived by individual nurses as having a commitment to serve, the nurse is likely to have greater job satisfaction.

**Critique and Synthesis of Previous Evidence**

All literature reviewed was critiqued and rated based on Let Evidence Guide Every New Decision, (“LEGEND,” 2012). The rating system uses a level 1 – 5 rating process based on the study design, and each numeric rating of 1 – 5 includes an “a or b” rating to reflect the quality of
the article. The letter “a” identifies the article as a good quality study, and “b” identifies the article as a lesser quality study.

The overall LEGEND grading of the body of evidence uses a grading scale of high, moderate, low, very low, and grade not assignable (GNA). A grade of high reflects the quality of studies rated as level 1a or 2a. A grade of moderate reflects the quantity and quality of studies rated a level 1b, 2a, or three or more studies rated a level 2b and/or 3a. A grade of low reflects the quantity and quality of articles rated as one or more a level 3a, two or more rated level 3a and 3b, five or more studies rated 3b and 4a. A grade of very low reflects one or more studies rated a 4a and/or 4b or insufficient quality to meet low criteria. A GNA rating is reflected in local consensus publications.

The systematic reviews (Aij & Rapsaniotis, 2017 and Parris & Peachey, 2013) were rated a level 1b, with three cross-sectional articles (Bao & Zhao, 2018, Hanse et al., 2015 and Rivkin et al., 2014) rated a level 4a and two cross sectional studies (Jenkins & Stewart, 2010, and Luk, 2018) rated a level 4b. The descriptive study (20eSousa and van Dierendonck, 2014) was rated a level 4b, and synthesis of the literature (van Dierendonck, 2011) was rated a level 4b. The overall grade for the body of evidence review conducted for this project is very low.

**Differences Across Studies**

Parris and Peachey (2013) note there is not an accepted consensus over the definition of Servant Leadership, which creates confusion among researchers. Nor is there an agreed-upon measurement strategy for Servant Leadership theory. Indeed, the literature reviewed for this project demonstrates a broad range of foci that examine psychological health, a sense of well-being work engagement job satisfaction team effectiveness, and leader-member exchange.
The studies also focused on different dimensions or behaviors of Servant Leadership and used various measurement tools. Examples of the measurement tools used by the authors are an adapted version of the Leader-Member Exchange (LMX) (Bao & Zhao, 2018, Hanse et al., 2015), the Barbuto and Wheeler Servant Leadership Questionnaire (Garber et al., 2009), the well-being workplace questionnaire (WWQ) (Luk 2018) and the Ehrhart Servant Leadership Scale (Rivkin et al., 2014).

**Similarities Across Studies**

Overall, given the different dimensions or behaviors of Servant Leadership studied and the variance or adaptation of measurement tools used, the studies find a positive impact of Servant Leadership on the psychological well-being or overall workplace well-being on employees a positive effect of Servant Leadership on employee work engagement, team effectiveness, job satisfaction, and leader-member exchange. There is consensus that Servant Leadership is a viable and valuable theory that can be applied in many different types of organizations.

**Limitations Across Studies**

Limitations across the body of literature reviewed were in design, sampling, and analysis. There were limited empirical studies on Servant Leadership overall and even fewer empirical studies on Servant Leadership within nursing management.

**Design.** Luk (2018) identified that the study only had a pre and post-test design; therefore, the long-term effect of Servant Leadership is unknown. A longitudinal study with the measurement at later points of 6 and 12 months may be of value. The literature synthesis by Van Dierendonck (2011) noted limitations that earlier writings were rather normative and
prescriptive, and there is a need for longitudinal research to study the development of the interactions between leaders and followers. Limitations noted by Hanse et al., (2015) were the cross-sectional design of the study does not enable inferences or causality concerning the directionality of relationships. There may be some common method bias. The LMX was measured by the follower perspective only, and the study was limited to four health care units, which may be limited in generalizability and may be culturally specific.

Aij & Rapsaniotis (2017) systematic review noted the majority of Servant Leadership articles were based on anecdotal or philosophical studies, not empirical evidence. The studies of Lean were of uneven quality, and there may have been inclusion bias based on one person selecting articles for review.

Jenkins & Stewart (2010) noted the job satisfaction measure used was a more general indicator of attitude toward the overall environment or climate rather than reflecting satisfaction with particular elements of the job. The study was also limited to one health system. Garber et al. (2009) identified the study had limited generalizability beyond the organization being studied. It was also noted that collaboration was self-rated versus rated by observation or ratings by others. There may also have been response bias such that respondents did not want to rate themselves as not collaborative.

