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Barbette Weimer-Elder

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BARBETTE WEIMER-ELDER
**ACTIONS, PRACTICES, AND
WORKPLACE CIRCUMSTANCES
THAT CHARACTERIZE HIGH-
ENGAGEMENT WORKGROUPS
IN A HOSPITAL ENVIRONMENT**

Abstract: In the United States a large number of people are not engaged at work. This lack of engagement affects the service outcomes as well as financial bottom line of organizations. This article shares the perceptions of highly engaged leaders and workgroup members regarding the practices that foster employee engagement. Four major themes emerged from the study: teams contribute to high engagement, valuing patients contributes to high engagement, workplace circumstances contribute to high engagement, and leaders contribute to high engagement. While this research study applied specifically to a healthcare setting, the principles could apply to other industries.

Keywords: *Employee engagement, hospital environment, team approach, leader characteristics, Social Exchange Theory*

In the United States a large number of people are not engaged at work (BlessingWhite, 2006). This lack of engagement affects the service outcomes as well as the financial bottom line of organizations (Lockwood, 2007). The cost of actively disengaged employees in the U.S. is about \$300 billion a year (Gordon, 2006, p. 71). Harter, Schmidt, and Hayes (2002) cite the importance of examining business units that score high on employee engagement to learn about actions and practices that drive business outcomes.

I undertook a research study to that end—to examine the perceptions of highly engaged leaders and workgroup members regarding the practices that foster employee engagement. Though this study focuses specifically on a healthcare setting, the principles related to workplace

Barbette Weimer-Elder, Ph.D., is president and founder of Weimer-Elder Consulting. She partners with and coaches individuals, teams and organizations to achieve their goals.

engagement could apply to other situations.

Between 2005 and 2010, The Community Hospital (TCH), part of a Healthcare Corporation in Valley Town, USA (pseudonym), assessed employee engagement using Gallup's Q12 survey. Some groups scored in the top quartile of the national healthcare database, showing they were highly engaged workgroups. Twenty-eight people, including seven leaders, participated in the study to learn what influenced their engagement. There were five clinical and two non-clinical workgroups and their leaders.

The encoding and analysis of the data began once a session had been transcribed. After a focus group or interview session, participants were asked to complete an online survey on the culture of engagement at TCH (Manion, 2009). Throughout the data collection process, I kept a journal to record reflections on what I was seeing, hearing, and learning in the data collection process.

Two research areas provide the conceptual framework for this study: Social Exchange Theory and employee engagement. Social Exchange Theory examines the benefits that individuals and groups perceive themselves as deriving from interactions and relationships in their workplace (Cropanzano & Mitchell, 2005; Kahn, 1990; Molm, 1994; Molm, Takahashi, & Peterson, 2000; Saks, 2006). Social Exchange Theory is called one of the "most influential conceptual paradigms for understanding workplace behavior" (Cropanzano & Mitchell, 2005, p. 874). Cropanzano and Mitchell described Social Exchange Theory (SET) as involving a series of interactions that generate obligations and commitments between people within workgroups and organization-wide. These are interdependent transactions that have the potential to generate high-quality relationships, which in turn foster high engagement and improve performance. Researchers agree on the essence of SET, that is, social exchange comprises actions contingent on the reactions of others, which over time provide for mutually and rewarding transactions and relationships.

Research by Kahn (1990) and Saks (2006) drew the line between SET and employee engagement. Kahn (1990) described how people experience themselves at work and "the depths to which they employ and express or withdraw and defend themselves during role performances" (p. 717). He asserted that SET looks at people's emotional reactions to conscious and unconscious phenomena, and the objective properties of jobs, roles, and work contexts—"all within the same moments of task performances" (p. 693). Kahn focused on people's experiences of themselves at work and their contexts. He grouped his findings under several

categories: psychological meaningfulness, psychological safety, and psychological availability (p. 694).

Saks (2006) took Kahn's work further and examined engagement as "a distinct and unique construct consisting of cognitive, emotional, and behavioral components associated with individual role performance" (p. 602). He underlined a basic tenet of SET in his research, that relationships evolve over time into trusting, loyal, and mutual commitments as long as the parties abide by certain "rules" of exchange. For him, rules of exchange involved reciprocity or repayment rules such that the actions of one party lead to a response or actions by the other party. Saks thought individuals "repay their organization through their level of engagement" (p. 603).

