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Motivation for Seeking a Nurse Manager Position: A Qualitative Study

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Motivation for Seeking a Nurse Manager Position: A Qualitative Study

by

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Abstract

By the year 2020, it is estimated there will be a need for 3.45 million bedside nurses – at least 1.2 million more than the projected supply (American Association of Colleges of Nursing [AACN], 2011). In addition to the lack of bedside nurses, nurse manager vacancy rates are estimated to be as high as 8.3% nationwide. There is limited empirical data available on a nurse's motivation to choose a nurse manager role. This qualitative research study's purpose was to explore the factors influencing nurses' motivation to seek a nurse manager role and to articulate a grounded theory of decision-making.

The research subjects were five nurse managers working in Southern California. Participants took part in one-on-one interviews, conducted in private locations. Interviews lasted one hour to one and half hours. Data analysis occurred concurrently with data collection. Tape recordings of each interview were transcribed and additional notes were made regarding the place of discussion, situational characteristics and events associated with the interview.

The model derived from the data provides a unique view of why nurses choose the nurse manager role that is particularly pertinent to sustaining nurse's in the manager position. The motivations of nurses presented in this view arose from both internal and external influences and included themes of a planned or unplanned move, opportunity, influence of others, preparation for the role, and personal satisfaction. Participants also identified a category of factors (non-reasons) that specifically did not influence their decisions.

Dedication

This dissertation is dedicated to my family. Words cannot express the appreciation I feel for the support and encouragement they provided me every step of the way during this transformational journey. For the endless hours, I had to say, "I can't, I have a paper due." Thank you for tolerating the incredibly boring weekends and long nights. Jessica and Jaxon, thank you for reading and reviewing and for finding those innumerable grammatical errors.

To my friends, Dan and Eileen who allowed me the tranquility of the Lake Ripley house to write. Karey, who covered for me at work and listened to my doubts and screams of frustrations, you are a remarkable friend!

Finally, thank you to my parents who started me on this educational journey so very many years ago. Who knew it would take so long?

encouragement to attend school and work full time. Dr. LeeAnn Hawkins, PhD, RN, who

listened to my fears and frustrations and who believed I could complete this journey.

I will never forget everyone's patience and kindness. I will apply what I have

learned as an educator and future researcher.

This journey has taught me to "NEVER GIVE UP!"

Judy

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Chapter 1

Introduction

The U. S. Bureau of Labor Statistics' Employment Projections for 2010-2020

(released in February 2012) estimated that by 2020, our nation will need 3.45 million

bedside nurses – at least 1.2 million more than the projected supply (U.S. Bureau of

Labor Statistics [BLS], 2012, Table 6). Who will lead 3.45 million nurses while they

struggle to make sense of federal, state, and organizational healthcare initiatives? Who

will ensure that the patient is at the heart of the practice of 3.45 million nurses? Who will

assure that quality care is occurring? How many nursing managers will be required to

help lead 3.45 million nurses? The problem for patients everywhere is too few nurses and

too few nurse managers. The number of nurse managers needed to lead 3.45 million

nurses is based on current healthcare organizations' (HCOs) designs for leadership. The

only published vacancy rates for nurse managers were estimated to be as high as 8.3%

nationwide in 2000 (HSM Group, 2002). However, within the next 10 years,

approximately 75% of our current healthcare leaders plan to retire adding to this vacancy

rate.

Despite the absence of nurse managers now and in the projected future, the

Institute of Medicine's report released in 2010, T*he Future of Nursing,* called for nursing

to take more of a leadership role than in the past. Understanding the stories of current

nurse managers and their reasons for choosing a leadership role will help the nursing

profession learn more about the attraction of the nurse manager role and prepare nurses to

play a more critical role in leadership. The purpose of this study was to identify what

motivates a nurse to accept a nurse manager role in an acute care healthcare organization

in southern California.

Background

A discussion of leadership inevitably leads to the question, "How do you become

a leader?" Some say leaders are born and others say that you can learn to lead. Traits such

as being charismatic or visionary can define leadership. Other times, the style, as in

autocratic or transformational, describes the leader. Leaders are also defined by their

actions and achievements. In some instances, the situation creates the leader, when one

'rises to the occasion' or 'seizes the moment.' The position of a leader can give formal

authority; others earn informal authority by their actions.

Leadership is an important component of nursing and bedside care. The nurse

manager plays a pivotal role in connecting management and employees and thus has a

direct impact on organizational performance (Casida & Parker, 2011; Cummings, 2011;

Germain & Cummings, 2011). Nursing organizations, such as the American Nurses

Association (ANA, 2013), American Organization of Nurse Executives (AONE, 2012),

and Sigma Theta Tau International (STTI, 2013), consider leadership a standard for the

professional practice of nursing. Nursing needs qualified and appropriately trained leaders and managers—not just nurses with years of experience—to lead 3.45 million nurses (Duffield, Roche, Blay, & Stasa, 2011).

Nurse leaders influence patient care in various ways. Research has confirmed that the detrimental effects of the nursing shortage range from medication errors, missed or inappropriate treatments, high staff turnover rates, increased cost to the consumer, and patient mortality, to name just a few negative patient outcomes (Faila & Stichler, 2008; Porter-O'Grady & Malloch, 2011). In addition, leadership's impact on a healthy work environment has been well documented (Duffield et al., 2011; Squires, Tourangeau, & Laschinger, 2010), and research has shown that a substantial factor in continued job satisfaction and organizational commitment is a positive relationship with immediate supervisors (Casida & Parker, 2011; Jarrin, 2012; Wang & Rode, 2010). The traits of effective nurse managers are based on the critical factor of emotional intelligence (Jordan & Troth, 2011; Taft, 2006) as well as the manager's ability to motivate staff, support collaboration, and inspire change–in other words, a person's ability to affect organizational culture (Duffield et al., 2011; Germain & Cummings, 2011; Henderson et al., 2010).

To date, the literature on why nurses choose the nurse manager role has been more anecdotal than empirical. The limited research available regarding the nurse manager role does not explain why nurses accepted the role in the first place and there is a gap in the literature regarding the factors that attract nurses to the manager role

(Laschinger & Wong, 2010).

Research Question

The aim of this study was to understand the motivations of a nurse in choosing a manager role in an acute healthcare setting. The question to guide this research is "what motivating factors led nurses in a southern California hospital to accept a nurse manager position?"

Because empirically based studies of why a nurse chooses a leadership position are scarce, a researcher should first use a method that creates a substantive or formal theory. Unfortunately, any insight into a nurse's motivation to accept the nurse manager role is notably absent from the literature. My interest in this topic emerges from my own employment course. I have been in nursing leadership roles for the majority of my career. I function in a nursing supervisor role, as well as being responsible for direct patient care. As a nurse, I exist between two different jobs—that of the bedside nurse and that of nursing administration. Being both a nurse and working in a nursing leadership role was expected to lend some credibility with the research participants since I can relate to their experiences and know the language they use. My interest in pursuing this study as a qualitative endeavor was due to the interpretive nature of qualitative research. As a new researcher, I have learned the importance of being committed to the qualitative research tradition, and I believe in the value of understanding the human experience. Interpretation of the socially constructed nursing experience has significance and may lead to practice changes, policy modifications, and subsequently more effective nursing leadership

practices.

Emergent design and inquiry characterize qualitative studies with their basis in the realities, insights, and perspectives of those participating in the study (Holloway & Wheeler, 2010). Qualitative research focuses on how people interpret and make meaning of their experiences and their environments. The overall strength of qualitative description is in the naturalistic inquiry design (without manipulation or intervention) and the ability to describe the phenomenon through the genuine voices of those experiencing it. Qualitative inquiry is suitable for the study of incompletely understood phenomena, with the researcher making meaning of the data (Creswell, 2009; Holloway & Wheeler, 2010).

Semi-structured interviews in grounded theory attempt to follow the major concerns of the participants to describe the dimensions and meaning of and explore relationships among phenomena (Holloway & Wheeler, 2010; Polit & Beck, 2012). People do not exist in a silo of experiences but rather have many life experiences and decisions that led to who they have come to be. Flexible interviewing allows the participant the freedom to answer in a dynamic perspective. This study used classical grounded theory and data collection through semi-structured interviews, coding, and the constant comparative method of data analysis and the development of a substantive theory.

Grounded theory gives the greatest contribution in research circumstances where little research is available (Creswell, 2009; Glaser & Strauss, 2012). The general purpose

of grounded theory for this study was to generate a theory to understand why nurses chose the nurse manger role.

Significance of the Study

The literature regarding nurses' motivations to assume a managerial role is sparse and contributes to a lack of understanding of nursing's involvement in nursing management. This grounded theory study utilized traditional qualitative methods for data collection; in-depth interviews with current nurse managers, on-going content data analysis, to address the phenomenon of concern. The result of this exploration is a theoretical explanation of why nurses are motivated to seek the manger role. It is important for the research to describe the motivation of the nurse in order to contribute to the larger body of literature on nurses' motivations to assume the leadership role of the nurse manager. This study focused on currently licensed registered nurses working as nurse managers in an acute care hospital in southern California. This research may shed light on a previously under observed domain of nursing leadership practice. It might also be useful to executive nurse leaders, healthcare administrators, and nursing leadership organizations. The information learned because of this research may be useful in redefining the nurse manager role to achieve positive patient outcomes and health care organizations' (HCOs) strategic initiatives. This study begins to address the gap in the literature, which may lead to other studies in in the area of nursing leadership.

Summary

Leadership is a vital component of any organization in producing superior results

(Griffith, 2012; Titzer, Phillips, Tooley, Hall, & Shirey, 2013; Trepanier & Crenshaw, 2013). The nursing profession is about to face a stormy future– embracing a new healthcare system with ever changing initiatives and a decrease in nurse managers. Leadership of any organization provides the means to accomplish the mission and vision by setting strategic goals. For healthcare, nurse managers are largely responsible for ensuring safe patient outcomes and engaging staff on a unit level. Without the proper nursing leadership, it will be virtually impossible to motivate and develop staff to achieve high-quality patient-centered care and contain healthcare costs.

Chapters 2 and 3 of this dissertation include a review of the literature and the methods used in the study. The review of literature also outlines motivational theories and studies of human motivation to set the context for the study. The results of the study and discussion of their implications follow in chapters four and five.

Chapter 2

Review of Literature

As noted earlier, organizational leadership studies and motivational studies provided the broader framework for this research study. The purpose of this chapter is to situate this research in the larger context of the motivation of nurses in choosing a nurse manager role. The practice specialty of the nurse manager arose out of two disciplines—nursing and leadership. In order to understand how nurses came to be part of the leadership team, we need to review some of the work surrounding organizational theory and motivational theory. The history of leadership and its introduction into nursing are also addressed.

In grounded theory research, literature review happens at different times in the process of the research study. This initial literature review stimulated potential research questions and helped to determine the extent of previous research regarding nurses' motivations in seeking a manager role. Following the definition of motivation, this chapter explores theories of motivation and studies of human motivation as well as studies of nurse manager motivation.

Defining Motivation

According to Merriam-Webster's Online Dictionary, motivation is

    1. "The act or process of giving someone a reason for doing something: the act

or process of motivating someone

2. The condition of being eager to act or work: the condition of being

motivated

3. A force or influence that causes someone to do something" (Motivation,

2013)

In this basic definition, motivation is an action noun that relates to the internal processes that move, drive, convince, or provoke people to do the things they do. It is the call to action that stimulates people to initiate behaviors. Human wants, drives, and desires are typically internal motives for our behaviors. Incentives, rewards, and reinforcement are motivations coming from external sources. For this study, the definition of motivation is the process that energizes behavior and directs it toward a goal. The process of being motivated helps to provide purpose and direction and determines why someone performs a certain act. Understanding why a nurse is motivated will help nursing leadership understand whether internal or external motives drive nurses to seek manager roles.

There are two types of motivation—intrinsic or extrinsic. Extrinsic motivators are found outside of the mind's control and originate as a reward for completing a particular behavior (Deci & Ryan, 2008). Intrinsic motivation comes from within one's self with internal values regulating it, and is thus independent of extrinsic motivational forces (Ryan & Deci, 2006). Autonomous regulation, acting in accordance with one's values, is

a universal psychological need (Deci & Ryan, 1985; Sheldon, Ryan, Deci, & Kasser, 2004; Wichmann, 2011). All humans are inherently motivated– to grow, to learn, to discover. In fact, motivation is the driving force for human behavior. Researchers have tried to answer questions of how and why humans are motivated (Robak & Nagda, 2011; Ryan & Deci, 2006; Sheldon & Schuler, 2011; Stone, Deci & Ryan, 2009).

Theories of Motivation

There are two main divergent views of motivation–the traditional view and the human relations view—to explain human drive and to help predict human behavior. The ancient Greek philosopher, Aristotle, developed one of the earliest theories of motivation. He believed motivation was an inherent human function (Cahn & Markie, 2002). In other words, being human meant operating relative to some outcome or end; if we are tired then we will rest; if we are hungry, we eat. Motivation implies that one makes a decision fully aware that effort is required to achieving something that is valued. What is valued is subjective and differs from one individual to another. Sigmund Freud proposed the 'pleasure principle' as the central mechanism of motivation. According to Freud, humans do not just seek pleasurable experiences while avoiding pain; instead, they are driven toward pleasurable experiences and away from painful ones. Freud developed a motivation theory called Theory X. This theory assumes that people are lazy and that they will avoid work at all costs as well as waste time at work by finding other things to do. Freud postulated that to get people to work, they must be rewarded, coerced,

intimidated, or punished. This method is often described as the 'carrot and stick' philosophy of management and was used in the 20th century but has been shown not to be a successful approach to management. Studies have demonstrated that this type of leadership creates an oppressed environment with no possibility for creativity or achievement (Drucker, 2009).

Modern theories of motivation continue to mirror Aristotle's model, suggesting that motivation derives from internal cognitive maps or expectations of the potential consequences of various actions. Motivation exists in many different forms; sometimes separately and sometimes simultaneously, including fear of losing one's job, financial incentives, and self-fulfillment objectives and personal aspirations to meet the goals of an organization (Hatch, 2013). According to cognitive psychologists, our primary source of motivation comes from the expectations we have of what will happen because of our actions. How people feel, and what they do, depends on the value that they attach, and the causes they attribute, to anticipated consequences. Strong positive expectations, for instance, can push people to put out extra effort in hope of reaching some desired outcome. Expected consequences perceived as negative will lead to either avoidance or perhaps apathy. Motivation relies on the time invested in the task along with the value it has for us. Other factors include whether we want to learn the task or if we think we can do the task. I want to be an actor and win Grammy award, but I do not think I will be able to do that. While my desire to act is strong, my expectation that I will be successful is

low; therefore, my motivation is low.