**Sampling.** Bao & Zhao (2018) limitations noted employees who self-select into the public sector may have higher altruistic tendencies compared to other working populations, and serving the public is part of their job requirements instead of a discretionary choice. This range restriction in their public service motivation may be an alternative cause for the insignificant mediation effect. The study was also in a single cultural context, and data were reported by
followers only. The data collected was during a limited period, and a more extended period should be considered. Rivkin et al. (2014) identified self-report bias, and a shared social identity may have been a factor that influenced both the perception of Servant Leadership on the part of employees as indicators of employee’s psychological health. Beck (2014) noted participants were self-selected, and the qualitative data was obtained from a small subset of the original study population and may limit the generalizability of the results. It was also noted all responses were self-reported.

**Analysis.** Parris & Peachey (2012) systematic review was limited to indexed journals available. Integrating quantitative and qualitative results may have limited the ability to explore all methodological considerations when fusing the findings.

**Implementation Framework**

A program evaluation of the planned pilot program used the Knowledge to-Action (KTA) framework. KTA is a translational framework based on change theory and consists of two components: 1). Knowledge creation includes the three stages of inquiry, synthesis, and tools/products, and 2). Action cycle, which is comprised of seven stages for effective implementation of knowledge-based change and evaluates practice in changing environments (Field, Booth, Ilott, & Gerrish, 2014).
Figure 3. The Knowledge to Action Framework. From Graham I, Logan J, Harrison M, Strauss S, Tetroe J, Caswell W, Robinson N: Lost in knowledge translation: time for a map? The Journal of Continuing Education in the Health Professions 2006, 26, p. 19.

The KTA model provides flexibility and adaptability to support a variety of settings for clinical or administrative practice elements making it practical for health care quality improvement projects (Bhogal et al., 2011). The project development and evaluation steps of the KTA model support the project aims: to provide Servant Leadership education, measure nurse manager self-assessment of Servant Leadership practices pre and post project completion, and implementation of staff engagement initiatives.

Action Cycle Step 1 identifies the purpose of the project and links to aim 1 to provide Servant Leadership education. Steps 2 and 3 evaluate the local context and barriers that impact barriers to knowledge use. The pre and post survey of an educational intervention provided information specific to the facility nurse managers regarding current practices of Servant Leadership and staff engagement initiatives. Step 4 identifies nurse managers as the specific
population with the education interventions, provision of a toolkit, and the weekly coaching calls provided. Steps 5 and 6 include the use of knowledge through the staff engagement initiatives implemented by nurse managers and Servant Leadership practice changes focused on by the nurse managers. Step 7 requires a continued review cycle determined by the nursing executive leadership team to meet the target measures of Servant Leadership practices and effective implementation of staff engagement initiatives and measuring the impact through selected metrics of staff satisfaction, staff turnover, staff engagement, quality improvement metrics, nurse manager turnover, and patient satisfaction.

Rationale for the Project

The role of the nurse manager is vital to organizations achieving successful outcomes. The literature provides support that Servant Leadership is a viable and valuable model for organizations and addresses the positive impact Servant Leadership has on empowerment, workplace well-being, job satisfaction, employee engagement, leader-member exchange and team effectiveness. Investing in nurse manager education and training on Servant Leadership development may impact nurse manager engagement with their staff and their role satisfaction.

The literature review provides a framework for this project to evaluate the relationship of Servant Leadership on the role of the nurse manager and their engagement with staff. Servant Leadership’s dimensions or behaviors are empowerment, accountability, humility, and leader-member exchange. Measurement would occur through self-reported practices by the nurse manager that are aligned with Servant Leadership dimensions/behaviors and the nurse manager evaluation of the education session provided on Servant Leadership and its perceived value to their role as a nurse manager.
This project may add value to the health care system the project is being conducted in. The provision of Servant Leadership education and staff engagement initiatives may increase nurse manager engagement with staff.
Chapter III

Methods

This chapter describes the methods, and design selected to meet the project’s aims. A description of the population and Human Subject Review is provided. The procedures and instruments are described. The tools to evaluate the phenomenon of interest are outlined. Data collection, data management, and analysis are provided.

Design

The design was a pre and post survey of an educational intervention provided in one required six-hour educational session for participating nurse managers on Servant Leadership principles adopted by the health care system, the role of the nurse manager as a Servant Leader and recommended staff engagement initiatives with a toolkit guide for implementation. Weekly coaching conference calls were scheduled to present more specific strategies to demonstrate the eight dimensions of Servant Leadership and strategies on how to implement the staff engagement initiatives. Time was reserved on the calls for anyone who may have questions, seek consultative guidance or share success on demonstrating the implementation of a dimension of Servant Leadership or staff engagement initiative throughout the three-month duration of the project.

Population

The setting was an academic tertiary medical center that provides acute care, ambulatory care, specialty care, behavioral health and, long-term care services. The facility is within an
extensive integrated health care system and was chosen related to the potential of 60 nurse managers as participants and the scope of services provided.