Saks (2006) made the distinction between job and organizational engagement. He found that such engagement is related to individual consequences. Like Kahn (1990), Saks's (2006) conceptualization of engagement was that it is individually role related, and reflects the extent of an individual's psychological presence in his or her given roles. Saks tested the consequences of engagement by examining individuals in their work roles, and in their roles as members of an organization. Saks coined two terms—"perceived organizational support" (POS) and "perceived supervisor support" (PSS)—to examine how employees viewed the support they receive at work.

Employee engagement literature builds from SET and describes practices and workplace circumstances that facilitate engagement at the individual, workgroup, and organizational levels (Buckingham & Clifton, 2001; Buckingham & Coffman, 1999; Fleming & Asplund, 2007; Harter et al., 2002; Kular, Gatenby, Rees, Soane, & Truss, 2008; Mackoff & Triolo, 2008a, 2008b; Manion, 2009; Rath, 2007; Shuck & Wollard, 2009). For example, Mackoff and Triolo (2008a, 2008b) examined individual behaviors and organizational factors that affected nurse manager engagement. They also suggested strategies to pursue in order to retain nurse managers in hospitals and sustain their engagement. Manion (2009) studied what it takes to foster a culture of engagement by managers in healthcare settings.

Four major themes emerged from the study: (1) teams contribute to high engagement, (2) valuing patients contributes to high engagement, (3) workplace circumstances contribute to high engagement, and (4) leaders contribute to high engagement. Each of these themes is described below, first from the perspective of the workgroup members and then from the leaders' perspective.

Engagement as Described by Workgroup Members

This section describes the actions, practices and workplace circumstances from the perspective of the workgroup members.

Teams Contribute to High Engagement

Shared Values and a Passion for Their Work. Findings indicated workgroup members used actions and practices that inspired and energized each other. Fundamental to these was being overtly passionate about patient care, cultivating friendships with each other, and having a common work ethic, purpose, and goals.

Cohesiveness Matters. The high-engagement workgroups liked to take on new challenges, and built trust doing so. They had a sense of collegiality and wanting to do more for each other. The trust and collegiality they had with each other opened the door for group members to candidly voice opinions and work together to solve problems. Cohesiveness evolved not only during daily work-based interactions, but also through joining in volunteer activities together, covering tasks for each other at work, job sharing, and keeping patients happy and engaged.

Balancing Professionalism with Having Fun. Having fun as well as being professional mattered a great deal to workgroups. Findings indicated they were mindful of maintaining professional decorum, yet equally invested in having social interaction, which lightened the intensity of their work. Group members used humor and the occasional joke to alleviate stress. It was part of their group culture. In clinical situations, patients too were engaged in the fun. Patients told staff that fun and humor kept them coming back for their treatments.

Support for Each Other. Workgroup members regarded supporting each other as groundwork that fueled their engagement. Findings revealed support as pitching in to help out wherever and whenever needed—there was no task too small or too large when it came to helping their group members. People said they “had each other’s back,” not “throwing anyone under the bus.” They developed a trust-based environment where they could candidly and forthrightly address their concerns. Outside their own departments, workgroup members did not think people supported each other in the same way as their highly engaged groups.

Demonstrating Care for Each Other. A common characteristic of the high-engagement groups was action they took to demonstrate care and compassion for oneself and for others in their workgroup. They spoke of “I Care” moments they practiced with each other when a person was

feeling down or having a bad day. Group members valued the deeper connections that developed among them over time.

Appreciating and Acknowledging Each Other. Workgroup members cited the importance of being able to recognize one's own skills, to acknowledge those of their colleagues, and to be appreciated by others. Often such acknowledgment was on an informal, rather than a formal basis. People portrayed themselves as knowing what they were good at doing, and building on each other's strengths and differences.

Valuing Patients Contributes to High Engagement

The findings in regard to valuing patients are presented in three subtopics below. For the most part, clinical workgroup members carried the larger part of this discussion because of their direct link to patients. However, non-clinical workgroups also spoke of their contributions in helping clinical staff get the personnel, space, and equipment to work with patients.

