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Actions, Practices, and Workplace Conditions that Characterize High-Engagement Workgroups in a Hospital Environment

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ABSTRACT

ACTIONS, PRACTICES, AND WORKPLACE CONDITIONS THAT CHARACTERIZE HIGH-ENGAGEMENT WORKGROUPS IN A HOSPITAL ENVIRONMENT

by

Barbette Weimer-Elder

Chair: Shirley Freed
Title: ACTIONS, PRACTICES, AND WORKPLACE CONDITIONS THAT CHARACTERIZE HIGH-ENGAGEMENT WORKGROUPS IN A HOSPITAL ENVIRONMENT

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Date completed: July 2013

In the United States a large number of people are not engaged at work. The lack of engagement affects the service outcomes as well as financial bottom line of organizations. The cost of actively disengaged employees in the U.S. is about $300 billion a year. Research cites the importance of examining business units that scored high on employee engagement to learn about actions and practices that drive business outcomes.

Between 2005-2010 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 and became the sample for the study. The purpose of this study was to learn from the high-engaged teams about individual actions, practices, and workplace conditions, which contributed to high
engagement. The research questions guiding the study were: How do workgroup member actions, practices, and workplace conditions contribute to high engagement? How do leaders contribute to developing high-engagement workgroups? How are the workgroup member and leader actions and practices similar or different? This study identified actions and practices that contributed to high engagement that can be expanded upon to promote high engagement at TCH in the future.

The population for this qualitative study consisted of workgroups and their leaders rated as highly engaged in the 2010 Gallup Survey. Out of 186 originally designated as members of highly engaged workgroups, 28 people were recruited and selected for the study. There were five clinical workgroups and their leaders, 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. The data were used to uncover deeper meaning in perspectives among workgroup members and their leaders on topics pertaining to the research questions. 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 provided the conceptual framework for this study. The first area was Social Exchange Theory (SET) that examines benefits that individuals and groups perceive themselves as deriving from interactions and relationships in their workplace. The second area was employee engagement literature, which builds from SET and describes practices and workplace conditions that facilitate engagement at the
individual level, workgroup level, and organization-wide. This study expanded on employee engagement research by looking specifically at exemplars in their field who had been quantitatively rated and designated as highly engaged prior to the study.

Findings indicated that the highly engaged employees stayed engaged in part due to the high engagement of their other workgroup members. Workgroups members identified themselves as teams based on their interactions and relationships with each other at their department or work unit. Workgroup members valued, supported, and cared for each other. When leaders were attuned to their workgroups, and provided the internal support that teams needed, workgroups saw their leader as being in alignment with the team. Yet for the most part leaders were unaware of their actions and practices that either fostered or hindered the engagement of the people who directly reported to them.

Consequently, it was not surprising that employees did not think that leaders always put them first, but leaders thought they did. This was particularly true when leader responsibilities took them outside the team’s work, or business-related matters took precedence over employee concerns about providing good patient care. Interestingly, contemporary healthcare literature indicates that if leaders do not put the employee first, employees will not be able to focus on the patient as their first priority.

In addition, leaders who had large numbers of direct reports were not able to foster the interactions and practices most conducive to high engagement on teams. The sheer number of workgroups and direct reports a leader had, tended to preclude an ability to consider how to model what was happening on a highly engaged team with workgroups that were less engaged.
This study laid the foundation for my future consulting work with healthcare leaders on actions and practices that can be used to develop a high-engagement workforce at the local work unit level within hospitals. It can be done by working with leaders to establish a culture of engagement where leaders put employees first, which, in turn, allows employees to put patients first.
Andrews University
School of Education

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A Dissertation
Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

by
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APPROVAL BY THE COMMITTEE:

Chair: Shirley Freed
Dean, School of Education
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External: Gene Milton
Date approved
I love you, O Lord, my strength.

Psalms 18:1 NIV

I dedicate my dissertation to my husband and soulmate, Scott Elder, and to our son, Joshua, for all the love and support you continuously give me.