The inclusion criteria for participants were nurse managers who: a) are full-time employees at the facility; b) have at least six months of nurse manager experience in their career; c) are educationally prepared at the BSN level or higher; d) have 24/7 responsibility for an inpatient unit, long term care unit, ambulatory or specialty clinic or procedural area and f) provide direct supervision of employees. A power analysis indicated 156 nurse manager participants would be needed for a full sample size which was not feasible given the time frame.

**Human Subjects Review**

Review of the project by the university and agency IRB deemed it not be to research involving human subjects as defined by DHHS and FDA regulations. Voluntary participation in the survey was determined to serve as informed consent.

**Procedures**

The CNO announced this pilot project at the monthly leadership meeting held for all nurse leaders one month before the scheduled education session. An invitation letter to the to the nurse managers via email explaining the purpose of the study. The invitation letter provided the program’s purpose, the value of participation, the eligibility criteria, and the expectations of the participants. The letter stated that participation was voluntary at all times, and participants could withdraw at any point in the project without negative consequences. The letter included the date, time, and location of the educational session, scheduled weekly coaching conference calls throughout the project, the name of the facility educator assigned to the investigator and it included the CNO’s support of their voluntary participation.
The CNO’s designated administrative support staff electronically distributed the invitation letter. An electronic calendar evite was sent by the designated facility administrative support staff to all nurse managers for the series of weekly coaching conference calls. The facility educator served as a liaison to guide the investigator through the organization and ensure compliance with facility policies. The facility educator served as a facilitator for administration and collection of the hard copy pre-survey and post-survey A on the day of the education session.

**Education Session**

One six-hour educational session was offered to nurse managers. The investigator and a faculty provider from within the health care system provided an overview of the health system’s Servant Leadership model and the role of the front-line manager as a Servant leader. The investigator presented evidence-based initiatives on employee engagement. The Handbook for Nurse Managers (Studer Group, 2011) and the American Nurse Credentialing Center (ANCC) Magnet™ and Pathway to Excellence™ programs served as the foundation for evidence-based engagement initiatives. Selected employee engagement resources available through the health care system for Servant Leadership were also included. A toolkit describing the initiatives with an implementation guide and templated forms (as applicable) for each initiative was provided to each participant.

**Coaching Calls**

Weekly one-hour coaching conference calls were scheduled, focusing on demonstrating the eight dimensions of Servant Leadership and how to implement the specific staff engagement initiatives. Time was reserved for questions, consultative support, and sharing successes among
participants. The conference line had a universal access code for participants to dial in.

Participant identification on the call was visual by the number of participants and included the participant’s identity if they chose.

Confidentiality

Confidentiality was maintained via several processes. The surveys did not have any participant identifiable data. Participants were assigned a number unique to them for the three surveys. The facility educator liaison maintained the numbers for this project. The distribution and collection of the hard copy pre-survey and post-survey A were managed by the facility educator assigned to the investigator, then given to the investigator. The data was entered into a spreadsheet by the investigator and electronically submitted to the statistician for this study. Post education data collection was conducted via an electronic survey. Electronic survey security includes Secure Sockets Layer (SSL) encryption and disabled IP address tracking. These safety mechanisms are established via the SurveyMonkey™ platform. Additionally, no response identifiers were included in the data analysis. All data were presented in aggregate form.

Instruments

Demographic Survey

The Demographic and Current Practice survey was developed by the investigator for this project and administered before the beginning of the session. Demographic data included age, gender, years of experience as a nurse manager, years employed within the facility health care system, the highest education level (BSN, MS/MSN, DNP, and PhD), and the number of employees supervised within the unit, clinic or procedural area. Specific questions regarding the type of unit, clinic, or department of oversight were not included to protect anonymity.
Participants were asked to select current practices from a list of the most frequent initiatives identified in the literature they have currently implemented unit-wide for employee engagement. Participants had an opportunity to free text initiatives that were not included on the list.

**Servant Leadership Survey**

A general measure of Servant Leadership Assessment Survey by van Dierendonck and Nuitjen (2010), was adapted as a self-assessment tool for this project. Van Dierendonck and Nuitjen developed the SLS in three stages. The first survey was a 99-item survey with 14 factors. Based on the responses, the authors developed a 39-item instrument, and based on those responses, a 30-item instrument was developed. The survey is comprised of eight dimensions: empowerment, standing back, accountability, forgiveness and courage, authenticity, humility, and stewardship. Green, Rodriguez, Wheeler, & Baggerly-Hinojosa, (2015), confirmed the tool demonstrated good reliability. The adapted Servant Leadership Self-Assessment survey was administered prior to the training session and at three months post-training.