Staff Cohesiveness and Its Effect on Patients. Findings indicated that clinical workgroups considered working with patients to be the best part of their job. They described a cyclical pattern of interactions with patients in which the patients observed staff cohesiveness, enjoyed it, and subsequently went back to work at achieving their health-related goals. Having fun with each other and the patient was part of the interaction.

Patient Experience, Feedback, and Empathy. Workgroups sought to improve the patient experience by practicing empathy and putting themselves in the patient's shoes. They truly wanted to see what was going on from the patient perspective. Findings showed a commitment to making the patient the first priority even in the face of conflicting demands. This included keeping communication open with patients from the time they entered the department until the moment they left. Direct-care staff emphasized a need for being a champion for the patient within and outside the department—even when administrative tasks seemed to override that priority.

Regulatory and Human Performance Concerns. Workgroups cited the incredible burden of all the regulatory mandates, metrics, and reporting requirements that came down to them from federal, state, and local levels. Findings indicated that they recognized that the goal of all these things is patient safety or better care. However, the dilemma for them was how to handle such mandates and still keep the patient as priority under the time and resource constraints they faced.

Workplace Circumstances Contribute to High Engagement

This section presents findings regarding circumstances that facilitated high engagement and some that did not. The findings are divided into four subtopics.

Opportunities for Continuous Learning. Continuous learning options brought both practical and philosophical benefits to workgroups. They noted how, practically speaking, they were able to stay current in best practices, including ongoing staff development, credentialing and certification requirements. On the philosophical side, they commented on how their leaders recommended books to them, which allowed them to stay current on leadership practices and staff development principles that were used for shared proactive planning in their departments.

Involvement in Recruiting, Selecting, Hiring, Orienting, and Retaining Staff. Workgroups wanted to hire only those people whom they considered a good fit for their team. They wanted people who had job and interpersonal skills, and who shared the values and common goals of the workgroup. Workgroup members were engaged in using processes and tools for orienting new staff into their departments. New employees spoke of how they reaped the benefits of comprehensive orientation to their new workgroup.

Work-based Communication Practices. Findings showed that people both liked and disliked frequent meetings. They were more engaged at the intra-department-level committees and meetings than at the inter-departmental-level ones. They preferred structured meetings with action-based outcomes. Workgroup members used e-mail, texting, and other technology for communicating with each other on a regular basis. They were concerned when too many meetings drew them away from providing patient care, or when inter-department meetings added overtime demands to an already intense work schedule.

Work Environment: Workspace, Equipment, and Attire. There was a wide range of findings detailing the advantages and disadvantages of current work circumstances. People who worked in a centralized area with each other found the camaraderie and interaction benefits a plus. Others disliked being allocated to a workspace separate from the hospital. In some cases, people cited problems with antiquated work areas that lacked sufficient space, equipment, or privacy to provide quality patient care. Some staff liked uniform attire, others did not. They particularly disliked a top-down decision that had been made regarding their attire.

Leaders Contribute to High Engagement

This segment presents findings regarding how workgroups saw leader contributions to high engagement. There are two subtopics.

Leader Characteristics. Workgroups admired personal and professional traits in their leaders. Clinical people liked having leaders who had both clinical and administrative expertise, and who were on the floor with them to back them up when needed. Workgroups praised leaders who were accessible to them, were transparent, had open-door policies, were good listeners, and provided constructive feedback in a private and supportive manner. Group members respected leaders who valued them for who they are, and for the strengths and skills they brought to their jobs. New employees had high regard for leaders who coached them, and who were available right away when a concern or question arose.

How Leaders Role Modeled Behaviors. Workgroups appreciated leaders who promoted goal setting, championed ongoing learning, developed good communication practices, and supported shared decision-making. They admired leaders who were fair, who looked out for the well-being of team members, and who drew them into problem-solving practices within the department. They also liked leaders who had a sense of humor and fun, and who promoted that within their workgroups.

Engagement as Described by Leaders of Workgroups

Teams Contribute to High Engagement

This section describes leader actions and practices that contributed to strong teams. It is reported under five subtopics.