Traditional motivational work developed from the labor market. Taylor (1916/2005) and Fayol (1916/1949) began compiling their theories of workflow into the School of Scientific Management. They firmly supported the beliefs that people dislike work, people will only work for money, people are not able to control or direct their own work, simple repetitive tasks produce the best results, and workers produce best when they are monitored and controlled. Taylor (1916/2005) based his management philosophy on the assumption that there is a right way to perform any task. However, the right way was management's responsibility to define. The 'right way' would increase productivity because it was easier and task driven.

The human relations view of motivation originated with the Hawthorne studies. The management of the privately owned Western Electric Company in Chicago, Illinois initiated a landmark motivational research experiment called the Hawthorne studies, which were conducted from 1924 to1932 (Hassard, 2012). Following the "principles of scientific management" introduced by Frederick Taylor (1916/2005), the design of the Hawthorne study was to increase employee productivity. The type of overhead lighting were the variables in the study (Mayo, 1933/2003). The results were not as Mayo expected despite a definite increase in productivity. The effect was due to the awareness and attention given to the employees from the research team, and not because of brighter or duller lighting. Many scholars criticized the Hawthorne studies for reasons ranging

from lack of research originality, to the fact that a consultant, rather than a researcher, conducted the study, to the many methodological limitations found in the study (Muldoon, 2012).

This dissertation is not a critique of the Hawthorne studies but it is important to note that the Hawthorne studies were a product of their time and became the standard for human relations and motivation. Through the findings of the Hawthorne studies, motivational research turned down a new avenue established by the causal link between employee motivation and the employee's perception of management. The Hawthorne studies showed that people want to feel appreciated and important, people want recognition for their work, and people want to be managed in a sensible manner. In addition, managers need to discuss the plans they make for staff, consider any objections, and encourage self-regulation in routine tasks. Jung and Lee (2012) corroborated the Hawthorne studies with similar (not identical) variables. In their study of public employees in non-management positions, they found that employees with positive perceptions of co-workers and management performed consistently better than those with negative perceptions.

The cognitive perspective states that our expectations concerning probable outcomes are the primary source of motivation (Oliver, 2015). The idea that people have strong reasons to perform various actions is the basis of the Humanistic Theory of Motivation (Maslow, 1943). Abraham Maslow's hierarchy of needs illustrates that

different motivations exist at different levels until those needs are met. A satisfied need is no longer a motivator of behavior. Maslow believed that the lower level needs took priority over the higher needs. Outlining the needs from the bottom of the pyramid (basic physiological needs) and moving to the top of the pyramid (need for self-actualization) allowed the establishment of Maslow's hierarchy. The assumptions of Maslow's hierarchy include that individuals have multiple needs and needs are ordered in levels, which create a hierarchy, but a need, once satisfied, is no longer a need.

Other cognitive theories of motivation continue to try to explain why humans are motivated to do what they do. William McDougall proposed in 1908 the Instinct Theory of Motivation (Petri & Govern, 2013). McDougall believed that because of evolutionarily programming, people are motivated to behave in similar and yet certain innate ways leading to one of the few theories that emphasizes a biological approach to motivation. An example of this is a human mother who will stay awake all night comforting a child who will not sleep until she sees that the baby is calm and finally asleep. Animals do not learn to do this; it is instead an inborn pattern of behavior. McDougall created a list of human instincts that included such items as attachment, play, shame, anger, fear, shyness, modesty, and love (Petri & Govern, 2013). The main problem with this theory is its lack of ability to explain behavior. The Instinct Theory of Motivation only describes behavior it is not able to tell us the why of behavior choices. Many known instincts are not universal. Some mothers do not have the instinctual impetus to take care of their children,

and motivation can exist on different levels of instinct, such as jealousy and aggression.

The Arousal Theory of Motivation suggests that people take certain actions to either decrease or increase levels of arousal (Petri & Govern, 2013). When arousal levels are too low, for example, a person might go for a run or watch an exciting movie. When arousal levels are too high a person would, according to this theory, look for ways to relax (e.g., meditation, massage, or reading). Human motivation comes through a need for homeostasis to maintain a peak level of arousal, even though this level can fluctuate based on the individual and/or the situation.

Drive Theory of Motivation postulates that people are motivated to take measures to decrease the internal tension caused by unmet needs (Petri & Govern, 2013). For example, you might be motivated to drink water in order to reduce the internal state of thirst. This theory is useful in explaining behaviors that have a strong biological component, such as hunger or thirst. The problem with the Drive Theory of Motivation is that motivation can drive behavior for more than physiologic needs. For example, people often eat even when they are not hungry.

One of the oldest theories of motivation, the Incentive Theory of Motivation and supported by behaviorist B.F. Skinner (1976), suggests that people are motivated to do things because of rewards received. For example, people might only be motivated to go to work each day for the monetary reward of being paid. The behavioral learning concepts of association and reinforcement play a significant role in this theory of

motivation. The incentive theory postulates that people are motivated because of a desire that pulls them toward a reward or a goal and the avoidance of an action that has perceived negative consequences. This theory differs in that the person is attracted toward the stimulus rather than reducing or eliminating the stimulus. Since an incentive is what motivates you to engage in a behavior to gain an external reward, the incentive can be positive or negative. Monetary and non-monetary incentives motivate employees in their work. Some positive incentives might be praise from a supervisor, job promotion, trophies, medals, and an increase in pay. Negative incentives can help to change employee behavior or remedy mistakes, and include various levels of corrective action, job demotion, and even termination. The problem with the incentive theory is that many behaviors require painful tasks even though the end goal is pleasurable. For example, Gandhi displayed altruistic behavior by sacrificing personal time and energy, even engaging in risking his life, in order to help the people of India.

Studies of Human Motivation

In the 1920s, the external rewards one received, (e.g., money, health benefits, day care, etc.) defined motivation for many people. Management designed itself around this philosophy in the belief that science had demonstrated that external rewards motivated better employee performance. Because rewarding behavior does temporarily work to motivate a person, management did not see the need to change what appeared to work. The employee either worked when and how told or another employee would be hired to

replace the non-conforming employee.

In 1938, operant conditioning theory, created and tested by Burrhus Frederic Skinner (B.F. Skinner), posited that the best way to understand behavior was to use observation in determining the causes of an action and its consequences. In experiments with pigeons, Skinner (1953) showed that the pigeon does not act of its' own accord but its environment shapes its behaviors by providing reinforcements. Skinner labeled these behavior-shaping actions as a neutral operant (responses that neither increase nor decrease the behavior being repeated), reinforcers (responses that increase the likelihood of a behavior being repeated), and punishers (responses that decrease the likelihood of a behavior being repeated). When the pigeon learned to peck on the red light, a piece of food appeared; the key was limiting when the reinforcement occurred. The bird had to peck repeatedly until the food appeared. Providing an intermittent consequence demonstrated that rewarding behavior in this manner strengthened the pigeon's behavior through positive reinforcement.

Another component of operant conditioning was the removal of an unpleasant reinforcer or adverse stimulus. Skinner referred to the strengthening behavior that happens because of the removal of the unpleasant stimulus as negative reinforcement. The third area of Skinner's experiments was punishment, which he defined as the opposite of reinforcement. Punishment weakens the pleasant response and provides a direct unpleasant stimulus or removes a rewarding stimulus (Skinner, 1953). Operant

conditioning suggests that free will does not create motivation. Instead, motivation derives from repetition of positive or negative outcomes, which have been environmentally stimulated by reinforcers or punishers. Despite current research, many managers and leaders still believe that operant conditioning motivates employees to perform better (Duffield et al., 2011).

In the 1980's researchers from the University of Rochester began a new and demanding journey to study human motivation and personality. Self-determination theory (SDT) is a set of assumptions about human nature and motivation. SDT states that human motivation is innately part of why we grow and seek to achieve (Deci & Ryan, 1985). Inherent motivation explains why people will fully commit and engage in a task even though it may not be interesting (Deci & Ryan, 2008). Understanding the purpose and value of a task creates a deeper commitment that results in a higher level of engagement. Assumptions about human nature and motivation provide the foundation for SDT with a focus on the intrinsic component of motivation.

SDT concentrates on the intrinsic importance of work. Studies support the connection between intrinsic motivation and better performance (Cho & Perry, 2011; Stone, Deci, & Ryan, 2009; Wichmann, 2011). According to SDT, there are three universal psychological needs, competence, relatedness, and autonomy, that are essential to understanding the 'what' (content) and 'why' (process) of goal pursuit (Deci & Ryan, 2008). Competence is the conviction that one can affect one's own significant outcomes.

Relatedness is the ability to have fulfilling and supportive social relationships. Autonomy is the choice to act with self-determination and volition. Deci and Ryan (2008), through their focus on SDT, distinguished between the amounts of motivation one might possess from the type of motivation one feels. They particularly examine autonomous motivation, controlled motivation, and non-motivation as predictors of performance. Autonomous motivation develops from intrinsic and extrinsic motivation and means that one performs a task because they feel a personal volition to or they feel that the task is personally important to them (Deci & Ryan, 2011). Controlled motivation involves doing a task more from a sense of demand or pressure. It has two sub-types: (a) external motivation means that the motivation to achieve a task comes from outside one's personal desire; and (b) introjected motivation that involves doing a task because the person would feel guilty or unworthy for not doing it. Non-motivation is an absence of any motivation. Deci and Ryan's (2008) research indicated what SDT hypothesized–the type or quality of motivation one exhibits is important for predicting outcomes of motivation such as effective performance and/or creative problem solving.

Cho and Perry (2011) studied responses from 212,223 participants (51% response rate) when they tested the impact of intrinsic motivation on employee attitudes and explored three factors influencing the effects of intrinsic motivation: managerial trustworthiness, goal directedness, and extrinsic reward expectancy, using the 2008 Federal Human Capital Survey (FHCS). The survey population was full-time, permanent

employees who worked in the President's Management Council. The study measured the dependent variables, employee satisfaction and intent to leave, and the independent variables of intrinsic motivation, managerial trustworthiness, goal directedness, extrinsic reward expectancy, and individual resources. Cho and Perry demonstrated that intrinsic motivation mattered for both employee satisfaction and intent to leave. Managerial trustworthiness was a useful resource to increase employee satisfaction and subdue intent to leave. In addition, managerial trustworthiness promoted relationships between intrinsic motivation and employee satisfaction. With high levels of managerial trustworthiness, the levels of satisfaction were stronger than from intrinsic motivation.

Cho and Perry (2011) demonstrated that managerial trustworthiness strengthened intrinsic motivation and employee satisfaction. Goal directedness supported the link between intrinsic motivation and satisfaction. However, goal directedness and extrinsic reward expectancy did not show interactions for turnover intention. Under high expectancy for extrinsic reward, the influence of intrinsic motivation on employee satisfaction decreased. They also found that extrinsic reward expectancy worked opposite of goal directedness and overrode intrinsic motivation. A very short story illustrates this point bests. A schoolteacher lives in a house very close to a grade school and has a beautiful sprawling green lawn where kids come to play and to have fun. Having so many children always on her lawn start to bother the teacher, and she decides to do something about it. She pays them a dollar every day for a week to come play on her lawn. The

children happily take the dollar and play on her lawn. The following week, the teacher

tells the children that she does not have enough money, so she can only give them 50

cents to come play on her lawn. The children are unhappy but they accept this decrease in

money to play on the teacher's lawn. The third week, she tells them she can only give

them a nickel to come play on her lawn. The children are so displeased with this that they

tell the teacher she can forget her nickel and that they will not play on her lawn for such a

cheap reward. These children, just a few weeks earlier, had played on her lawn for

absolutely nothing, but now, they quit playing, even though the incentive was only a

nickel! The teacher changed the children's expectation for playing on the lawn to an

external reward. Once the reward was established, the teacher slowly removed the

reward, and in doing so, she reinforced the children's desire for the reward to play on the

lawn. By the time the reward dramatically decreased, the children did not have the same

intrinsic motivation present for playing on the lawn.

Cho and Perry's analysis supported the prediction of self-determination

theory—intrinsic motivation and employee satisfaction strengthens under increased levels

of managerial trustworthiness and goal directedness. Moreover, this study also confirmed

crowding-out theory, which states that high levels of extrinsic reward expectancy weaken

intrinsic motivation and employee satisfaction. Motivation crowding theory argues that

both intrinsic and extrinsic motivations have direct positive or negative effects on

performance and that extrinsic motivation has a crowding effect on intrinsic motivation

that can be either positive or negative (Deci & Ryan, 1985; Frey, 1997). The perception

of the extrinsic motivation factor determines the direction of the crowding effect. Cho

and Perry noted when high levels of managerial trustworthiness and goal directedness

were present, intrinsic motivation was crowded-in for employee satisfaction and was

crowded-out under high levels of extrinsic reward expectancy (Cho & Perry, 2011).

Although Cho and Perry demonstrated the pivotal role that the middle manager

plays in shaping perceptions of managerial trustworthiness and goal directedness, they

did not address the motivation of why a nurse chooses a nurse manager role. If the

involvement of the nurse manager is critical for successful implementation of managerial

initiatives then understanding why the nurse chooses the nurse manager role would be the

first step in connecting organizational strategy to employee satisfaction and engagement.

Studies of Nurse Manager Motivation

In the preliminary literature review conducted for this dissertation, there was only

one study found that looked at possible motivations for why nurses do not seek the nurse

manager role. The findings of this two-part study are discussed in Chapter 5.

Organizational Theory

History books do not give a specific date when organizations began structuring or

managing employees and work processes (Shafritz, Ott, & Jang, 2005). The Industrial

Revolution resulted in the adoption of many management principles that redefined both

values and beliefs. Perhaps the greatest contribution from the Industrial Revolution was

to help define the manager role. In many respects, healthcare has always embraced classical organizational theory, with its basic conventions and philosophies deeply rooted in the Industrial Revolution. The tenets of classical organizational theory include the premise that people and organizations act in accordance with balanced economic principles (Shafritz et al., 2005). According to classical organizational theory, the purpose of the organization is to accomplish production-related and economic goals by means of specialization and division of labor that maximize production. During the Industrial Revolution, employees were treated as if they, too, were interchangeable parts in an industrial machine (Shafritz et al., 2005).

During the Industrial Revolution, the management role was designed to coordinate the interaction of upper level of management and employees to keep the industrial machine functioning and, thus, producing (Taylor, 1916/2005). Henri Fayol (1916/1949), the father of modern management, originated the concepts of functions and principles of management and organizing that are still in use today. It is important to note that Fayol was managing a large French mining company when he embarked on his journey to creating mechanistic effectiveness. Classical organizational theory incorporated many motivational principles from the world of machines and the idea of human efficiency.