**Education Evaluation**

Survey questions developed for a survey following the education evaluated the education session on the day of training were provided by the evaluation and measurement division of the Employee Education System within the health care system. The majority of questions were based on requirements for American Nurse Credentialing Center certification of education programs and used a Likert type scale to address the overall rating of the learning activity, effectiveness of learning activities, content, job impact, and learning environment, and a question measuring intention of implementing a staff engagement initiative was included.
Repeat Measures

A repeat Servant Leadership practice self-assessment was collected three months after the education session with additional questions on the value of the weekly coaching conference calls and a survey on additional staff engagement initiatives implemented since the education session. A panel of experts was asked to review the survey tools for pre and post-surveys for content validity and administration utility. The expert group consisted of the DNP Faculty Mentor, the DNP external subject matter expert, a Nurse Researcher within the Health System, and the study statistician.

Data Management

The hard copy pre-survey and post-survey was administered and collected by the facility educator and given to the investigator who manually entered the data into a Microsoft Excel© database and forwarded it to the study statistician. Only the investigator and the study statistician had access to the data.

Data Analysis Plan

Descriptive statistic techniques such as frequency, distribution, percentages, and measures of variability were used to characterize the participants. The demographic data were used to examine correlations between the tools used before and after the education session.

The Servant Leadership pre – and post-assessment results were analyzed with a paired t-test to demonstrate whether any statistical differences existed between the means of nurse managers’ practices. Statistical analysis was conducted comparing the percent of nurse managers who indicated the intention of implementing a staff engagement initiative compared to the percent who reported an initiative was implemented by the end of the project.
Data analysis was conducted using Microsoft Excel © and IBM SPSS version 26 statistical software. Content data analysis was used to analyze the thematic content of responses to free text questions.
Chapter IV

Results

Analysis of Data

The pre-education survey was completed by 42 (82%) of the 51 participants who met criteria for inclusion. The post-education evaluation survey was completed by 32 (76%) of the 42 participants. The three-month end-of-project survey included a repeat Servant Leadership practice self-assessment with additional questions on the value of the weekly coaching conference calls and a survey on additional staff engagement initiatives implemented since the education session. The survey was completed by 15 (35%) of 42 pre-education survey participants. Descriptive statistics were utilized for demographic data and the evaluation of the learning intervention. Paired t-tests were utilized for the pre- and post-Servant Leadership self-assessment surveys to determine any statistically significant differences in Servant Leadership practice dimensions. Wilcoxon signed ranked tests were utilized to determine any statistical differences in the individual items in the pre- and post-Servant Leadership self-assessment survey. Differences in staff engagement initiatives implemented by the nurse managers before and after the intervention were tested using chi square analysis.

Summary of Findings

Demographics

Demographic information was collected reflecting age, gender, education preparation, years of experience as a nurse manager and overall years of nursing experience, number of years in the health system, and the number of employees supervised. Table I reflects the sample (N=42) of which 52% of the respondents were female, 41% were middle aged (> 55 years), 59%
were Masters prepared, 36% had 20-25 years of nursing experience, 43% had 16-25 years within the health care system and 44.7% supervised 30 or more employees.

Table 1

*Characteristics of the Sample*

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>11</td>
<td>26.2</td>
</tr>
<tr>
<td>Female</td>
<td>22</td>
<td>52.4</td>
</tr>
<tr>
<td>Missing</td>
<td>9</td>
<td>21.4</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35-44</td>
<td>9</td>
<td>21.4</td>
</tr>
<tr>
<td>45-54</td>
<td>13</td>
<td>31.0</td>
</tr>
<tr>
<td>55-64</td>
<td>16</td>
<td>38.1</td>
</tr>
<tr>
<td>65 and older</td>
<td></td>
<td>2.4</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BSN</td>
<td>8</td>
<td>19.0</td>
</tr>
<tr>
<td>Masters</td>
<td>25</td>
<td>59.5</td>
</tr>
<tr>
<td>Doctorate</td>
<td>3</td>
<td>7.1</td>
</tr>
<tr>
<td>Missing</td>
<td>6</td>
<td>14.3</td>
</tr>
<tr>
<td>Nurse Manager years of experience total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>11</td>
<td>26.8</td>
</tr>
<tr>
<td>6-10 years</td>
<td>7</td>
<td>16.7</td>
</tr>
<tr>
<td>11-15 years</td>
<td>3</td>
<td>7.1</td>
</tr>
<tr>
<td>16-20 years</td>
<td>5</td>
<td>11.9</td>
</tr>
<tr>
<td>21-25 years</td>
<td>15</td>
<td>35.7</td>
</tr>
<tr>
<td>Number of years in the health care system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>2</td>
<td>4.8</td>
</tr>
<tr>
<td>6-10 years</td>
<td>8</td>
<td>19.0</td>
</tr>
<tr>
<td>11-15 years</td>
<td>14</td>
<td>33.3</td>
</tr>
<tr>
<td>16-20 years</td>
<td>9</td>
<td>21.4</td>
</tr>
<tr>
<td>21-25 years</td>
<td>9</td>
<td>21.4</td>
</tr>
<tr>
<td>Number of employees supervised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10</td>
<td>6</td>
<td>14.3</td>
</tr>
<tr>
<td>10-19</td>
<td>8</td>
<td>19.0</td>
</tr>
<tr>
<td>20-29</td>
<td>4</td>
<td>9.5</td>
</tr>
<tr>
<td>30-39</td>
<td>9</td>
<td>21.4</td>
</tr>
<tr>
<td>40 or more</td>
<td>14</td>
<td>33.3</td>
</tr>
</tbody>
</table>