Shared Values and a Passion for Their Work. Leaders saw it as their job to locate and hire people who have a passion for their work and are dedicated to their work and the patient. These leaders were more focused than their workgroups on linking “the right fit” to improving business outcomes as well as patient outcomes. Leaders looked for staff who had values compatible with their own. They wanted staff who had commitment to the workgroup, and who saw the whole group as greater than the sum of its parts. Leaders valued staff who realized that everyone has a stake in outcomes and objectives they have to meet, people who fully contributed their unique talents and skills and realized the importance of working well together.

Cohesiveness Matters. For the highly engaged team, leaders thought it was incumbent on them to clearly articulate goals and desired outcomes with staff. Only one leader voiced the opinion that the team is the team, that “there is not me and the team.”

Balancing Professionalism With Having Fun. Like their workgroups, leaders mentioned occasions when fun occurred. Unlike their workgroups, however, they spoke of fun and humor less as day-to-day spontaneous actions and more as planned events or initiatives in which fun activities were built into the agenda. All workgroup leaders saw professionalism as mattering more than having fun.

Support for Each Other. Findings revealed that leaders wanted to be attuned to what was happening with their staff. They gave examples of how they practiced transparency, open-door policies, coaching, being candid and honest, and helping staff who met obstacles along the way.

Appreciating and Acknowledging Each Other. Leaders gave more examples than their workgroups of how they formally built recognition into their activities. They mentioned doing so in regular meetings in which they had people publicly recognize team contributions and in more informal on-the-spot moments when they could speak with a person one-to-one. One leader was unique in that she used her work bonus to take her workgroup out to dinner, because she felt they shared in making her successful. That same leader initiated a weeklong series of fun-filled events to acknowledge the contributions and interconnectedness of other workgroups in her department.

Valuing Patients Contributes to High Engagement

Leaders talked about patients in terms related to length of stay, treatment planning, and care coordination. There are three subtopics in this segment.

Patient as Priority. Findings indicated that the patient is a priority for leaders from both a business and clinical perspective. From the business perspective, leaders addressed value-based services, which revolved around the consumer and metric components of healthcare. From the clinical perspective, leaders spoke about wanting to improve patient care by having staff practice more empathy for the patient and what he or she faces in navigating the departments and services in the hospital. The focus for leaders differed from their workgroups in that more emphasis was placed on the business aspects of patient care than on the clinical aspects. An exception to this pattern was leaders who had both clinical and administrative roles in the organization. Those

leaders addressed the dilemma of having to monitor clinical and financial outcomes while also keeping an eye on the patient quality and safety concerns they shared with their staff.

Patient Experience, Feedback, and Empathy. Clinical leaders spoke about how the best form of recognition they ever received was from patients. Patients had provided them with feedback on the positive and lasting impressions that they and their workgroup members had had on them. Leaders supported their staff in practicing empathy and making patients' hospital stay the best experience possible.

Regulatory and Human Performance Concerns. Leaders wanted their workgroups to be informed about changes in healthcare practices and regulations at local, state, and national levels. They deemed regulatory audits as a fact of life for hospitals, and wanted their workgroups to be prepared to act when an audit was called. Clinical leaders were concerned that the demands of such audits were a drain on staff and pulled them from other tasks more immediately connected to direct patient care.

Workplace Circumstances Contribute to High Engagement

This segment presents what leaders said about workplace circumstances: those that contributed to high engagement and some that did not. The findings are presented below in four subtopics.

Opportunities for Continuous Learning. Leaders, like the workgroups, identified practical and philosophical reasons for continuous learning. The practical perspective addressed the necessity of having people in the workgroups stay current in best practices in their fields as well as developing career ladders for them, including cross-training when possible. The philosophical perspective was about leaders sharing their own reading and learning with their teams regarding leadership principles and tools they could apply in the workplace.

Recruiting, Selecting, Hiring, Orienting, and Retaining Staff. Leaders reported steps they followed in moving from hiring and selection into orientation and retention. They described skills and competencies they looked for in potential hires, often requiring a combination of clinical and administrative skills for their workgroups. Leaders were quite specific regarding the procedures they used—from hiring through orienting to retaining new employees. They were not always clear about how much their workgroups were involved in these processes, except that they were very involved in orientation.