Several aspects of nurse management continue to follow the principles of Fayol and the Industrial Revolution in an effort to improve the quality and safety of patient

outcomes, yet insufficient progress continues. Today the responsibility for implementing quality improvement processes and providing clinical expertise falls to the nurse manager. Previous studies related to nurse managers and leadership largely focused on the organizational impact of nurse managers' job performance (Casida & Parker, 2011; Cummings, 2011; Germain & Cummings, 2011; MacLeod, 2012). Managers do play a central role in elevating the effects of employee motivation by providing meaningful work, clarifying organizational goals, and creating climates of trust. Research shows a relationship between leadership styles and patient mortality (Casida & Parker, 2011; Cummings, 2011; Faila & Stichler, 2008), as well as building healthy work environments (Espinoza, Lopez-Saldana, & Stonestreet, 2009) and cultures of engagement (Song, Kolb, Lee, & Kim, 2012). However, nursing management continues to follow the traditional management principles left behind by the Industrial Revolution.

The Institute of Medicine has consistently repeated themselves over the years in their quality reports in asking nursing to step up to the plate and provide more dynamic leadership. To improve health and healthcare, we need leaders who are more effective, or we will be unable to provide the additional 3.45 million Americans entering the new Obama Health Plans with positive patient outcomes. Research to date has not fully addressed what motivates nurses to choose to be nurse managers and how this information might help to fill the anticipated gaps in the number of nursing managers.

Definitions of Leader and Manager

With nursing's emphasis traditionally on patient care, leadership can become a secondary focus. Both leadership and nursing are disciplines within themselves, and each requires its own dedication. It is important to define the terms 'leader' and 'manager.' There are many authors who discuss the ambiguity of these terms (Draper, Felland, Liebhaber, & Melchar, 2008; Fennimore & Wolf, 2011; Yukl, 2010). The leadership role is an active dynamic process involving purposeful influence over others so that the employee knows what is required as well as the method of performing specific tasks and achieving common goals (Yukl, 2010). A leader or manager is the person who incorporates the following four attributes in their job description: (a) designated authority from the organization with the title of manager, (b) empowerment to direct and enable others to do their work effectively, (c) the ability to utilize resources appropriately, and (d) answerability to superiors for results (Drucker, 2009; Longest & Darr, 2008; Roussel, 2006). Thus, leader is not just a title one assumes but it is a purposeful role designed with power and responsibility matching the organization's mission and vision.

The expectation was that the nurse manager would adapt to leadership the same way she or he had adapted over the years to bedside nursing. No formal leadership training or experience was required because on-the-job training would weed out who was a leader and who was not (Titzer et al., 2013). This approach to leadership is a very costly gamble for any organization (Casida & Parker, 2011; Drucker, 2009). An experienced

nurse was a valuable asset because of the established relationships with physicians and with ancillary departments. These relationships helped create easier interactions resulting in a smoother flowing unit. The tradition of promoting the longest employed nurse to the head nurse position (aka nurse manager) was a simple method and helped nurses, as well as administrators, falsely claim that the best clinical nurse made the best manager. Leadership studies have shown this belief to be false (Casida & Parker, 2011; Cummings, 2011; Faila & Stichler, 2008). Leadership, the process of leading, is not the same as nursing, the process of patient care, and yet healthcare organizations continue to mix the two as if knowing how to provide excellent clinical care for patients' enables one be an effective nurse manager. Understanding how nursing managers came to be in the nurse manager role is a first step in looking at why so many nurse managers are missing.

The difference between a leader and a manager is often very nebulous. Experts have written many distinguished books on what a leader should be and what a manager should do (Drucker, 2009; Longest & Darr, 2008; Shafritz et al., 2005; Yukl, 2010; Zaleznik, 1977). Yet, it is still unclear what the definitions of manager and leader are because of the overlap in these roles. As simple as it sounds, the manager is a component of the leadership team who engages in the process to control the work environment. The role of the manager is not the same as the role of other leadership team members. The focus of the nurse manager can also vary from organization to organization, but managing usually has a different set of competencies from other leadership roles.

The leader, for purposes of this dissertation, is any one member of a group who is recognized by others (organization or individual) that influences others to understand and agree about what needs to be done and how to do it. Yukl (2010) went further to define leadership as engaging individuals and organizational collective efforts as a process of undertaking shared objectives. A manager would then be one who engages in the leadership process. The nurse manager is the person who, not only self-identifies as the manager, but has recognition within a healthcare organization as 'the manager' and who is accountable for patient outcomes and safety though the actions of the department's direct reports or subordinates. The manager not only has employees who report to him or her but is also in a follower position. The manager reports to a leadership team member considered a superior to the manager role within the organization.

Study Assumptions

This qualitative study recognized that there are multiple realities in any given situation; the researcher's, those of the individuals participating, and the audience interpreting the results. From the ontological perspective, reality is socially constructed. This study included multiple perspectives from its participants. Following the constructivist paradigm, the researcher interacted with those she studied and actively worked to minimize the distance between her and those studied (Polit & Beck, 2012). The researcher openly recognized and acknowledged the value-laden nature of this research. Qualitative research is context-bound and based on inductive forms of logic.

Categories of interest emerged from participants, rather than being recognized *a priori* by

the researcher (Creswell, 2009; Glaser & Strauss, 2012). The interpretive research

approach to the relationship between theory and practice posits that the researcher will

not be able to maintain a value-neutral stance. The researcher is always connected to the

phenomena being studied (Polit & Beck, 2012; Schwartz-Shea & Yanow, 2012). The

objectives were to uncover and discover patterns or theories that help explain the

phenomenon of nurses' motivations to be nurse managers. Determinations of accuracy

involved verifying the information with informants, triangulating among different sources

of information, and collecting information from different sources as needed.

Summary

Today productivity is more than just cracking a whip and expecting results.

Performance is about the relationship between the healthcare organization and the

nursing staff. What motivates individuals to work at their best and the satisfaction they

derive from their work determines a healthy work environment and safe patient

outcomes. Without the willingness and cooperation of motivated staff, no organization

can be effective. The literature identifies circumstances that contribute to the nurse

manager shortage but few, if any, studies describe the motivations of the nurse to seek a

manager role. This study employed a qualitative research focus exploring why nurses

became nurse managers. Knowing what motivates nurses to assume the nurse manager

role provides the nursing profession and healthcare organizations with knowledge to

make key decisions to support recruitment to the role.

Chapter 3

Study Methodology

This chapter describes the details of how this qualitative grounded theory study was conducted. First, the purpose of study is reiterated to frame the objectives for studying why nurses choose the nurse manager role. The rationale for choosing the research methodology of grounded theory and the logistics of its application are also addressed.

Purpose

The purpose of this study was to explore the reasons why nurses choose the nurse manger role. I explored the motives of nurse managers in an acute healthcare setting and obtained a rich description of why nurses chose the nurse manager role from an emic perspective. The question that guided this inquiry was as follows: What motivated you to choose the manager role?

Research Design

Generally, qualitative research explores and attempts to understand the meanings people ascribe to the social realities in their lives. This paradigm utilizes an inductive approach to inquiry; Holloway & Wheeler, 2010). Qualitative research is useful when

there are no predetermined theoretical frameworks explaining a phenomenon and focuses

on the emic perspective. The central aspect of qualitative research is

interpretation. The interpretation of data may create new theoretical understandings,

change existing theories, or expose the core of the phenomena (Holloway & Wheeler,

2010).

There are several methods employed in qualitative research (e.g., ethnography,

phenomenology, grounded theory). Given the gaps in knowledge presented in the prior

chapters, I utilized grounded theory methodology to describe why nurses chose the nurse

manger role. Grounded theory enabled the development of a theory, which offers an

explanation of why nurses choose the nurse manager role and how having this knowledge

can influence how healthcare organizations recruit and even retain future nurse managers.

Grounded theory offers healthcare researchers an appropriate methodology to

develop a theory inductively from the data gathered that can clarify and guide practice

(Breckenridge & Jones, 2009). This study followed Glaser and Strauss (2012) in their

widely used method of building a theory based on qualitative data. Generating theory by

comparative analysis does not require a multitude of interviews. One interview generated

many conceptual categories and a few more interviews confirmed these categories. Using

constant comparison helped to generate the elements of the theory and highlight the

similarities and the differences between them. Abstract categories were generated from

this data and were significant in explaining the theory. Glaser and Straus emphasized that

the concepts should be logical and yet informing based upon the ability to grasp

references in terms of one's own experience. As the categories materialized, they began to form patterns and themes or relationships, and this ultimately formed the core of the emerging theory.

The iterative process of building grounded theory included data collection, coding, analysis, and planning. Theoretical sensitivity required collecting and coding data to sense where the data led and what to do next. As a novice researcher, I required the expertise of my dissertation chair to facilitate this process.

Data collection occurred through interviews with the participants, observations, and memos or notes made during the study. The interview process affects the data gathered because as the researcher collects the data, the participant may be answering only as the researcher would like him/her to answer. One way to deal with interviewer bias is to have a third neutral party conduct the interview, but that has the potential to lose the human interaction between researcher and participant (Polit & Beck, 2012). For this study, the researcher was the interviewer, the bias is expected to be minimal from the research questions being asked; this researcher had few preconceived ideas as to the answers to the research questions. The training this researcher has received, along with coaching, from her dissertation chair helped to minimize this bias. Researcher bias has important implications for research methodology, the validity of the results, and for subsequent implementation and/or changes in policy as a result of the research outcomes. However, researcher bias cannot be completely avoided in qualitative studies, and bias was noted in memos and notes as this researcher perceived them during this study and noted in the study where it occured.

Literature searches, as secondary data can become part of the data to be analyzed (Glaser & Strauss, 2012). In grounded theory, interview questions can be framed and ordered to set the tone, seek in-depth information, feeling, and reflection, search for the narrative, and end on a positive note (Creswell, 2009; Holloway & Wheeler, 2010). Since there were effects from the quality and type of material gathered, the framing, shaping, and managing of interview questions (Appendix A) were guided by my dissertation committee.

Sampling and Setting

Based on my study's purpose, significance, and my desire to obtain information-rich data, I used a purposeful sampling method in this study. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term "purposeful" sampling. Holloway and Wheeler (2010) asserted that, in qualitative descriptive studies, any purposeful sampling technique might be successfully used. Sampling continued until the study achieves "informational redundancy" or "theoretical saturation" (Holloway & Wheeler, 2010). It was anticipated that interviews would be conducted with approximately 20 to 30 current nurse managers to reach data saturation and detail a theory. Glaser and Strauss (2012) recommended that core theoretical categories should be more thoroughly saturated than peripheral ones.

After IRB approval from a large southern California acute care system and the University of San Diego, I contacted the organization's research department. The director of research contacted nurse managers system wide within the healthcare organization. I contacted nurse managers only after they had contacted me first via mail, email, and/or

phone. A meeting time and place was established and then I traveled to the participants'
preferred meeting location in southern California. The cost of travel and time were at this
researcher's personal expense.

Participants

The intended participants for this study were nurses currently working as nurse
managers in a single large metropolitan health care system. Any nurse that self-identified
as a manager was eligible to participate. Nurse managers were invited to participate
through two methods; email invitations based on this study's recruitment letter
(Appendix B) sent by the healthcare organization's director of researcher and by flyers
(Appendix C) posted in the HCO.

Participating nurse managers were given a $25 VISA gift card in appreciation for
their contribution. While there are no fixed rules for sample size in qualitative research
studies, most authors suggest a sample range of 4 to 40 participants, higher on the range
for studies other than phenomenology (Holloway & Wheeler, 2010). Although I
anticipated recruiting 10 to 20 nurse managers, data saturation was reached after the 5th
interview. Polit & Beck (2012) emphasize that sample size in qualitative research is
without rules, but data saturation is a suggested guideline. Time, availability, resources,
and informational redundancy influenced the final number of participants.

Data collection

Data were collected through one-on-one interviews with participants. Interviews
are a common method of data collection for qualitative descriptive studies (Creswell,
2009). Utilization of unstructured in-depth interviews encouraged the participants to

disclose their perspective on why they chose the nurse manager role. In the grounded

theory tradition, theory development guides the interview (Glaser & Strauss, 2012). In

order for the field of inquiry to unfold, the narrative from the participants' perspective is

necessary. With this in mind, the interviews followed the interview guideline (Appendix

A). I arranged the interview with the participant in the most convenient location for the

participant. Different venues were chosen but often it was the participants' office as the

preferred location. Interviews lasted approximately 45 to 90 minutes.

The participants had the choice to end the interview as they pleased at any time

but each interview ended when the participant believed they had nothing more to

contribute. Interviews of each participant occurred only once even though the option

existed to have a second interview via telephone or video conference call, to explore their

perspectives on phenomena that may have emerged from the interview process and to

allow for clarification. All participants agreed to a follow-up interviews and their contact

information was verified at the end of the interview.

The main questions asked were

1. Why did you choose to become a nurse manager?

2. What factors contributed to your decision?

The interview guide (Appendix A) consisted of three to four basic questions with

probe questions that allowed the researcher to expand on and clarify the responses

provided. Demographics collected at the start of the interview and included age, gender,

and length of time as RN, as well as length of time as the nurse manager.

Written memos or background notes were part of the data collected prior to and during the interview, as well as field notes written immediately after the interview. The background notes encompassed the method used in contacting the participant for the interview and the setting of the interview. Field notes addressed the behavior of the participant during the interview, my thoughts on how the interview went, and any personal notes on the interview in general. As unobtrusively as possible, notes were made during the interview and were included as data. In addition, after the conclusion of the interview, analytical, methodological, and personal in-process memos were written. Field notes (including all contact between researcher and participants) and in-process memos are an account of the field experience and document the reflective and reflexive process. This rendered the research process visible and enhanced the rigor of the study (Holloway & Wheeler, 2010).

Protection of human subjects. All nurse mangers signed an informed consent (Appendix D) form prior to any interviews. A description of the purpose of the study and the voluntary nature of their involvement was given to participants. They were also given the opportunity to ask questions at any time and particularly prior to the interview. The participants were assured that they could withdraw from the study at any time with no consequences; they were also assured that they could decline to answer any question for any reason.

All information acquired and identifying records will remain confidential and secured in a locked file and digital files (including audio recordings) in a password protected computer file in my office for a minimum of five years. Participants were

assigned code numbers that appeared on the interview tapes and transcripts, and participant's names were stored in a separate location from the tapes/transcripts (locked file). My dissertation chair and I were the only ones who had access to the file identifying the participants' names with the assigned number codes and possible contact information.

All information and discussion was gathered using a digital audio recording. All audio equipment was set up and tested prior to the start of use. Identifiers were kept to a minimum and participants were reminded not to use their last names.