I pray that our love of learning and education, from past, present, and future, are an inspiration to generations to come.
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There are different kinds of spiritual gifts, but the same Spirit is the source of them all.
There are different kinds of service, but we serve the same Lord.
God works in different ways, but it is the same God who does the work in all of us.

1 Corinthians 12: 4-6

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As I journeyed to completion of my PhD, my family (all 57 of you 😊), colleagues, and friends have encouraged me. Thank you all from the bottom of my heart for supporting me in achieving this goal!
CHAPTER ONE

INTRODUCTION

Background of the Problem

Employee engagement is becoming a popular concept in human resource development (HRD) and management circles, and among business-consulting organizations and professional associations interested in the links between employees who are engaged in their work and subsequent business outcomes. However, questions persist regarding what engagement is and what the outcomes of engagement might be for organizations.

With its publication of *First Break All the Rules* (Buckingham & Coffman, 1999) the Gallup organization helped popularize the term *employee engagement* in the business-consulting world. Based on extensive research data associated with aspects of employee engagement, the Gallup publication primed other professional groups such as Towers-Perrin, Blessing-White, and the Association for Training and Development (ASTD) to stake a claim to expertise in the area of employee engagement (Shuck & Wollard, 2009). In doing so, these groups encouraged their clients to adopt strategies and frameworks like the Gallup Q12 employee engagement survey to identify levels of employee engagement in the workplace.

The stakes are high and the benefits of increased employee engagement are attractive to organizations. Indeed, HRD and consulting literature are promoting the idea of getting better business results through employee engagement. Organizations want to
know how to maximize human capital and to keep maintaining productivity advances (Gordon, 2006). They are attracted by the promises that consulting groups make and that employee engagement data offer: employees who are more productive, profitable, safer, healthier, less likely to turnover, less likely to be absent, and more likely to be loyal and committed to their organizations (Fleming & Asplund, 2007; Wagner & Harter, 2006). Wagner and Harter (2006) cited data that engaged employees averaged higher customer satisfaction ratings and generated increased revenue.

Business consulting firms have done extensive surveys of employee engagement both in the U.S. and elsewhere to better understand what encourages and maintains engagement in the workplace. The need for answers is in part fueled by recent findings that show low productivity among actively disengaged employees costs the U.S. economy about $300 billion every year (Gordon, 2006, p. 71). There is concern that a majority of employees are not engaged in their work and their organizations (Chalofsy & Krishna, 2009, p. 199).

The importance of the workgroup leader in fostering employee engagement has been recognized in research. Blessing-White (2006) found employees were proud to work in their organizations when they trusted their immediate managers. The Gallup research cited the importance of managers to business outcomes, especially managers who encouraged employees’ use of strengths, talents, and skills at work (Buckingham & Clifton, 2001). Another finding was that managers often matter more than executives in reducing employee turnover, enhancing productivity, and increasing customer satisfaction (Wagner & Harter, 2006).
Harter, Schmidt, and Hayes (2002) examined the business unit relationship between employee satisfaction, employee engagement, and business outcomes and reported, “Companies could learn a great deal about the management talents and practices that drive business outcomes if they studied their own top scoring employee engagement business units” (p. 279). Manion (2009) took this a step further by offering tools for assessing the manager-employee relationship among workgroups in the healthcare sector. She proposed strategies for improving and maintaining those relationships over time. Manion asserted that leaders must work harder to identify what it takes to produce highly engaged employees and workgroups in order to affect better business outcomes.

A study analyzing patterns of human behavior in the workplace found that no organization large or small has only one culture. Indeed, the locus of a culture is at the local level, where five, 10, or more people work together every day (Fleming & Asplund, 2007).