Note. N=42
Pre-Education Servant Leadership Self-Assessment and Post-Project Servant Leadership Self-Assessment

The pre-education survey was completed by 42 nurse managers of 51 nurse managers in attendance, representing 82% of potential respondents. The post-project self-assessment surveys were completed by 15 of the 42 initial respondents for a participation rate of 35%.

Internal reliability for the SLS survey was run as a whole and on the subscales based on factor analysis in the literature (Green, Rodriguez, Wheeler, & Baggerly-Hinojosa, 2015).

Table 2

Reliability of the Servant Leadership Survey

<table>
<thead>
<tr>
<th></th>
<th>Cronbach Alpha</th>
<th>Number of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Servant Leadership Survey</td>
<td>.742</td>
<td>30</td>
</tr>
<tr>
<td>Empowerment</td>
<td>.732</td>
<td>7</td>
</tr>
<tr>
<td>Standing Back</td>
<td>.279</td>
<td>3</td>
</tr>
<tr>
<td>Accountability</td>
<td>.646</td>
<td>3</td>
</tr>
<tr>
<td>Forgiveness</td>
<td>.439</td>
<td>3</td>
</tr>
<tr>
<td>Courage</td>
<td>.614</td>
<td>2</td>
</tr>
<tr>
<td>Authenticity</td>
<td>.201</td>
<td>4</td>
</tr>
<tr>
<td>Humility</td>
<td>.686</td>
<td>5</td>
</tr>
<tr>
<td>Stewardship</td>
<td>.602</td>
<td>3</td>
</tr>
</tbody>
</table>

The full SLS survey for this project had a Cronbach Alpha of .742 which is acceptable reliability (Real Statistics, 2020).

The Servant Leadership self-assessment pre-education survey had an overall mean score of 5.0 (SD =0.3), using a six-point Likert-Type scale, indicating a strong level of self-reported ratings of mostly agree and fully agree to the thirty items on the survey which were factors of the eight dimensions of Servant Leadership practice as seen in Table 3.
Table 3

Servant Leadership Self-Assessment Survey- Pre-Education Session,

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Servant Leadership</td>
<td>5.0</td>
<td>0.3</td>
</tr>
<tr>
<td>Empowerment</td>
<td>5.5</td>
<td>0.4</td>
</tr>
<tr>
<td>Standing Back</td>
<td>5.4</td>
<td>0.5</td>
</tr>
<tr>
<td>Accountability</td>
<td>5.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Forgiveness (reverse coded)</td>
<td>4.7</td>
<td>0.9</td>
</tr>
<tr>
<td>Courage</td>
<td>3.9</td>
<td>1.3</td>
</tr>
<tr>
<td>Authenticity</td>
<td>4.6</td>
<td>0.6</td>
</tr>
<tr>
<td>Humility</td>
<td>5.4</td>
<td>0.5</td>
</tr>
<tr>
<td>Stewardship</td>
<td>5.2</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Note. N=42

Table 4

Participant Examples of How They Would Apply Learning from the Education Session.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Quote</th>
</tr>
</thead>
</table>
| Leadership practices               | “Incorporating Servant Leadership in my practice “  
|                                    | “I plan to utilize these templates to help stay organized. I appreciate not having to create these tools and find them adaptable”  
|                                    | “I wish I had this information when I started my role as a new nurse manager”                                                      |
| Specific Staff engagement initiatives | “IDP schedule, recognition survey”  
|                                    | “Try to increase staff 1:1”  
|                                    | “Scheduling 1:1 with staff, help staff to make goals, individual development plan”  
|                                    | “Use specific recognition activities, IDP”  
|                                    | “Staff recognition, routine retention meetings, building cohesiveness”  |
Table 5

*Education Session Helpful Content*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Servant Leadership</td>
<td>“Empowerment”</td>
</tr>
<tr>
<td></td>
<td>“8 Pillars”</td>
</tr>
<tr>
<td></td>
<td>“All about Servant Leadership”</td>
</tr>
<tr>
<td></td>
<td>“The pillars provided new awareness to me that I will have put into perspective in my daily work”</td>
</tr>
<tr>
<td></td>
<td>“Learning what Servant Leadership is verses what it is not”</td>
</tr>
<tr>
<td>Staff engagement and toolkit</td>
<td>“Examples given in the toolkit are excellent”</td>
</tr>
<tr>
<td></td>
<td>“Handout book”</td>
</tr>
<tr>
<td></td>
<td>“Staff communication and respectful of each other. Time management, staff engagement and accountability”</td>
</tr>
</tbody>
</table>