Risks. This study involved no more risk than the risks encountered in daily life. Research with sensitive topics may reveal information not related to the original purpose of the research. For this reason, this researcher carefully considered the risks, including possible psychological and emotional responses related to the issues (such as embarrassment or nervousness at being interviewed) that might have surfaced and was prepared to answer questions about participation or end the interview if necessary. I also reassured the participant of the confidential nature of the interview.

Potential benefits. Nurse managers who are given an anonymous platform to tell their story might feel relieved after the interview. Being able to talk about one's experience has been reported as having positive results for the participant (Niederhoffer & Pennebaker, 2009). While there may be no direct benefit to the nurse manager from participating in this study, the indirect benefit included better understanding of the work of registered nurses who have chosen the nurse manger role. This qualitative research proposal provides new knowledge to nursing and healthcare organizations by identifying

why nurses choose the nurse manager role. This knowledge helps provide a better

strategic plan for nursing leadership in achieving better patient outcomes and engag.

Data Management and Analysis

The individual interviews were manually transcribed verbatim by this researcher

following the classical grounded theory methodology of Glaser and Straus (2012). Using

constant comparison helped to generate the elements of the theory and highlight the

similarities and the differences. Abstract categories generated from this data were

significant in explaining the developing theory. Glaser and Straus emphasized that the

concepts should be logical and yet informing based upon the ability to grasp references in

terms of one's own experience. As the categories materialized, they began to form

patterns and themes or relationships and this ultimately formed the core of the emerging

theory. Holloway & Wheeler (2010) recommended transcribing field notes immediately

after the conclusion of each interview. The reflexive and analytic process for this study

began with in-process memos.

Glaser and Strauss (2012) endorsed the use of comparative analysis of data in

grounded theory research studies. The constant comparative method was a four-stage

approach to deriving meaning from data that often occurred sequentially or

simultaneously during the analysis (Glaser & Strauss, 2012). Although there are

computer software programs available to assist with coding and analyzing data, such as

Ethnograph, Atlas ti and QSR N6, coding does not have to employ a computer software

program. This researcher accomplished the same thing with Microsoft Word 2010 and

the highlight function. The first stage included a general reading of the data all the way

through (notes, transcripts, etc.). I read and reread the transcripts of the interviews to gain a sense of the data as a whole. Then I read it word for word to develop codes or open codes, which involved drawing attention to exact words that represented crucial feelings or perceptions. I made careful notes of my impressions and thoughts of this analysis as I progressed. Actual coding of the data included coding the data into as many categories as possible. When instances of the same category continued to reappear then I stopped coding and recorded a memo on the ideas about this category. New codes were added as they arose from the data, otherwise existing codes were used to compare incident to incident. Glaser and Straus have a defining rule in this first stage that while coding an event for a category, the researcher needs to stop before moving on, and compare it with other previous codes in the same category. This process helped to generate theoretical properties of the category. After repeated coding of a category three or four times, if a conflict in the emphasis of the researchers' thinking started to occur then, as Glaser and Straus recommended, coding stopped and a memo of the researcher's idea was recorded. Doing so helped to keep the researcher focused on a logical conclusion grounded in the data and allowed resolution of the conflict.

The second step of the analysis integrated categories and their properties. After this point, each event was compared with the accumulated knowledge regarding the event category. The accumulated knowledge of a category then started to become integrated. Codes were examined and collapsed into higher level concepts or categories. Glaser (1978) pointed out that the researcher constantly compares the first-level codes against existing and incoming data and identifies categories compared with data and prior codes.

This step generated "an emergent set of categories and their properties which fit the data, work, and are relevant for integrating into a theory" (Glaser, 1978, p. 56).

Glaser and Straus (2012) called the third stage of analysis "delimiting the theory". The theory congealed because there were fewer events to compare back to its properties. By looking for any consistencies in the original categories, a higher level of concepts emerged and the theory emerged with less terminology. The process of examining the relationships between and among the categories moved between inductive and deductive thinking. Constant comparison helped to reduce the words used and even generalize the theory to a wider audience. As the events became delimited, they reached theoretical saturation.

The fourth stage was writing the theory. The major themes formed the content of the theory and represented a statement of why nurses choose the nurse manager role. The notes were organized from the memos on each category. The researcher saw the categories differently at this stage than at the first stage because now the categories had gone through internal development (Glaser & Strauss, 2012). A core category was expected to emerge that would account for the pattern and behavior of those involved in the study (Glaser, 1978). The core category was central to the emerging theory and Glaser stated that the researcher must remain open to the messages contained within the data. Several properties of a core category were identified with significant explanatory power. The core category enabled the analyst to carry through the analysis and not 'dead-end' (Schreiber & Stern, 2001).

Summary

The decision to use grounded theory was not an easy one. After realizing how little research was available that asked why nurses chose the nurse manager role, grounded theory seemed to be the perfect fit for this uncharted territory. The purpose of grounded theory research is to understand what is occurring in a given situation, particularly in common settings that have not been exhaustively researched. Grounded theory (a) produced an ongoing conceptual theory that would be (b) recognizable to other nurses who are familiar with the nurse manager role and was (c) modifiable in similar settings. In meeting these three criteria, the theory generated from the data will meet the definition by Glaser and Straus (2012) for grounded theory.

This qualitative research proposal was designed to provide new knowledge to nursing by identifying the motivation of nurses who choose the nurse manager role. This knowledge will help healthcare organizations develop better strategic plans for their leadership team to achieve better patient and organizational outcomes and engage a more productive workforce. The resulting findings and their implications are presented in Chapters 4 and 5.

Chapter 4

Findings

This chapter describes the motivation nurses have for accepting a nurse manager role. Based on the qualitative methodology described in Chapter 3, the data were derived from a total of five individual interviews. In addition, observations, document review, and field notes enriched and accompanied the data. Each interview was tape recorded and transcribed. Following an in-depth initial evaluation of data by this researcher, core categories were discovered.

This researcher, not a computer program, conducted the data analysis for this study. Researcher-based analysis of the data provides a unique experience in that the data means something more when it is remembered – the researcher not only captures the spoken word but the nuance of communication comes alive. Strauss & Corbin (1990) believed such analysis builds theoretical sensitivity while bringing the researcher closer to the data. Researcher-based analysis also provides a unique opportunity to critique and improve on the interview process in subsequent interviews. The data for this study were not extensive and thus manageable.

Participants

The original plan of sending out recruitment letters was not utilized at the request of the research site. Instead, potential participants were contacted via a recruitment email

(Appendix B) that was distributed via in-house email. Once a potential subject contacted the author, a letter of intent explaining the study, recruitment procedures, and responsibilities of the participant was presented to the individual for review. The author's first contact with potential participants occurred in a variety of ways – email, text, and phone calls. A total of seven participants contacted the author, and five interviews were completed. One manager had agreed to participate but decided against it because of perceived possible implications. The second nurse manager scheduled an interview, but was never able to complete the interview after five attempts.

The participants ranged from 36 to 63 years of age with a median age of 50.8 years. The participants had an average of 16.4 years' experience as nurses with a mean of 6.3 years as a nurse manager. All participants were female and all had obtained a Master of Science in Nursing degree. All participants were from the same healthcare system. Three of the four hospitals in this particular healthcare system were represented by these participants.

The Interview Process

All interviews were conducted in private at a location of the participant's choice—four in the participants' offices and one in the home. The purpose of the study as well as their roles as participants were restated and informed consent was obtained. All participants that started the interview process completed the process in its entirety. All five interviews were completed, transcribed, and utilized in data analysis.

The length of the interviews varied by participant; the shortest interview was one hour and 10 minutes and the longest was one hour and 45 minutes. All but one interview continued after the formal conclusion and the audio tape was turned off. Frequently the participants added anecdotal thoughts to their decision to be the manager; these comments became part of the field notes.

Prior to the start of the interview, the researcher and participant engaged in small talk to develop rapport. I used this time to observe physical surroundings and gain a better sense of the participant; these observations were recorded as field notes. The interview questions included in Appendix A were incorporated in each interview, but the sequence of questions reflected the responses of the individual participants.

Analysis of the Data

In grounded theory, the theory grows from the data as it is collected and analyzed; the process of analysis takes place from the very beginning of data collection and it does not end until the research is completed. The five interviews for this study took place over a 14-week time period. The method of analysis used for this inductive study was thematic content analysis. This involved analyzing transcripts, identifying themes within the data and gathering examples of those themes from the interview data. Following the constant comparison analysis method of grounded theory, the codes and concepts identified in the preliminary coding analysis were refined, extended, and cross-referenced.

While following the process of grounded theory, it is important to note that this researcher did not necessarily see themes emerge. Themes were the result of a process of

filtration. I began with masses of data, hours of interviews and discussions and reading. Then I began to summarize the data by choosing key words or codes. Next I began to group similar codes together, again narrowing the field. After looking at these groupings, I re-read the specific field notes and then re-grouped categories when I remembered the tone and manner in which the words were spoken. This process continued until the important pieces were identified. The concepts that are present in all of the data, the predominant concepts that say something about the data, are the key themes. These themes became the essence of my data. The interesting words and phrases were used to make the theory of nursing leadership and this satisfied my research question. So my themes did not emerge, they were discovered.

Identified Themes

In reviewing the data, six theme categories were identified: career plan for some – not for others, opportunity, prepared for the role, influence of others, personal satisfaction, and "non-reasons." This was the first step in organizing and analyzing the data from the participants' interviews.

Planned or unplanned move. The study found that participants fit into two categories when it came to the decision to become a nurse manager – a planned or an unplanned move. Three of the five participants sought out the role of nursing leadership, while two of the participants waited to be asked to take a nurse manager role. However, of those who sought out nursing leadership, all three waited for the opportunity to present itself before they actively applied for the role. All but one of the participants had worked

for the same healthcare organization in a different role prior to accepting the nurse manager position. The one exception had changed healthcare organizations to obtain her current nurse manager position. Three subthemes were noted within this theme: "life's next step:" planned movement, "investing in myself," and "it chose me:"

Life's next step: Planned movement. For those participants who knew their next career step was moving to a nurse manager position, accepting a leadership position was a planned event. For example, one participant stated, "I felt that at that time it was a step I would like to do to move onto the next level of my career." For one manager, she had a desire to do something more with her career without fully understanding any leadership role. "I started taking classes on my own with no thought as to the manager role. I just wanted to do something more with my career but wasn't sure what, since I had little kids at the time." Another participant who sought the nurse manager role only after consulting with her peers said that she knew she "wanted to be in a leadership role, not necessarily in a managerial role."

Some participants saw the nurse manager role as way to do more for their community as well as for themselves. The nurse manager role was not something that they choose for themselves but what they could do for those around them. "I wanted to be an intelligent intellectual person that could converse with people, interact with people, and be able to voice her concerns or opinions when needed." The data also demonstrated that, for some participants, choosing the nurse manager role was how the participants saw their life evolving in their nursing career. "I just felt that it was the next chapter in my life

and it wasn't so much an age thing; I think it was a maturity thing." "I didn't know at all that I wanted to be a nurse leader because I had small children when I was first out of nursing school. I didn't think it was possible." Another sought the nurse manager role when she realized that she had what it took to be the person in charge.

> I didn't really think that much about it (a leadership role) before or during nursing school. When I took my first job and I realized that I understood nursing and leadership from a charge nurse perspective, then it seems like that is what I gravitate towards.

Even though one participant had been a nurse manager and was now in her second management position, she remembered there was still a drive to be more. This internal drive created her motivation to seek out something more.

> I had been in the NICU for almost 5 years as the manager. To give you a little bit of context, it was still 64 beds but I added an extra nursery on another floor that had 8 more beds, so that was 72. We were already achieving 100% census. I was supervising a staff of 215 and an $18 million dollar budget. I loved my job, I knew what I was doing and I felt like I was effective. But I thought, there might be something else out there that would be more satisfying. Because when you have a work force that large, sometimes the human resource issues and the operational issues bury you.

Another participant felt that she was destined to be in a leadership role. Her motivation for leadership was something that had started in her youth. She had always

been familiar with leadership roles, so when she moved from animal medicine to nursing, she felt comfortable assuming a nurse manager position.

> For some reason I have always ended up in management. Even at the age of 16, working in fast food, I became an assistant manager. My career most of my adult life was in animal medicine, as a registered vet tech. I worked my way up to the San Diego Zoo and was the manager of their animal hospital.

One participant felt that being in the nurse manager role was not something she really controlled. Even though she planned her career to be in leadership, she still felt that it was an innate sense of destiny. "I don't go out of my way to pursue leadership roles but I am drawn to them in the same sense. It's kind of complicated."

Investing in myself: Planned movement. Other participants believed that their future was determined by their ability to invest in themselves as well as others believing in them to reach their goals. The support was important whether it came from faculty as the graduate school, "The instructors in the SON (School of Nursing) wanted me to be successful. They knew they were investing in me," or if it was identified as internal influence from personal experiences, "You know my Mom didn't graduate from college, she graduated high school, and I was able to do this in my mid 30's. I felt I was a lot more mature and I wanted to invest in myself. "

The results of this study showed support as a motivator on a two-way street. The participants not only felt the need to support their team but the participant also needed support. Despite believing in herself, a nurse manager must also believe in the team that

she is leading. For example, one manager said, "I feel that the people that were here before just didn't' invest, and that's what I felt I needed to do was invest in the staff, invest in my patients."

It chose me: Unplanned movement. One participant believed that the nurse manager role sought her out instead of her seeking the position. She had not entertained the thought of being the nurse manager prior to an encounter during graduate school. When asked why she chose the nurse manager position, she participant replied,

> It chose me. . . . My last semester in school, I was precepting with the CNO of this hospital. At a meeting we were attending, I was attending as a student; she announced a new model for our organization. It was going to be one manager and one CNS per one unit, and that was brand new. I had a manager who had two units. It was April, and I was graduating in May. I was asked if I was interested in being a nurse manager.

Opportunity. Opportunity was another major theme voiced by the participants. Four of the five participants chose the nurse manager role, in part, due to an opportunity that presented itself at a certain time in their lives. The occurrence of the opportunity was independent of whether or not the participants had planned or not planned to be in leadership roles. Some participants had planned to be in nursing leadership at some point in their career but chose the nurse manager role at the time they did because of the opportunity that presented itself. For example, one participant stated, "My previous

manager decided to take a director role, and asked if I was interested in taking an interim manager role. I agreed."