Work-based Communication: Meetings and Processes. Leaders spoke about procedures they followed for meetings, both intra- and inter-departmental. They addressed how they stayed in communication with staff, whether through formal meetings, use of technology, or less formal mini-sessions. Leaders spoke a lot about the importance of their attendance in inter-departmental leadership meetings. They wanted to break down silos hospital-wide, and also have their voices heard among others outside their departments. Leaders spoke of the benefits of such meetings far more than did their workgroups, and in terms that were more positive than workgroups indicated.

Work Environment: Workspace, Equipment, and Resources. Leaders spoke of the challenges associated with creating good workspace and provided up-to-date equipment for their teams and for patients. Akin to their workgroups, they spoke of the benefits of working with their teams in a centralized location, and the disadvantages that occurred when that didn't happen. In addition, leaders saw it as their responsibility to make sure staff had adequate workspace and current technology for employees and patients. One leader identified all the problems her workgroup faced with inadequate equipment and antiquated workspace. She insisted that as a leader it was her job to give employees the environment "that will make them successful, friendly and nice."

Leaders Contribute to High Engagement

This segment presents findings regarding how leaders saw themselves contributing to their workgroup's high engagement. There are three subtopics.

How Leaders Support Leaders. Findings indicated that workgroup leaders enjoyed peer-to-peer relationships with other leaders as well as with their own leaders (or bosses, if you will). They spoke about how these relationships affected their own engagement. Leaders reported the professional advantages of working openly with their peers on problem solving and matters of common concern. They also spoke of the comfort and fun that peer-to-peer relationships provided. Actions and behaviors they liked about their own leaders (bosses) included being invited into decision-making processes, having an approachable boss with open-door policies, being coached by their boss in how to deal with tough work or personnel situations, having their leader's trust and confidence, and having the autonomy to do their jobs. These traits were similar to those that workgroups appreciated in their workgroup leaders.

Leader Characteristics That Foster High Engagement. Leaders described characteristics and actions that they thought contributed to workgroup engagement. These included listening to staff, asking questions, getting staff input on matters affecting the workgroup, setting goals with clear expectations, and holding staff to high standards of best practices. Leaders indicated that they focus on individual strengths, coach staff members in using them, and network with other professionals outside the department regarding the rapid changes in healthcare. They also said they publically recognize staff for their contributions to achieving set goals.

How Leaders Model Behaviors Conducive to Fostering High Engagement. Findings indicated that leaders thought they had to model the actions and behaviors they wanted to see in others. They used “being on a stage” as a metaphor for expressing how they sometimes felt they had to behave with patients and staff. They thought they had to put on a happy face when that wasn’t necessarily how they were feeling.

Leaders cited new practices they were implementing for working with physicians to address problematic behaviors. In addition, they talked about difficulties collecting performance metrics, the pressure that put on their staff, and how to handle outcomes that did not meet organizational expectations. Leaders also addressed the issue of accountability. They were distressed about how often accountability does not occur up the chain of command in the larger healthcare corporation where they work.

Workgroups and Leaders: Similarities and Differences

A series of currents crossed through this comparison of leader and workgroup perceptions. Some highlighted the similarities between what the highly engaged workgroup members and leaders thought contributed to high engagement. Others highlighted differences.

One point of intersection was how workgroup members associated their high engagement to what was happening immediately within their teams. They valued colleagues and leaders whose actions and practices indicated that they were flexible and supportive, willing to balance professionalism with having fun, and acknowledged and appreciated the people with whom they worked. Also, workgroup members attributed high engagement to actions people genuinely practiced towards each other on a consistent basis. Interestingly, employees were more aware than leaders about how important such team-based characteristics were to the passion people had for their work, especially regarding patients.

Another intersection point was how workgroups and leaders spoke

about the patient as priority. Clinical workgroup members and their leaders were most closely attuned to what it takes to provide quality care for patients. This was particularly true for leaders who had both clinical and administrative backgrounds and still worked on the floor (e.g., the Cardiac Rehab director, the Nuclear Medicine working supervisor, and the Clinical Education director). That said, there was a sense that many leaders viewed patient care as a secondary matter. This clearly applied to non-clinical leaders who were not involved in direct patient care, but it was also true for people like the Executive Services leader, the leader of the Nursing Administration group, and the Radiology Department director whose attention was more broadly spent. Findings in the Manion (2009) survey bore out this same inconsistency. Leaders rated themselves more highly on knowing what mattered to employees than employees rated them as knowing.