Table 6

*Servant Leadership Scale, Pre to Post Comparison*

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
<th>t(14)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (SD)</td>
<td>M (SD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empowerment</td>
<td>5.4 (0.5)</td>
<td>5.2 (0.8)</td>
<td>0.87</td>
<td>.397</td>
</tr>
<tr>
<td>Stand Back</td>
<td>5.4 (0.5)</td>
<td>5.2 (0.5)</td>
<td>1.46</td>
<td>.166</td>
</tr>
<tr>
<td>Accountability</td>
<td>5.3 (0.7)</td>
<td>5.2 (0.7)</td>
<td>2.09</td>
<td>.056</td>
</tr>
<tr>
<td>Forgiveness</td>
<td>4.7 (1.2)</td>
<td>4.9 (0.9)</td>
<td>-1.09</td>
<td>.296</td>
</tr>
<tr>
<td>Courage</td>
<td>4.0 (1.3)</td>
<td>4.3 (1.4)</td>
<td>-0.61</td>
<td>.553</td>
</tr>
<tr>
<td>Authenticity</td>
<td>4.7 (0.7)</td>
<td>4.7 (0.7)</td>
<td>0.07</td>
<td>.944</td>
</tr>
<tr>
<td>Humility</td>
<td>5.2 (0.6)</td>
<td>5.5 (0.4)</td>
<td>-1.33</td>
<td>.204</td>
</tr>
<tr>
<td>Stewardship</td>
<td>5.1 (0.6)</td>
<td>5.2 (0.7)</td>
<td>-0.64</td>
<td>.535</td>
</tr>
<tr>
<td>SLS Total</td>
<td>5.0 (0.4)</td>
<td>4.9 (0.3)</td>
<td>0.43</td>
<td>.677</td>
</tr>
</tbody>
</table>

Note. n=15

The SLS survey was repeated three months after the pre-education self-assessment.

There were fifteen respondents representing 35% of the potential respondents. There were no statistical differences between pre and post survey results using paired samples *t*-tests.
Table 7 compares individual items from pre-education to post-project, looking at how many participants increased their rating (higher agreement), how many decreased their rating (lower agreement) and how many remained the same. There were three individual statements with statistical differences using Wilcoxon’s signed ranks test.

Table 7

Post Project Servant Leadership Self-Assessment Survey

<table>
<thead>
<tr>
<th>SLS Item</th>
<th>Increased Rating</th>
<th>Decreased Rating</th>
<th>Same Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>I give employees the information they need to do their work well.</td>
<td>2</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>I encourage employees to use their talents.</td>
<td>3</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>I help employees to further develop.</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>I encourage employees to come up with new ideas.</td>
<td>2</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>I keep in the background and give credit to others.</td>
<td>2</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>I hold employees responsible for the work they carry out.*</td>
<td>0</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>I criticize people for the mistakes they have made in their work.</td>
<td>4</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>I take risks even when I am not certain of the support from my own superior.</td>
<td>6</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>I am open about my limitations and weaknesses.</td>
<td>4</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>I learn from criticism.</td>
<td>6</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I emphasize the importance of focusing on the good of the whole.</td>
<td>4</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>I give employees the authority to take decisions which make work easier for them.</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I do not seek recognition or rewards for the things I do for others.</td>
<td>1</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>I am held accountable for my performance by my superior.</td>
<td>1</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>I maintain a hard attitude towards people who have offended me at work.*</td>
<td>0</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>I take risks and do what needs to be done in my view.</td>
<td>8</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Pre and post staff engagement initiatives were measured prior to the education session and at the end of the project. The staff engagement initiatives of one to one meetings and shared decision-making were expected leadership practices for the last three years at this facility. Each of these practices were rated as the highest engagement initiatives currently practiced at 79% and 74% respectively. Daily staff huddles were currently practiced by 48% of the nurse managers, followed by Individual Development Plans (IDP) by 36% and Stay interviews by 26% of nurse managers. The lowest ranking staff engagement initiatives were thank you notes, reflective
practice and weekly staff recognition, all rating an eight percent implementation rating. The end of project survey revealed there were a combination of twenty-four additional staff engagement initiatives implemented by nurse managers at the end of the project. Weekly staff recognition initiatives were implemented by 49% of the respondents and thank you notes and reflective practice implemented by 20% of the respondents. The results are not statistically significant based on chi square analysis, however, the objective of increasing staff engagement initiatives implemented by nurse managers was met.

The weekly coaching calls featured one - two Servant Leadership dimensions as a focus each week and provided examples of how the dimensions are demonstrated in leadership practice. The calls were open to all nurse managers and averaged 30 nurse managers (50%) each week. Coaching call participants reported they attended 75-100% of the calls. The nurse managers found the calls helpful and would recommend the format for future programs.