Opportunity arose. Three of the participants accepted the nurse manager role as a result of being in the right place at the right time when the opportunity presented itself. For example, one manager reported, "I had been an AC [advanced clinician] for only a few months when this opportunity came up," and another said, "The manager role was an opportunity that came up as I was just finishing grad school." A third participant described the occurrence of a specific opportunity that motivated her choice, stating "I would not be a manager if this oncology job didn't come up. I wasn't climbing the ladder. If the manager job had been on the transplant unit or the ICU, I didn't want it. I love oncology." One participant saw a serendipitous opportunity when no one else wanted the role. "I also felt how is this very experienced work force in this unit (there's a lot of longevity there) going to perceive me as a newbie? Then I thought, well none of them are jumping at the chance. None of them want to make that transition. So this would be a good, no great, open door for me."

Opportunity to make a difference. Based on the participants' responses, the opportunity to make a difference was a strong influence on accepting the nurse manager role. The participants perceived five areas in which they could make a difference. These areas included: organizational needs, changed expectations, "planting the seed," and advancing Hispanics in the profession.

"*What the organization needs.* One of the participants, who had not planned on being in nursing leadership, saw the prospect of her helping not only her patients but those she worked with to change lives.

> I believe the only motivation was that the unit needed someone and I felt I was that someone. I had to figure it out because it's not about yourself, or what you want, it's what the organization needs so that the staff can take care of the patients.

For some, making an impact through the staff they lead was an important factor in accepting the nurse manager role. For example, one nurse manager said,

> Coming into this unit, there was a lot of negative factors, the high turnover rate, some patient complaints. It was a unit that had struggled for a while, and I felt that it was a challenge and something that I could make a difference.

Change expectations. The results indicated that nurses who accepted a nurse manager role were motivated by a desire to make life better for the team they worked with. "I knew the expectations that I did when I was with my patients and those are the expectations that I kind of changed here and I held staff accountable and doing the same thing that I did for my patients."

Planting the seed. I asked participants, as part of this study, what was the best way to fill the nurse manager vacancies that seem so difficult to recruit to and even to keep filled? Their responses all involved the ability to build and maintain relationships. "Just like the lead did to me, plant a seed, have them think about it, and cultivate that

seed so they can become all they can become. I feel like that helped me figure out how I can pay this forward. I tried to do that since that time." Another commented,

> So you are constantly planting the seed. And from getting to know them so well, I just saw one of my nurse residents who had been a nurse for 2 years. We were walking out to our car and I asked her why she isn't in an advanced nurse [role]. You are always planting a seed, I wouldn't have told her that but she has already gotten involved in a nurse study already and coming in on her days off when she doesn't have to do this. I see a lot of promise in her. We started the dialogue and why not? I get to see these people even though they are no longer in the yearlong residency, and again when you get to know them that well, you just start planting those seeds. They are going to be the ones taking care of me. I want them to become all they can be. And you are in the right organization because there are positions for you if you choose to not stay at the bedside because this organization has many options; whether it is a clinical track for CNS or leadership track and more clinical lead/ manager path. I am always working on it.

Advancing Hispanics in the profession. One participant felt a strong motivation as a role model for women and for her ethnic group. She said, "Well, one of the main reasons [that influenced my decision] is that being a Hispanic female I would look at other departments and saw mainly Caucasian, you know males. There weren't too many Hispanic females in a leadership role"

Influence of others. Another major factor affecting decisions to become nurse managers was the influence of other. All the participants reported such influences. For example, one participant commented, "I felt I received the emotional, educational and especially family support." Another noted the support received from faculty, saying, "As a female you know it's hard to be in a leadership role sometimes because there are so many males out there but I felt that the support was at the school." Categories of support for choosing a nurse manager role included leader/mentor support, peer support, staff support, and support from family members.

Leader/mentor support. Several participants reported having a leader who directly influenced them. For example, one manager said,

> I was only a nurse for 2 years when one of the clinical lead nurses came up to me (I was at the bedside) and she said we have a lead position open. You should apply. I looked at her and thought she was absolutely crazy. Me? I only have 2 years of experience. She said I would probably have to go back to night shift (I was already on day shift). I thought why not? I'll put my name in the hat, and I got the interview; then I got the job. And again I had the support of that lead.

The influence of leaders on nurses choosing a manager role also came from higher administrative levels.

> Without the support of my director, I wouldn't have been able to do this job. I have missed out on so much because the job really demands so much more of my time than a staff job….She [director] understood that I had a commitment to my

family and that I needed to leave early sometimes or rearrange my schedule. She

was also the reason I took the job.

The data suggest that part of a nurse's belief in whom he/she is comes from the

confidence of another in her ability to do the role.

More than that, the boss, who is now the CNO, of her really, seeing a flicker of

light in me that was worth cultivating and worth encouraging to be a leader. . . I

didn't realize she was doing it at the time but she was doing true succession

planning. She was molding and guiding me to become a manager. Frequently she

would tell people that I was her assistant manager.

Similarly, when a participant was asked about support from her director affecting

her decision to accept the nurse manager role, she replied, "Sure, support was the main

reason I kept moving forward. I don't think I could have done it without the support of

the majority."

The infrastructure of support also included the mentors that had crossed the paths

of the participants. A mentor is a more personal form of support allowing a more

informal level of interaction.

I have had mentors all along the way and I just encourage them [nurse residents]

to be a mentor to somebody even newer than you are because that is what carries

us along. Build those relationships, and I could name all those people who took

me under their wing and helped me along the way, and I didn't even ask them.

One participant found help from her director so that the participant could grow

into the role of nurse manager.

> The director really mentored me and told me she would give me the tools I
> needed to be successful. For example, there was a component (even though I had
> been a charge nurse for 5 years in the lead role), a component of finance that was
> really foreign to me. I hadn't yet taken economics in the master's program. I had
> private tutoring by financial analyst here, and I learned everything plus – how to
> make a budget, how to ensure that you are productive, how to make sure that you
> went every step of the way (whatever your bucket [budget] was) to stay within
> that bucket. So indeed, she gave me those steps I needed to be successful. She and
> I met at least once a week for personal mentoring and tutoring besides the
> financial tutoring.

Still another participant commented, "My former manager, who became the
director and now she is the CNO, she really mentored me." One study participant,
however, found just the opposite to be true. This participant had wanted a mentor, but
found that she did not have the supporter she was looking for.

> I think I kind of jumped the gun a little. If I had to go back and redo everything, it
> would have helped to start as a charge nurse then moved to supervisor, then to
> assistant manager, and finally the manager. And it would have been very helpful
> that, while I went to school, I also backed up my learning with experience. But I
> just jumped in with the management experience I had from other careers. In

nursing there is a lot going on and not having the nursing background, I had to

learn it pretty quickly and on my own.

Peer support. The participants spoke to the importance of being able to speak

with other nursing leaders to help them decide to take a nurse manager position. One

participant relied heavily on a nursing friend's view as her motivation for choosing the

manger role.

I have another person who I am still friends with who is a director but she was

doing the master's program; she also influenced my decision to take the nurse

manager role. She really did convince me. She said, 'It's something intrinsic.

Either you have it or you don't. And you have to figure out if you have it.' She

really meant that and I know she has met a lot of people in managerial roles. I do

believe her.

Another participant sought out a friend prior to accepting a nurse manager role.

The participant's friend had accepted a nurse manager role just 12 months earlier, and

this helped the participant to find out what was really involved in the manager role. She

indicated,

I knew one of the other managers who was new as well, and he told me what he

was doing. I felt comfortable enough, you know, because I trusted him. Not only

were we colleagues but we were friends, so I trusted his motivation for me.

Another participant had worked as a Clinical Lead prior to her manager role

and felt that the support of her peers was a big motivator in her decision to accept the nurse manager position.

> The clinical leads supported me a hundred percent. They immediately respected my role as their manager not their peer level. Partly because I had that kind of role among the peers and it just made it more concrete. So that was huge. The majority of the staff was all for it.

Staff support. Staff support, when the nurse manager had been in a staff position, also influenced motivation to seek a nurse manager role. One participant stated, "Well we had a high turnover of NMs at the time, and the staff wanted me to take the role." Staff negativity, combined with positive support, also played a role for one nurse manager, who felt she had to demonstrate that she could do the job.

> I think probably just perseverance because it was difficult. I can remember one nurse in particular who kept saying, 'prove yourself, just prove yourself, if you think you are so hotshot.' And that was not why I took the role. A little bit of lateral violence going on, but again I had enough people pulling for me that I compartmentalized her and I just thought that is her problem.

Family support. When it came to family support, one nurse manager had her spouse's unwavering support to a surprising degree.

> My husband actually changed his job so that he would be home with the kids and I could stay at work. If I hadn't had that resource then I don't know if I would have stayed a manager. He really picks up the majority of home responsibilities so

I can focus here.

Conversely, another manager said her family did not play a role in her decision until later. "My family did not influence my decision at first but they did later after all the hours I was spending here."

Personal satisfaction. The participants' motivation to move forward in their careers and accept the nurse manager role also came from each person's ability to find her strengths and how personal goals were satisfied within the nurse manager role. The data provided three main subthemes within personal satisfaction; autonomy, shaping the work force and flexibility.

Autonomy. The motivation of the participants to choose a manager position often came from the higher level of autonomy that accompanies the nurse manager role. Stating this in the negative, one participant commented, "What makes me not want to do my job is if I worked for somebody I don't respect or I lose the autonomy and creativity and that voice." Another noted,

> In a leadership role, I get a lot of autonomy, and I get to voice my opinion and my ideas. People will often listen and go with those ideas. And I love that. That is probably the biggest fueler of why I do what I do.

Developing the work force. The participants spoke to the nurse manager's ability to influence staff by shaping and developing them as a motivator for choosing the role. "I love being on the cutting edge - being at those quality meetings and hearing about where we had a gap and where we needed to be in helping to mold and shape the work force to

achieve those patient outcomes. I love that! I thought, 'wow this is amazing!'"

The second participant to voice this same drive to shape and develop others said, "And that's why I do what I do. I love this part of my job–to shape and develop people who want to go somewhere and have potential. I will do anything for them."

Flexibility. The structure of the nurse manager role has some advantages over the staff nurse role. The nurse manager is often able to creatively manage their assigned unit following the mission and vision of the healthcare organization.

> I love the flexibility of doing what I want when I want it. I like not being on a
> time clock. I like being involved in everything and being involved at the system
> level, which I empower my nurses to do the same. It's not that you couldn't but
> the nurses on this unit are given the time and encouragement to be on committees
> and task forces. I think I like the flexibility the most. If I took tomorrow off, I
> could, it will impact my workload and the next day is more difficult. My
> accountability is different. I like being responsible for myself and accountable for
> myself.

Prepared for the role. Participants believed that they were ready to be nurse managers because they possessed the ability to manage. Management skill sets developed over time are not the same as those that are taught in a classroom. Being prepared for the role encompassed both. One nurse manager stated, "I didn't really think that much about it [a leadership role] before or during nursing school. When I took my first job and I realized that I understood nursing and leadership from a charge nurse perspective then it

seems like that is what I gravitate towards." Elements of being prepared for the role included knowing the system and how to manage, as well as having relationships and connections and trust and respect. Another aspect of being prepared was already engaging in the role without the title. Having personality traits that fitted one for the role was another element of being prepared for a managerial role. Finally, the managers described being educationally prepared for the role as an element in their decisions.

Knowing the system. For some participants, the choice to accept a nurse manager role was influenced by being familiar with the unit and the organization. For example, one participant said, "I knew this hospital, I knew my unit, and I knew the people. I knew the daily operations and that gives a manager a lot of credibility." Feelings of being ready to take on the nurse manager role also arose from an increased awareness of leadership. One participant knew she could be a manager "just because I was a supervisor and I could do the operations but the new word around town was leader. And I thought maybe I could be a better leader because I know how to manage." Another manager voiced similar thoughts, "I thought it would be better for me to have it, since I knew everyone and I knew what needed to be done. I saw that the job was better suited for someone who knew the staff and the doctors." Interestingly one participant referred to knowledge of the system as having "street smarts," saying, "You have to have some street smarts and you have to be able to understand what the expectations are without being told."

Having connections and relationships. Relationships influenced the participants' decisions to accept a nurse manager position. Relationships with staff, doctors, ancillary

departments, as well as leaders above and below the nurse manager were noted by all the participants to be key factors in their decisions to become nurse managers.

>The relationships I had and continue to build are why I will be here another 3 years. I love the people I work with. This staff is the most incredible and hardworking, patient-minded, communicative group of people to each other as well as to their job. It's a second home to me.

The participants also spoke to the need for various relationships as well the degree to which having a relationship was important in reaching their goals as a manager. "I like having relationships, and as clinical lead, even more as a manager, you need relationships with staff, doctors, ancillary departments, visitors and vendors. It's about many people doing many things and making it means something."

Connections with patients. Two of the five managers interviewed for this study spoke to the value of relationships with patients.

>I think personally they would have to be able to build and maintain relationships. What we do is all about the patient; it's not about me and the radiology department, or me and the lab, or me and the physician. It's about what are we all doing and that's caring for the patient. You can't take things personally; you can't project anything negative so that your department isn't perceived as not knowing what they are doing. And make sure the patient is number one and keep that in your perspective as to how you do your job and you are always doing what is best for the patient.

Connections with staff. No one specifically mentioned that they chose the nurse manager role as a result of any relationship other than to say they 'knew the staff' or that they felt they knew what was needed for the unit or staff. One participant who has been a nurse manager for over 10 years remembered,

Oh yeah, I thought it would be easy because I knew the unit, I knew the staff. The staff loved me, the doctors loved me. I was going to have a great relationship with everybody; that's the irony of it all. So I thought I could really do this job and do it well and be well received. But the reality is quite the opposite. It's a different role and you're a different person.

Another manager commented,

I think they [nurse managers] have to feel very connected so that when they are having an issue they have like 20 people they can go to for advice. And just feeling that camaraderie, I think that is what keeps people. Is it a tough role? Absolutely very tough role but again our organizations would absolutely be sunk without great leaders.

Another participant realized early in her career that she needed relationships with the staff and physicians just so she could understand all the nuances of her unit.

If you have relationships then you are better able to know because staff will fill you in and keep you updated. Doctors will also let you know when they can't get what they need or if staff is not taking care of patients.

One participant remarked that she had taken the nurse manager role because she

knew the staff since she had worked as Clinical Lead before accepting the nurse manager role. She also commented on why her relationships kept her going.

> Managers must be able to build relationships, whether with physicians, co-workers, patients or other departments. That's how you succeed – by the relationships you have. Those relationships don't come easy and you have to work at them, even when you are tired and feel like today you just can't follow through with one more thing because of all the madness.

While a nurse manager must always work on building relationships with many people and departments, it is the trust within the relationship that is important. As noted by one participant, "You cannot afford to not be 100% accurate when you take information up the ladder of leadership. No one really survives in a manager role unless they have done their due diligence and knows what is going on and why." Motivations to connect as a nurse, even as a nurse leader was a strong influence for one participate to stay in her nurse manager role.