A third intersection point pertained to how people spoke of workplace circumstances that fostered their engagement. It was the clinical workgroups and leaders who were more aware of the impact of work environment, tools, and equipment on the ability to do their jobs and provide good patient care. In addition, workgroup members were more aware than their leaders were of their departmental culture—what it took to support each other, through shared values, valuing patients, or keeping their eye on department-level goals and activities. There was little conversation among workgroups about working with other departments, a topic of wide concern to leaders. Workgroup members said little about what was going on outside their workgroups unless it directly impacted their jobs.

Building on this, the fourth major point of intersection was how people perceived themselves functioning locally within their work unit versus within the larger organization. Workgroup members and leaders, clinical or non-clinical, spoke about each other in positive terms. When the conversation was focused intra-departmentally, group members and leaders were more similar in how they described actions, practices, people, priorities, and workplace circumstances that fostered engagement. The focus got murkier when leaders had their eye turned outside the department, rather than on how their leadership actions and practices were affecting people inside their workgroups.

Application of Findings

What was unique about this study was that, unlike much of the employee-engagement literature, this research looked more specifically

at exemplars in their field that had been quantitatively rated as highly engaged by an entity external to the organization. Following are some ways the findings may be applied in hospital or other settings.

1. Well-functioning teams are critical in today's economy. Each team in an organization has its own unique culture. Therefore, it is imperative that leaders put employees first, and focus time and attention on building the relationships and reciprocity that foster engagement between themselves and team members. When teams become dysfunctional, administrators must facilitate processes to help the team resolve their differences and move to high engagement.

2. Clinical and non-clinical workers in healthcare organizations have a responsibility first and foremost to patients. Employees must take the initiative to be involved in problem solving, and above all else continually champion what is best for patients.

3. Leaders have to work in partnership with employees and with patients to find better, more equitable, and transparent ways of working together. Fear should never be the driver for clinical or business decisions in healthcare or any other situation. Leaders in all environments need training to develop the skills required to facilitate high engagement workgroups.

4. Since hierarchical leadership exists in many organizations, it is incumbent on leaders to drive the kind of collaboration needed to get to high engagement and performance. Leaders should conscientiously acknowledge highly engaged staff, provide continuous learning opportunities, and offer incentives and rewards to continually support and recognize team achievements and outcomes.

5. Achieving and maintaining high engagement is a process that occurs over time. Leaders can use easily accessible and inexpensive surveys (like those Manion [2009] developed for healthcare) to take a quick pulse on how much engagement currently exists within their work units. Leaders can then draw on the knowledge and skills of exemplary employees to build an infrastructure that develops and maintains engagement within their workgroups.

6. Patient + Leader + Workgroup Member = Team. Current literature on engagement in healthcare is challenging the traditional ways of looking at leadership roles and responsibilities in hospitals (Michelli, 2011; Spiegelman & Berrett, 2013). These studies describe repetitive cycles in which employees believe it is the leader's responsibility to provide quality patient care, when in reality it is the employees' responsibility to connect with the patient. In turn, the leader believes it is his or her

job to acquire resources, meet regulations, and maintain the financial solvency of the organization, when first and foremost the leader's responsibility is to connect with the employees. No one has real clarity or accountability for who does what. This pattern was also apparent in the findings of this study and suggests the importance of developing policies and practices to ensure high engagement for the benefit of exemplary patient care.

7. Those in Christian contexts will view employees from a biblical worldview. Recognizing each person as one created in the image of God will open possibilities for conversation about individuals' strengths and their service to the organization. The broader perspective of God's purpose and plans for each individual and the world in general will provide a meaningful focus.

This study makes clear that workplace engagement is critical for organizational effectiveness. The importance of the workgroup and the leader is dramatic for high workplace engagement. Deliberately taking time through dialogue and questionnaires to draw workgroup members and leaders into discussions about what matters is powerful when one understands that engagement is a means to getting remarkable results from people who are passionate about their work and talents. These interactions can generate commitments between people within workgroups and generate high-quality relationships, which in turn foster high engagement and improve performance.

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