Descriptive statistics were used to measure self-reported Servant Leadership dimensions the nurse managers focused on implementing as a result of this project. The highest self-reported Servant Leadership dimensions of practice were accountability and empowerment with 80% of respondents focusing on these two dimensions, followed by forgiveness, courage and stewardship at equal implementation rates of 47%.

A majority of nurse managers strongly agreed that Servant Leadership connected with their role as a leader. They planned to implement at least one new staff engagement initiative and they would recommend the education session, coaching calls and toolkit to others.
Chapter V
Discussion and Conclusions

Discussion of Findings

This pilot program aimed to compare nurse managers' self-assessment ratings of their Servant Leadership practices before the educational session and a post-self-assessment evaluation of their Servant Leadership practices three months after the educational session. A secondary aim measured staff engagement initiatives implemented by nurse managers as a result of the educational session, implementation toolkit, and coaching calls. The third aim measured the value of the educational session and the weekly coaching calls.

The Servant Leadership Survey designed by van Dierendonck and Nuitjen focused on a manager's subordinates rating the Servant Leader characteristics of their manager. Due to time constraints for this study, the survey was adapted to reflect a manager's self-assessment of their Servant Leadership practices. The data collected was self-reported assessment information and was not measured against a formal 360 evaluation to include peers, supervisors, and subordinates. A 360 evaluation enables eight to ten employees that may be comprised of subordinates, peers and bosses to provide feedback to an individual leader in competencies such as communication, inclusiveness, ability to deal with problems, listening skills, composure under pressure, and effectiveness in motivating others. A 360 evaluation can be a positive way for leaders to demonstrate they are willing to learn how they are perceived and how they can improve (Keyser, 2014). Research studies are mixed regarding the reliability and validity of self-reported assessments and 360 evaluation assessments. Posner (2016), conducted a review of the reliability and validity of the Leadership Practices Inventory (LPI), a tool that measures the
transformational leadership model. The database included 2.8 million responses to the LPI online assessment from 2007-2015. Seventeen percent were leaders (N=4745,891) and the remainder were from observers of that leader. Posner noted the relationship between self and observer scores on the LPI were mixed. Self-scores were reported to be higher than observer scores in some studies, and observer scores were higher than self-scores in other studies. In other instances, no significant differences between self and observer responses had been reported. Specific to nursing, McGuire & Kennerly (2006) noted that nurse managers had perceived themselves as having higher levels of Transformational Leadership behaviors than the perception of their direct reports.

The nurse managers who participated in this project identified a strong connection between the model of Servant Leadership and their role as a leader. The connection to serve was also noted in Luk’s (2018) research findings that noted a culture to serve and care was reinforced during the year-long study. DeSousa and van Dierendonck (2014) findings support the view that when the needs of the individual are focused on in Servant Leadership, there is a higher effect on employee engagement.

Nurse managers indicated the top two Servant Leadership characteristics they focused on implementing as leaders were accountability and empowerment. While all of the Servant Leadership characteristics and practices are valuable, it is positive to see nurse managers concentrate on accountability and empowerment as two key characteristics essential to professional practice. Accountability is a cornerstone of professional nursing practice. The American Nursing Association's Code of Ethics (2015) defines professional accountability as being answerable to oneself and others for one's actions. When a culture of accountability exists,
all members of the organization hold themselves and each other accountable, thereby building credibility for themselves and the organization (Rachel, 2012). Empowerment refers to the ability to fully practice as a professional nurse and is a foundational base for a healthy work environment. "Workplaces that are empowered are linked to positive organizational environments, behaviors, and attitudes, and these characteristics are linked to increased retention of nurses. Nurses in these environments enjoy job satisfaction, autonomy, and dedication to their organizations (Swearingen, 2017)." A study conducted by Garcia-Sierra & Fernandez-Castro (2018) found that nurses' empowerment perceptions exist according to the management style most displayed by the nurse manager at the unit level.

There were improvements noted in the Servant Leadership dimensions of humility and interpersonal acceptance. The results may be an early indication of improving leader-member exchange (LMX). When leaders focus on LMX, it improves a follower's well-being by creating a positive work climate which may increase employee job satisfaction (Hanse et al., 2015; Parris & Peachey, 2013). LMX is based on the belief that leaders and followers have a relationship that is measured by the level of trust, respect, support and loyalty (Janse, 2019). The goal of LMX from the leadership aspect is to have a high quality relationship with each individual employee. The staff engagement initiatives of one-to-one monthly meetings between the manager and individual employee, the utilization of Individual Development Plans focusing on employee professional goals, and formal weekly staff recognition are engagement examples that build support and trust.