> I think the further you get up in leadership, the further the distance between the staff and being that nurse that gets her hands dirty. And you become all administrative and lose the connection with the staff. I don't think that would suit me as much as where I am at now.

Three of the five participants felt prepared for the manager role because they had "walked in the staff shoes". As one participant noted, "I think it happens that others manage that haven't walked in the staff shoes. I think it helps to walk in their shoes and

know their pain and understand it at the staff level. I think the staff has a different level of respect. I think you can't have respect if you don't know the details." The second participant, who also felt strongly about walking in the staff's shoes, had also worked in the same unit she was now managing. "I know they say that once you are a manager you can manage a lot of different areas. I think it really helps me to have that background. I actually worked here in this unit as a clinical nurse while I went to grad school. I really feel I know their processes and what it is like to be a staff nurse here; because I was."

Trust/respect. Trust was a quality that appeared in various statements from one the participants. "It (the manager role) gave me the opportunity to connect with a lot of the patients and a lot of the staff in and around the unit because they felt that they could trust me and they could come to me." This nurse manager was bilingual and worked in an area that had a diverse population. Another participant also felt that respect was very much needed for the role, although it was not her motivator for accepting the role. "You have to be someone who commands a bit of respect. You can do the job without respect but not very well. You have to be respectful as well."

Already doing it. Working as an interim manager, one participant felt she had walked in the shoes of the manager and had a strong sense of the manager role. This familiarity was part of her motivation to accept the nurse manager role. She commented,

> After doing it for probably 3 months, there was another applicant. She was an
> outside applicant. I thought, "Wow, I am going to go back to the clinical lead and
> I am going to have this stranger who doesn't know our hospital, doesn't know our

unit, be my manager. And I thought why would I do that? I have the qualifications and I was almost done with my master's degree or half-way done. And I thought, 'I am going to go ahead and apply for the role.' I got the role.

Two of the nurse managers interviewed felt that they were largely doing a nurse manager's job as a clinical lead. One of them noted, "I was already doing a lot of the operations and daily management."

Just my personality. Another subtheme in being prepared for the nurse manager role addressed the personal traits that participants' believed fitted them for the role. When asked why they chose the nurse manager role, participants often commented "it's just my personality." This area reflected the perceptions of the characteristics or qualities needed for the job. Characteristics reported ranged from a practical "I am very proactive, and I am very out spoken, and I speak up for not only the patient but for my staff when I see something that I think should be changed" to being a stickler for details. In the latter case, the participant felt that her motivation to accept the nurse manager role was due in part to innate abilities that she found in her personality.

I am a little bit of a perfectionist. I think that is part of the reason I do the role. If I am going to do something then I want to do it the best I possibly can, and others recognize that and want that person to be on their team.

Being active was also reported as a desirable trait, "I'm definitely not the person that can sit in the office for 8 hours. I get up and I go in and around the unit as I would if I were checking on my home to see what's not where it's supposed to be." Other personal

traits that participant believed qualified them to be nurse managers included having a "human touch," being a good listener, and being fair.

The human touch. More than one participant spoke about traditional nursing qualities that were part of the characteristics needed in a manager. "I think I have the human touch and that's important because that's what people want to see and they want to work with a leader who has the human touch." Another participant had a similar thought about being compassionate, "You have to be human, and if I don't know something, I go to the nurse at the bedside and say, 'tell me, how do you find this in the electronic medical record (EMR)?'" It was interesting that in a hierarchical healthcare system one participant said, "On the one hand, you have to be on the same level as everybody and ask questions and let them know you respect them as an expert and I can't do my job without you. And you need to say that."

A good listener. Being a good listener was another trait that participants felt qualified them to be effective nurse managers. Listening to staff and patients requires a person to stop what they are doing and focus on the person speaking. A nurse manager has many things happening at once and at times it takes concentrated effort to hear what another is saying. One participant noted, "I try to really listen to what is being said when I hear complaints; often times it's not about what it seems to be on the surface." Some participants equated having a human touch as a nurse manager with being nurturing and compassionate. As one participant noted, "I often feel like being a manager is very similar to being a mom. I listen with empathy and I care, but I won't let the staff take

away from meeting the goals of the unit and of the hospital. A manager can't be allowed to chase rabbits down a hole. You have to know where you are going and lead the staff to that same place."

Being fair. Another trait associated with the nurse manager role was treating all employees fairly. Impartiality was also related back to the participant gaining and keeping trust with the staff and with others. One nurse manager stated,

The accountability is mine but I have to be consistent. If one person can't work because their safety modules aren't done, then 5 people can't work if their safety modules weren't done either. I can't leave that to chance. I have to be consistent and fair and just with every single staff person and that means I have the ultimate responsibility."

Educationally prepared. The path of being prepared varied among each interview but two themes were consistently reported by all participants. Not only were personal characteristics important, but the need for educational preparation was articulated by all participants. Two participants spoke to the differences they felt existed between masters-prepared and bachelor's-prepared managers.

I didn't have a lot of the foundation, such as in economics and finance. I had statistics, but the courses were much different from my bachelor's degree. Could I have done it? Probably, because I am a motivated learner and quick study. I think the masters' is the appropriate step and requirement for the manager role.

A manager with eight years of experience in the role noted that advanced

education was a path to learning the "correct way" to lead. She said, "I realized I would probably end up in leadership eventually and wanted to go back to school and really learn the correct way to be a leader." Another said, "I chose the nurse manager role coming out of a master's degree prepared program." A nurse who had been the manager for two years stated, "I felt I was well prepared in the school that I attended to prepare for this endeavor."

Another manager also believed that advanced education and the content taught at the graduate level was the key to being a nurse manager.

> There is more to managing than just finances and it takes the education of a master's prepared nurse to wade through it all. I don't think I could have done this without the educational piece. I know they used to promote nurses into manager or head nurse positions and then just teach them as they went. Healthcare organizations don't have the time or resources to teach management as an on-the-job position.

One manager who had worked as a bedside nurse knew she wanted to be a manager, but waited. "I decided that when my kids were out of college and doing their own thing, I would go back and get my masters in nursing." Another nurse manager spoke directly to how an educationally prepared nurse manager meant having leadership skills, "I had leadership courses in the master's program. I had written a business plan or a strategic plan, great mentors, and also the Clinical Lead role was really considered an assistant nurse manager position." One of the participants had pursued advance education

(MSN) before accepting a manager position. She had always known that she wanted to return to school but did not know when.

When the college visited the hospital, they told us about their Masters in Nursing Leadership, which at the time was called Masters in Nursing Administration. I thought the timing was right. I hadn't realized at the time that it was just one more step in becoming an affective manager.

The courses required for a master's degree in nursing prepare a manager in many different aspects. A manager's job and all the responsibilities that are attached are often not seen by the bedside staff. One nurse who had been a manager in two different areas remarked how graduate education really opened her eyes to things she would not have thought about.

It [master's degree] prepares you to become a public speaker, which, in a managerial role, you are doing all the time – whether it is quality council or whatever, even in a staff meeting. I took two semesters of economics that prepared me and became polished at writing. I wrote a thesis, and I presented it; all those things, again just more and more steps to becoming a more effective leader. So yes, absolutely the master's program just opened my eyes to a bigger picture instead of having blinders on and just thinking about the bedside.

Healthcare is always about patient care but the financial side of healthcare plays an ever increasing part in the nurse manager role. Nursing leadership involves trying to help patient care become a financially solid business. Economics were discussed by a

manager with over 13 years of experience who stated that she was influenced to take the

nurse manager role as a result of learning the financial aspects in graduate school.

> There is so much now, like value-based purchasing and the fact that you really
>
> can't separate nursing skills from the economics of the hospital organization and
>
> business. I feel very fortunate through my continued education and the health care
>
> policy class I took. It opened my eyes wide that every nurse needs to know that.
>
> Every nurse needs to do this.

"Non-reasons." Some participants stressed the lack of importance of some

factors in their decisions**.** Such factors included monetary reimbursement and a need for

power.

"Not for the money." One participant noted that accepting a nurse manager

decision was not a monetary decision, saying, "I know it wasn't the money (chuckling)."

Another agreed, stating, "Well apparently there was not much of an impact of money on

my decision (giggling) because I took the role." Another said,

> She (my director) looked at me and said 'when we choose to take managerial

roles, we never do it for the money.' Either you really want to do this and give back or

it's about the transaction. I do a job, I get money and go home and don't think about it. A

third participant commented, "Money is definitely not my motivator." Another manager

went into more detail, "There was a huge perception at the time, and I still think it

somewhat exists, that a clinical Lead nurse has the potential to make a lot more money

than a nurse manager did because they got paid for every second they were there, they

were still on the timecard. As where I was exempt and I could work 60 hours and wouldn't get paid past 40 hours. So there was this perception that if they stayed in the lead role and had to work an extra shift they would get the incentive; because we offered them incentives all the time because of the horrendous census. And I think that they talked enough amongst themselves that they wanted the extra money when they wanted it."

A slightly different view was voiced, by another manager, "They [the Leads] do not see my position as being fairly compensated for the work I do. No, I don't remember that I did consider salary changes when I accepted the position. I do know that I am here at least 5 days a week where they are only here 3 days a week. Only working 3 out of 7 days makes life so much easier for their families and to be able to do other things without burning through their PTO [paid time off]."

"Not to rule the world." Many times the concept is that nursing leadership makes all the rules and controls the lives of others. The nurse manager role has the ability to support the administrators above the position as well as managing her direct reports. The participants answered the study's research question with what she knew she did not want to do. "I don't see myself as being hungry for power or feeling like I needed power. I was fairly happy as a Lead." Another participant commented, "I don't necessarily want to rule the world. I want to support the person who rules the world."

The nurse manager role can be seen as both and administrative role as well as a nursing role. Keeping the nurse as part of the manager was important to some participants

as a motivation for accepting the manager role. As one manager noted, "That's the part of leadership I like. I like to still be a nurse."

Another participant disagreed with the need to continue to be a "nurse", stating,

I have given up the nursing part. It is something that lurks within so that I use it to better assess a nurse's ability to care for a patient or something like that. The real nursing does not exist. It really can't in a leadership role. You have to be able to separate the two and know that it is the manager in you that keeps the staff engaged and it's the manager who keeps the budget going. It just isn't possible to give nursing and leadership a true 50/50 split.

Theoretical Construct

When analyzing qualitative data theoretical constructs are developed. As noted by Creswell (2009), the theoretical constructs are supported by the identified themes and are grounded in the data collected. Glaser & Strauss (2012) discussed how to capture the complexity of reality by developing a theoretically dense theory that has many concepts and many linkages between them. The researcher identified six major themes - a planned or unplanned move, opportunity, prepared for the role, influence of others, personal satisfaction, and non-reasons for choosing a nurse manager role. Creswell (2009) suggested using visual approaches such as diagrams or taxonomies to display theoretical constructs derived from grounded theory methodology. To help the reader visualize this theoretical construct and understand the linkages between the major themes, the researcher developed the conceptual model depicted in Figure 1.

Figure 1. Influences on the Decision to Become a Nurse Manager

Internal Influences

External Influences

• Life's Next Step
• Investing in myself

• It chose me

Planned or
Unplanned Move

Opportunity
•Opportunity arose
•Opportunity to make a difference

Prepared for the role
•Knowing the system
•Relationships/connections
•Trust/Respect
•Already doing It
•Just my personality
•Educationally prepared

Influence of others
•Leader/mentor support
•Peer support
•Staff Support
•Family support

Motivation for choosing
the nurse manager role

Personal satisfaction
•Autonomy
•Developing the workforce
•Flexibility

Non-reasons

• Money

• Rule the world

The data demonstrated that both internal and external influences motivated the participants to accept a nurse manager role. These influences were reflected in five themes that supported the decision and one theme (non-reasons) addressing factors that were specifically noted as **not** affecting the decision to accept a nurse manager position. The six themes are noted in the diagram within heavily outlined boxes. Some influences are completely internal or external to the participants; subthemes for these themes are included as bullets within the theme boxes. Two of the themes, "planned or unplanned move" and "non-reasons" incorporate both internal and external factors as indicated by the subthemes in the separate pointed boxes on either side of the main theme box. Internal influences are depicted on the left side of the diagram, and external influences are displayed on the right.

The six main themes start at the top of the diagram with "planned or unplanned move." This theme reflected the fact that some participants consciously planned on moving into a nurse manager or leadership role, while others had no such plans at the time. This theme represents both external and internal influences as indicated by the boxes to the right and left of the main theme box. Views of the move to a managerial position as a planned step in their career trajectories or as investing in themselves were internal factors and are depicted to the left of the theme box. For others, there was no conscious desire for a managerial position, but they accepted one when it became available, an external factor reflected in the subtheme "it chose me" in the left column.

Following the upper portion of the diagram in a clockwise fashion, the next

external influence was the theme of "opportunity." Several participants referred to their motivation as incorporating external factors, such as an opportunity that arose coincidental to whether or not they had planned for a nursing leadership role. The external drive was simply that the "opportunity arose" at the time the participant had thought about being a nurse manager. Another motivator to accepting the manager position was the "opportunity to make a difference" as the manager on their designated unit and with their staff.

The third of the six themes was the influence of others with subthemes that reflected different sources of influence reported by participants. "Leader/mentor support" was a significant subtheme with every participant discussing the effect that another nurse leader had on their decision to accept the manager role. "Peer support" came from other nurse managers that influenced participants' decisions to accept the role. One participant sought the advice of another nurse manager specifically to discover what the nurse manager position was really like. "Staff support" was provided by participants' co-workers and staff that they had worked with prior to accepting the manager role. The last subtheme, "family support," was only reported by one participant; this participant's spouse changed jobs to accommodate her nurse manager role. The other four participants did not voice family considerations as an influence on their decisions, and one participant noted that she never consulted her family until she started spending 16-hour days at work.

Moving to the left side of the diagram, first wholly internal category was feeling prepared for a nurse manager role. Perceiving themselves as being prepared for the role

was a highly influential factor for all participants. This category included several subthemes as indicated by the bullets. The first subtheme that arose from the data was "knowing the system" or the operations of the unit and the healthcare organization. Participants felt that their knowledge gave them an advantage in the managerial position because they knew what needed to be done as well as the constraints operating in the situation. "Relationships/connections" were felt to have an impact on their success as nurse managers, and having already established connections was viewed as a reason for accepting the position. Similarly, already having the trust and respect of staff was an important aspect of their motivation.

Some of the participants felt that when it came right down to why they choose the nurse manager role it was due to "just my personality." They viewed themselves as having traits that would be required in the position and would make them effective managers. Finally, being educationally prepared for the requirements of the role was discussed by all participants. Each had completed a Master's degree in nursing, and that they were adequately prepared for the duties of the nurse manager.

The next internal influence theme was personal satisfaction, which included three subthemes. "Autonomy" was a driving force for all the participants to act with creativity to develop their unit. "Developing the workforce" was reported as an important motivator for three of the five participants. Their ability to shape their direct reporting staff members affected their motivation and was a factor in considering the nurse manager role. They described it as satisfying to promote the growth of others as well as the

advancement of specific segments of the profession (e.g., Hispanic nurses). The perceived flexibility of the manager role was also a stimulus for some participants as they were not held to the same rigid schedule as staff. The participants all felt that flexibility worked within the other subthemes of autonomy and developing the workforce so the participant had the ability to come in early or stay late as needed to achieve their goals for the unit and the staff.

All these forces interacted and affected the participants' motivation, and the interaction among these forces led to the participants' decisions to accept the nurse manager role. As illustrated in the conceptual model, the arrows represent the link between the subthemes and themes and their influences on the participants' motivation to choose a nurse manager role.

Moving to the bottom of the diagram, the final theme that arose from the data was information about factors that participants indicated did not influence their decisions. Although this theme deviates somewhat from the initial research question of what motivates nurses to choose a managerial role, the data provide some important insights into what did not motivate these nurses, potentially allowing health care systems to develop interventions to promote movement into managerial positions. As depicted in the diagram, "non-reasons" did not influence motivation as indicated by the blocked arrow from the theme box to the central decision circle.

Non-reasons were both internal and external as reflected in the placement of these subthemes to the right and left of the theme box. Money was an external factor that

participants specifically indicated did not influence their decisions. When the participants spoke of money, they were humorous and felt that this was the least of their concerns in accepting a nurse manager role. They also noted that they were not influenced by a need for power or the desire "to rule the world." One participant went so far as to say that she was motivated by a desire to support others who did, in fact, "rule the world," or, in other words to assist with making a difference, a theme that was addressed earlier.

The theoretical construct presented here summarizes the influences on participants' decisions to accept a nurse manager role. In the following chapter, the researcher will discuss the findings and conceptual model in the light of other motivational theories and address their implications for practice and for future research. The credibility of the findings and study limitations are also addressed.

Chapter 5

Discussion

The purpose of this interpretive descriptive qualitative study was to explore and describe the reasons nurses choose a nurse manager role. This study is the only study found to date that focused on the motivation of nurses for entering into a nursing leadership position. Participants described their motivation for choosing a nurse manager position within the context of a large southern California healthcare system. Six major themes were discovered in the analysis of data collected through one-on-one interviews. Major findings are described from a theoretical perspective and are discussed in the context of the literature reported in Chapter 2. Limitations to generalizability, along with implications for nursing practice, education and research conclude this chapter.

Meaning of the Findings

The first theme articulated in this study found that participants' felt that the nurse manager position was either planned or unplanned. One participant felt that the manager role found her instead of her actively looking for a nurse leader position. Others felt that their motivation for being a nurse manager was part of the next step in their careers or that they were investing in themselves and their future.

The second theme articulated by nurses in this study was their identification with the opportunity to be a nurse manager and to make a difference. No other studies to date

have focused on the motivation of a nurse to take on a nurse manager role when the opportunity just arose. The participants articulated an important opportunity, which was the opportunity to make a difference with the staff through their development and for patients by ensuring quality healthcare at the bedside. Although no other studies addressed this factor as a motivator for nurses choosing a managerial role, previously discussed motivational theories provide some background as to why nurses are motivated to accept a nurse manager position. The cognitive perspective, reflected in the Humanistic Theory of Motivation, incorporates this need to take care of others. For the nurse manager, the need to take of others has a broader scope, which extends beyond patient care to staff, physicians, and ancillary departments.

A third theme articulated by the nurses in this study was the influence of others on their motivation to accept a manager role. The participants all spoke to having a leader or mentor of whom they asked questions about the role and their ability to be successful in its execution. The theme of support from others is not given the emphasis in the literature that it was in this study. Support was a major factor in accepting a nurse manager role.

A fourth theme articulated in this study was one's perception of being prepared for the role. Being prepared involved knowing the healthcare system prior to accepting the nurse manager position, having relationships and/or connections within the system, and having trust and respect for the role as well as for those in leadership positions abov the role (e.g., director, administrator, etc.). Some participants were motivated because they had already been doing the manager role (or part of it) previously in the Clinical

Lead role or as an interim manager, demonstrating that they had the skills needed for the role. Finally, participants felt they were prepared for the role because of the advanced education they had received prior to accepting the manager position.

A fifth theme verbalized by participants was personal satisfaction. The nurse manager role is perceived to involve long hours and many late nights, with greater stress than a staff nurse position carries. All the participants understood these negative aspects of the role and still decided to accept the position in order to meet personal goals. Autonomy, developing the workforce, and flexibility were subthemes that all reflected the participants' motivation based on the perceived personal satisfaction to be found in the role. This is congruent with self-determination theory—motivation, which comes from within, describes why nurses engage in and dedicate themselves to responsibilities that may not be very glamourous (Deci & Ryan, 2011).

A sixth theme articulated in this study was an outlier theme that reflected factors that did **not** influence the participants' decisions to take a nurse manager position. Not one nurse manager took the role for an increase in salary. A second subtheme within non-reasons to choose a nurse manager role was the absence of a need for power. For example, one participant was very aware that her motivation came from the need to support the person who "rules the world" rather than being that person. She noted that she had no further motivation for a leadership role outside of her current nurse manager position.

Theories of human motivation do not necessarily include professional motivation.

Based on the results of this study inferences are made between what the data demonstrated and the theories. Aristotle theorized that motivation was an innate function of being human. Not one participant verbalized that she was without any motivation at all. Motivation existed in various forms among all the participants. Aristotle's theory of motivation holds true. Freud theorized that people are motivated only through force and external rewards. However, not one participant spoke to being forced to accept a nurse manager role, and they expressly spoke to not considering rewards in the form of additional salary in making their decisions. In this respect, Freud's theory is not supported by this study. Traditional motivational studies based on the carrot and stick philosophy of employee incentives failed to be supported in this study.

After the Hawthorne studies, people began to realize that employees were to be treated like people and given choices about their work. This is supported by the data in this study as well. Nurse managers verbalized that their motivation to accept the manager role was due to the support they received, both formally and informally, from other nurse leaders and from mentors. The Drive Theory of Motivation states that motivation comes from reducing internal tension caused by unmet needs. This theory is not entirely supported in this study because of the limitations of this study. The research question in this study did not completely explore all the unmet needs of the participants.

Maslow's hierarchy of needs states that people have multiple ordered needs, arranged in pyramidal levels. The bottom levels are more basic with increasing levels of needs as the pyramid grows. The data in this study supports Maslow's theory by

suggesting that nurses chose the role to meet needs of self-actualization (Maslow's highest level) in terms of having planned for the role and outcomes associated with personal satisfaction, as well as the opportunity to make a difference.

Operant conditioning theory states that free will does not create motivation and yet each participant believed she choose the nurse manage role as a result of free choice. It is beyond the scope of this study, but perhaps there are bits and pieces of reinforcers and punishers that keep us in our job or help us move on to another one. In this study, however, operant conditioning was not demonstrated by the data.

A combination of internal and external influences were noted in two of the six themes, while two themes demonstrated a strong effect for external influences and two others showed a strong effect for internal influences. SDT begins its supposition by following Aristotle in that motivation is intrinsically a part of why people grow and seek to achieve. However, SDT proceeds to state that, with a deeper appreciation of the purpose and significance of a task, a deeper commitment is created that results in a higher level of engagement. In this study, participants verbalized increased knowledge of the nurse manager role through the influence of others and through preparation for the role. SDT theorizes that there are three universal psychological needs, competence, relatedness, and autonomy. This study supports all three of these needs. Competence was noted in the participants' perceptions of themselves as prepared for the role. Relatedness can be seen in the importance of connections and relationships in being prepared and the influence of others in supportive relationships. Autonomy was also a subtheme of

personal satisfaction as a motivator for choosing a nurse manager role.

Although levels of external or internal influences were not measured in this study, it is important to note that the participants were motivated by both external and internal influences. This result is congruent with Laschinger et al.'s (2012) findings that nurses' motivation for nurse leadership roles involves both external and internal influences. A national survey of Canadian nurses, looked at personal and situational factors that influence a nurse's choice to pursue a nursing management role (Laschinger et al.). Although the study was not specific to nurse managers, it still sheds light on why nurses are motivated to move into nursing leadership. Laschinger and colleagues found that the nurses in their study were more intrinsically motivated to pursue management roles and that working with positive role models (an external factor) was also an important motivator in pursuing the manager role. They also noted that middle career nurses continued to need support for the educational qualifications to supplement knowledge and skills. This finding is congruent with the emphasis on educational preparation found in the current study.

Study Limitations

This study was conducted using a convenience sample of nurses currently employed as nurse managers. Several limitations are inherent in this study design. First, participants were volunteers and many not have been representative of all nurse managers, so study findings may not be generalizable to all nurse managers. In addition, all of the managers worked in the same health care system. This system has magnet

status, which requires a higher level of nursing participation in governance. Findings may differ in other health care systems. The nurse managers interviewed in this study were generally satisfied in their roles. Different findings, however, may arise with nurses who are dissatisfied with their managerial roles. Second, the data were self-reported. The participants in this study described their attitudes, behaviors, and beliefs; however, reported behaviors may differ from actual behaviors. Third, the face-to-face interviews were semi-structured, using predetermined questions, so that responses would also be structured, to some degree, by the researcher. Most of the questions were open-ended. Some aspects of the practices and perceptions of these nurse managers may not have been uncovered.

Fourth, the presence of a nurse manager as the interviewer may have influenced the content of the participants' responses. On the other hand, having this researcher as the interviewer made the data more relevant. To minimize her influence on the study results, the researcher tried to maintain an appropriate balance of relevance and objectivity. The researcher used open-ended questions to control for personal bias during the interviews without providing suggestions to participants, trying to avoid guiding their answers.

During data analysis, the researcher used several additional strategies to control personal bias. First, the judgements made in identifying the themes were made explicit and clear, so the researcher's conclusions are easily noted. The next strategy was to use two independent coders in analyzing the data. In this study, the researcher's dissertation chair participated in coding and analyzing the data. Strong intercoder agreement suggests

that the themes are not just an invention of the researcher's imaginations and adds to the credibility of these themes. Finally, the researcher maintains that the findings of this study could not have emerged using a quantitative research design. Face-to-face interview discussions allowed for a more in-depth examination of the motivations nurses have to choose the nurse manager role.

Implications for Nursing Practice.

Highlighting implications for nursing practice is important in interpretive description. This study identified possible motivations a nurse has for becoming a nurse manager. Recognizing these factors and integrating this knowledge into future nurse leadership roles may enhance health care systems' ability to ensure that nursing leadership vacancies are filled by effective nurse managers. Healthcare organizations need to be aware of the crucial role the nurse manager plays in successful patient outcomes and adopt strategies that not only recruit and retain nurse managers but also support them in the role.

Planned or unplanned move. This study found that an external influence on a nurse choosing a manager position rested on the position "finding" the nurse. However, the internal influences were more strategic in that some participants planned for a leadership role. Not actively planning to fill nurse manager positions is an unpredictable way to ensure our 3.4 million nurses in the future have an effective nurse manager to lead them. Part of effective succession planning would be to anticipate vacancies and changes in leadership and identify nurses early who might have potential for a leadership

role, effectively "planting the seed" for the choice of a nurse manager position before one

arises. This will allow nurses to begin to develop the knowledge and skills that will be

required of a manager role increasing their perceptions of themselves as prepared for the

role. Such actions will ensure that HCOs are effectively responding to the changing needs

for leadership healthcare (MacLeod, 2012).

Opportunity. Being devoid of any organized process, some participants chose

their manager position as a function of the position being open. Nursing can ill afford to

continue the practice of happenstance for frontline nursing leadership. Preparing future

nurses for leadership may determine which organizations simply survive and which

thrive (Kim, 2012). Again, HCOs need to actively plant the seeds that lead nurses to think

of themselves in leadership roles, including those of nurse managers.

Participants also spoke to the opportunity to make a difference as motivation for

choosing a nurse manager role. Understanding the external influences on a nurse's ability

to affect change is paramount in realizing how the role can be constructed to allow for

recruitment into the manager position. A good succession plan enables a smooth

transition with less likelihood of disruption in patient care. By planning the exit of nurse

managers well in advance, HCOs can maximise their value and at the same time be

enabled it to meet future needs. This could be enhanced by a "handover" strategy that

allows exiting managers to mentor their successors in the position. The importance of

such a strategy was highlighted by the findings related to the need for mentoring.

Influence of others. All participants spoke to the external influence of another

nurse leader or mentor on their motivation in choosing a nurse manger role. Support form peers, staff, and occasionally family was also a factor in their decision to be a nurse manager. Effective nurse managers are those who able to foster healthy work environments for safe patient outcomes. Without support for a nurse manager, work environments will fail to enable and inspire employee work productivity and organizational effectiveness. Future studies that address nurturing environments for nurse managers that improve empowerment will have positive effects on staff and increase overall HCO effectiveness.

Prepared for the role. Participants believed that there were numerous internal influences on being motivated for a nurse manager role. The ability to retain and recruit nurse managers is noted in the subthemes discovered in this study. Listening to the voices of those already in the manager position can help future recruitment practices and help change retention rates. The importance of leadership to healthcare is unquestionable.

It is apparent that leadership is not only a function of management but is something that should pervade professional nursing practice. The development of excellence in nursing leadership should begin at the earliest stages of basic nursing education and training to ensure adequate nurse mangers.

Personal satisfaction. Autonomy, developing the workforce, and flexibility were internal influences on the participants' choice of a nurse manager role. Job satisfaction has been linked to personal satisfaction and is well documented in the literature (Cummings, 2011; Duffield et al., 2011; Espinoza et al., 2009; Germain & Cummings,

2011; Kim, 2012; Laschinger & Wong, 2010). The satisfaction of nurses in their roles as managers has previously been studied for the impact on patient outcomes and staff engagement but no study to date has studied nurse manager satisfaction as their motivation for choosing or remaining in the role. Filling nurse manager vacancies will depend largely on the HCO being able to understand the relative importance of the many identified factors relating to job satisfaction among nurse managers.

Implications for Nursing Education.

Healthcare is facing a number of stresses (e.g., current and projected nursing shortages, changes in reimbursement systems, and the growth and cost of technology) that require strong visionary leadership. Without planning for these stresses and those to come, it seems unlikely that healthcare will be ready to adapt effectively.