Nurse managers self-reported an increase in their practice of the Servant Leadership dimension of courage. In an organization with a recent history of a strong corporate hierarchal
structure and focus on policies serving as the foundation of management, managers did not feel they could make decisions that may not be supported in a policy. This change may reflect practicing courage and empowerment in their role and may align with the training for all healthcare system leadership on the characteristics of highly reliable organizations.

Of the responding nurse managers 80% were in the age range of 45-64 years, and 80% had more than six or more years of experience as nurse managers. A study conducted by Warshawsky and Cramer (2019) suggests that nurse managers rate themselves as proficient by year seven as a nurse manager, using Benner's Theory of Competency Development. The nurse managers who responded to the end of the project survey were likely "proficient"; they see situations as "wholes" rather than parts. They can modify plans in response to different events or be "expert"; able to recognize demands and resources in situations and attain their goals. Instead of relying on rules or policies, they rely on their experience and knowledge, and intuition. They focus on the most relevant problems to address and ignore irrelevant issues (Petiprin, 2016). The engagement level of the experienced nurse managers who responded to the post-project survey was positive related to Servant Leadership practices they focused on and staff engagement initiatives implemented.

The weekly coaching calls provided a continued connection to the initial education session. The calls provided more specific information with guidance on implementation strategies for each of the Servant Leadership dimensions of practice and staff engagement initiatives. The calls were open to all nurse managers regardless of their participation in the educational session or any of the surveys. The goal was to provide information and leadership development for all managers. The coaching development model for the weekly calls utilized
the domains of *Building a Coaching Foundation* and *Coaching Teams to Higher Performance* as described by Sherman (2019). The goal was to build emotional trust with the nurse manager group by listening to their unique experiences and share strategies for their consideration on how each of the Servant Leadership dimensions of practice can be demonstrated. The average weekly participation rate of 50% of all nurse managers was higher than anticipated. Attendance was noted to be consistent from the beginning of the call to the end of each call, which may indicate the coaching development model domains utilized and the agenda content had a positive impact on engagement.

**Limitations**

There were several limitations to this pilot project. The project was limited to one facility, and the small sample size limited the ability to show statistical significance for the project's results. The self-assessment survey design may have been a limitation with the possibility of participant response bias. Therefore, it is not possible to generalize the results beyond this sample.

**Implications for Practice, Education and Policy Dissemination**

There is an opportunity for Servant Leadership to become an influential leadership model in health care. The association of the tenets promoted in healthcare and the principles of Servant Leadership come together to achieve alignment of this model. Health care leaders can connect the nurse manager's role in the Servant Leadership model through formal education and training sessions at the local facility level. Incorporating this education into the core orientation curriculum for new nurse managers is recommended. Providing a nurse manager colleague who
has successfully demonstrated Servant Leadership practices as a peer mentor during the new manager's first year is recommended to support their leadership development.

Linking the leadership role of the nurse manager with Servant Leadership dimensions of practice can strengthen nursing leadership's alignment throughout the organization, establishing consistency in leadership practices. Servant Leadership dimensions of practice by nurse managers and all other health care leaders in an organization can create a positive working environment that results in higher productivity, staff loyalty, trust and commitment to the organization and job satisfaction for the nurse manager and employee.

The recommendations support the health care system's journey to becoming a High-Reliability Organization (HRO). Effective leadership is the primary component of an HRO. HealthCatalyst (2020) cites that "leadership takes charge of the culture and engages staff, promoting a culture of safety and continuous learning and improvement (para. 12)." In proactive organizations, local leaders model the behaviors to create a culture of empowerment for staff to speak up, and be accountable, not just for individual responsibilities but also for systems responsibilities. HROs develop standardized processes to reduce variability and achieve consistent outcomes (HealthCatalyst, 2020).

**Recommendations for Nursing Practice and Further Study**

There are a number of opportunities for future scholarly work on this topic. An expanded study involving multiple sites within the healthcare system over a nine to twelve-month period may provide more complete information regarding knowledge, practice, and staff engagement. Incorporating a 360-degree assessment using the original survey tool for subordinates, peers, and supervisors and the adapted self-assessment tool may provide broader information for the
nurse manager to consider in focused areas of Servant Leadership dimensions of practice to
develop. Coaching calls would be recommended to continue weekly throughout the project along
with qualitative data about the impact on leadership performance. Measurement and sustainment
of initiatives should be conducted at months three through eight of the study. A repeat 360-
degree assessment for nurse managers at the end of the project would provide valuable
information on the strength of this study. Outcomes that may evaluate the impact on staff
engagement may be measured through the unit-specific All Employee Survey (AES), nurse-
sensitive quality outcomes, patient satisfaction, and staff turnover. The nursing department may
review aggregate or clinical service-line nurse manager turnover data provided by Human
Resources and nurse manager satisfaction measured through the AES at the end of the study's
nine to twelve month-period of time. A final interesting dimension to examine would be the
impact of Chief Nursing Officer engagement in the project on nurse manager participation.
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