Effective succession planning is the process of ensuring leadership continuity. Succession planning prepares future managers and leaders). Organizations that currently use effective succession planning help to improve work environments, increase nurse retention and decrease staff turnover (Swearingen, 2012). Leadership development should include the strategic process of teaching succession planning at all levels of nursing education. Deliberate education is required by nursing education programs and HCOs in order to ensure nursing managers are qualified and in place to lead. In addition, nursing education can be used to foster personal perceptions of leadership abilities in graduates, as opposed to merely teaching leadership theory.

Implications for Nursing Science.

The nurse manager is becoming one of the most dramatically increasing minorities in nursing leadership. Little is known about why nurses choose a nurse manager role, how they perceive internal and external influences, and the stressors they experience as nurse managers.

This model provides insight into the various internal and external influences that may be operating when nurses choose a nurse manager role. The motivators identified in this study provide guidance for healthcare organizations in recruiting and retaining nurse managers. This model represents the experiences of the nurse manager participants and reflects what influenced them to accept a manager role.

The study has identified a need to validate the themes discovered in this study in future research on motivation for choosing a nurse manager role. The current study did not directly examine the participants' level of commitment to their role as a nurse manager and how this level might influence their decisions to stay in the role. Future research should test this relationship through participant observations to evaluate the level of commitment of the nurse manager to being the manager and how that influences staff nurses to pursue nurse leadership roles.

Another finding that needs to be examined further is the influence of social support and the influence of others on the participants' decisions to accept nurse manager roles. Studying the effects of social support on nurse managers' perceptions, beliefs, and practices will provide a more comprehensive understanding of the phenomena.

Additional research is needed to validate the theoretical constructs developed in this study and examine the transferability of these constructs. Researchers should conduct similar studies with nurse managers who are in other healthcare organizations, both large and small.

Conclusion

Well-motivated, professionally developed nurses are needed to meet the IOM's identified need for nurses to step up to leadership roles. Nurse managers need skills and knowledge to lead their departments in a visionary manner. Healthcare organizations should draw up visions of future nursing leadership needs. They should start planning recruitment and retention policies that focus on the motivations of nurses to accept nurse manager positions. It is important that nurse managers have peer groups, as well as leaders and mentors, to help them develop as managers. It is the healthcare organizations' responsibility to set up a clear vision and goals and make successful nurse leadership possible.

Current research focusing on a nurse manager's work complexity and related issues will enable us to increase our understanding of RN decision making in actual situations. Additional research is needed to explore the complex environments in which nurse mangers work to contribute to patient safety, quality of care, and healthy work environments. A commitment to understanding and appreciating the complexity involved in the motivations of nurses in accepting a nurse manager role is needed to guide the

more substantive and sustained improvements required to and recruit and retain nurse

managers.

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Appendix A: Interview Guide

Motivation for Seeking a Nurse Manager Position: A Qualitative Study

1. What is your official title?

2. How long have you worked in this position?

3. Tell me why you chose the nurse manager role.

4. What factors contributed to your decision?

Demographics

1. Age

2. Sex

3. Race/Ethnicity

4. Education: highest degree obtained in nursing and other educational preparation

5. Professional management or leadership organizations?

6. Certifications in management?

7. Number of years as RN?

8. Number of years as RN when you accepted the nurse manager position?

Appendix B: Letter to Prospective Participants

Dear:

I am Judy White, a Nursing Doctoral Student in the Hahn School of Nursing and Health Science at the University of San Diego and a nurse researcher. As part of the requirements for my doctoral degree, I am conducting a study to explore why registered nurses choose the nurse manger role.

I want to learn why you, as a registered nurse, chose the nurse manager role. Data will be elicited using an interview guide and will be audio taped during a face-to-face interview, a telephone conversation, or a video conference call. The session will require about 45 to 90 minutes of your time. The audio tape will be transcribed and analyzed. Each transcript and tape will be assigned a code for purposes of confidentiality and identifying information will not be attached to any data obtained from this study. The code number, interview answers, and tapes will be retained in a locked file at my home office. All information will conform to the University of San Diego's Internal Review Board Guidelines for conducting research studies.

I plan to call in a few days to determine your willingness to participate in this study.

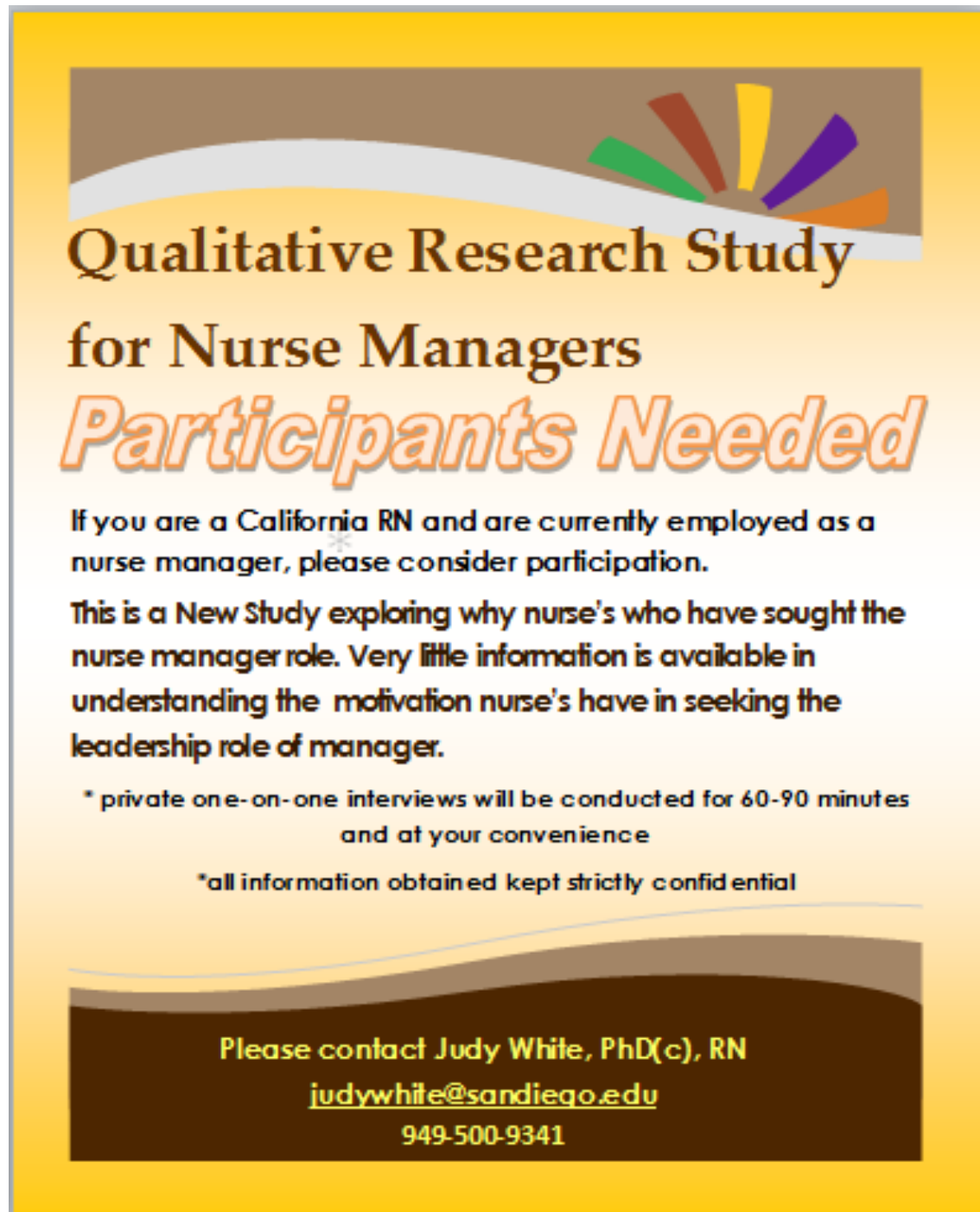Thank you very much for your consideration.

Sincerely,

Judy White, MSN, RN

Email: judywhite@sandiego.edu   Cell Phone: 949-500-9341

Appendix C: Recruitment Flyer

Appendix D

University of San Diego

Institutional Review Board

Research Participant Consent Form

For the research study entitled:

Motivation for Seeking a Nurse Manager Position: A Qualitative Study

I. Purpose of the research study

Judy White is a doctoral student in the Hahn School of Nursing at the University of San Diego, Hahn School of Nursing and Health Science. You are invited to participate in a research study she is conducting. The purpose of this research study is to explore why nurses choose the nurse manager role.

II. What you will be asked to do

If you decide to be in this study, you will be asked to:

A. Participate in a semi-structured tape recorded interview about your motivation in seeking the nurse manager role. This interview will be conducted either face to face or by telephone or video conferencing. You will be asked about your age,

education, race/ethnicity and about the work you do as a nurse manager. You will

be audiotaped during the interview.

Your participation in this study is estimated to take 45 - 90 minutes.

III. Foreseeable risks or discomforts

This study involves no more risk than the risks you encounter in daily life.

IV. Benefits

While there may be no direct benefit to you from participating in this study, the

indirect benefit of participating will be knowing that you helped researchers better

understand the work of registered nurses who have chosen the nurse manger role.

V. Confidentiality

Any information provided and/or identifying records will remain confidential and

kept in a locked file and/or password-protected computer file in the researcher's

office for a minimum of five years. All data collected from you will be coded with a

number or pseudonym (fake name). Your real name will not be used. The results of

this research project may be made public and information quoted in professional

journals and meetings, but information from this study will only be reported as a

group, and not individually.

VI. Compensation

If you participate in the study, the researcher will give you $25 VISA gift card in the following way: either in person or via mail.

You will receive this compensation even if you decide not to complete the entire interview session.

VII. Voluntary Nature of this Research

Participation in this study is entirely voluntary. You do not have to do this, and you can refuse to answer any question or quit at any time. Deciding not to participate or not answering any of the questions will have no effect on any benefits you're entitled to, like your healthcare, or your employment or grades. You can withdraw from this study at any time without penalty.

VIII. Contact Information

If you have any questions about this research, you may contact either:

1) Judy White, MSN, RN

Email: judywhite@sandiego.edu

Phone: 949-500-9341

2) Mary Jo Clark, PhD, RN

Email: clark@sandiego.edu

Phone: 619-260-4574

I have read and understand this form, and consent to the research it describes to me. I have received a copy of this consent form for my records.

_____

Name of Participant (Printed)   Signature of Participant   Date

Judy White
_____

Name of Investigator (Printed)   Signature of Investigator   Date

Appendix E: Sharp Healthcare IRB

SHARP

National Quality Award 2007 Award Recipient

Institutional Review Board
8695 Spectrum Center Blvd
San Diego, CA 92123
P (858) 499-4836 / F (858) 499-3105
http://sharpnet/irb/ www.sharp.com/research
E-mail: research@sharp.com

1409811
Ecoff
09/17/2014
8-11

October 17, 2014

Laurie Ecoff, PhD, RN, NEA-BC
Sharp Memorial Hospital
7901 Frost Street
San Diego, CA 92123

RE: IRB #1409811
        Motivation for seeking a nurse manager position: A qualitative study

Dear Dr. Ecoff:

The Sharp HealthCare Institutional Review Board (IRB00000920; FWA00000084) has reviewed and approved your application for the above-referenced research activity in accordance with 45 CFR 46.110(b)(1) Categories 6 & 7. This approval includes:

- Protocol Sep2014
- Letter to Prospective Participants Appendix A (Sep2014)
- Recruiting Flyer Appendix B (Sep2014)
- Interview Guide & Demographic Questions Appendix C (Sep2014)
- Research Participant Consent Form Appendix D (Sep2014)
- Interview Code Sheet Appendix E

This action will be reported to all committee members at the September 17, 2014 meeting.

The following site(s) and site personnel are approved:

Sites:
Memorial
Coronado
Chula Vista
Grossmont
Mary Birch
Mesa Vista
Rees-Stealy

Principal Investigator: Laurie Ecoff, PhD, RN, NEA-BC

Study Coordinator: none

Sub-investigators and Other Site Personnel:
White, Judy RN   Clark, Mary J

The IRB reference number is 1409811. Please include this reference number in all future correspondence relative to this research activity.

As a reminder, it is the responsibility of the Principal Investigator to submit periodic status reports to the IRB. Periodic review of this research activity may be conducted via an expedited process and is scheduled for inclusion on the August 19, 2015 IRB meeting agenda. Approval for this research activity will expire if periodic review is not conducted on or before 9/10/2015. Please provide a completed Continuation Request with required supporting documentation to research@sharp.com no later than 08/04/2015 to assure timely review and continuation of this research activity.

Changes or amendments to the research activity protocol, informed consent documents, and to other research activity-related documents, as well as new documents, tools or advertisements to be utilized as part of this research activity, must be reviewed and approved by the IRB before changes are implemented.

It is the policy of Sharp HealthCare IRB that the investigator(s) submit a copy of any abstracts, papers, manuscripts, posters, presentations, articles, etc. to the IRB prior to publication or dissemination. Sharp HealthCare would expect that if the results of the research project came to publication, their role would be properly recognized in the research or have the opportunity to have the organization's name withheld. This also gives the organization the opportunity to prevent disclosure of data or information that is beyond the scope of the research agreement.

Thank you and please feel free to contact me at (858) 499-4836, if you have any questions.

Sincerely,

Lois Collier, CIP
IRB Specialist

Enc.

Appendix F: University of San Diego IRB

University
of San Diego

ENTERED

**Institutional Review Board
Project Action Summary**

Action Date: October 29, 2014   *Note: Approval expires one year after this date.*

Type: ___New Full Review _X__New Expedited Review ___Continuation Review ___Exempt Review
        ____Modification

Action: _X__Approved   ___Approved Pending Modification   ___Not Approved

Project Number: 2014-10-055
Researcher(s):   Judy White Doc SON
            Dr. Mary Jo Clark Fac SON
Project Title: Motivation for Seeking a Nurse Manager Position: A Qualitative Study

Note: We send IRB correspondence regarding student research to the faculty advisor, who bears
        the ultimate responsibility for the conduct of the research. We request that the faculty
        advisor share this correspondence with the student researcher.

Modifications Required or Reasons for Non-Approval

None

The next deadline for submitting project proposals to the Provost's Office for full review is N/A. You may submit
a project proposal for expedited review at any time.

Dr. Thomas R. Herrinton
Administrator, Institutional Review Board
University of San Diego
herrinton@sandiego.edu
5998 Alcalá Park
San Diego, California 92110-2492

**Office of the Executive Vice President and Provost
Hughes Administration Center, Room 214
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