In examining contemporary employee engagement literature, it is clear that much of it evolved from Social Exchange Theory (SET), particularly findings that bridged theoretical analyses to the practices associated with engagement in the workplace. SET researchers studied rules and norms of social exchange; the interpersonal and interdependent relationships that build social exchange in workgroups and organizations; and the cognitive, behavioral, and physical factors that advance employee engagement in the work setting. Although not always acknowledged explicitly in contemporary employee engagement literature, social exchange research laid the foundation for many of the employee engagement studies that followed.
Overall, SET literature (Cropanzano & Mitchell, 2005) and employee engagement literature (Kular, Gatenby, Rees, Soane, & Truss, 2008; Shuck & Wollard, 2009) point to both the history of SET and challenges that exist for people who want to better understand employee engagement along with how to implement it in their organizations. One challenge for researchers of employee engagement is the multiple definitions and constructs of engagement which are neither concise nor consistent within or across business sectors because “none share a common conceptualization or definition” (Shuck & Wollard, 2009, p. 100). Another challenge is the preponderance of products and services offered by for-profit business-consulting groups that promote employee engagement. Since for-profit consulting organizations are invested in selling the products and services they offer, the risk to potential consumers is that what is being offered may not always be as transparent or as empirically sound as findings grounded in academic research. A third challenge for the consumer of employee engagement research is deciding where to focus attention in an organization interested in promoting employee engagement—be that at the individual employee level, the workgroup level, or organization-wide.

**Statement of the Problem**

The importance of the workgroup and its leader in initiating and maintaining engagement has been cited in the SET and employee engagement literature (Blessing-White, 2006; Eisenberger, Stinglhamber, Vandenberghe, Sucharski, & Rhoades, 2002; Manion, 2009; Rath, 2007; Saks, 2006; Wagner & Harter, 2006). In addition, Harter et al. (2002) cite the importance to organizations of examining their business units that have
scored high on employee engagement in order to learn about the talents and practices that drive business outcomes.

The Community Hospital (TCH), part of a Healthcare Corporation in Valley Town, USA (pseudonym), has been collecting Gallup-based data at various intervals on unit engagement since 2005. A Gallup survey conducted in 2010 at TCH indicated that it had 12 workgroups that scored above the corporation median on employee-engagement indicators. However, no one in the organization has examined what fostered that high engagement or whether high engagement has continued since the last Gallup Q12 survey in 2010.

**Purpose of the Study**

The purpose of the study was to learn from the high-engagement workgroups at TCH about individual actions, practices, and workplace conditions that contribute to high engagement.

**Research Questions**

The research questions guiding the study were:

1. How do workgroup member actions, practices, and workplace conditions contribute to high engagement?

2. How do leaders contribute to developing high-engagement workgroups?

3. How are the workgroup member and leader actions and practices similar or different?
Context of the Study

TCH belongs to a healthcare system that employs more than 7,200 people and cares for more than 450,000 men, women, and children in the community each year among its various entities and services. Since 2005, TCH has examined employee engagement using the Gallup organization’s Q12 survey to assess the levels at which its employees are committed to their jobs and workplaces (Appendix A). From 2005 to 2010, the Healthcare Corporation employee engagement scores have monitored the ratio of “engaged” to “actively disengaged” employees organization-wide as seen in Figure 1. The engagement ratio indicates the number of “engaged” to the number of “actively disengaged” employees. The figure shows the “engaged” percentage at TCH has increased by 4% from 2007 to 2008. In addition, from 2008 to 2010, the data show that “engaged” employees have remained flat at 46%. The engagement movement is really from “disengaged” to “not engaged.” The focus needs to be moving the not engaged to engagement. Also, the data show the “not engaged” employees at the Healthcare Corporation decreased by 4% from 2007 to 2008. The “actively disengaged” employees at the Healthcare Corporation remained the same during this time period.

In reviewing the broader data which Gallup provides for all industries (i.e., the accumulated index as noted in Figure 1), Gallup numbers show the “not engaged” and the “actively disengaged” employees comprise 70% of the workforce population surveyed.

In general, these data indicate the Healthcare Corporation staff was above average relative to engagement compared with Gallup’s accumulated U.S. working population data.
Figure 1. Non-profit healthcare system engagement index ratios.

**Conceptual Framework**

Two research areas provided the conceptual framework for this study. The first research area was Social Exchange Theory (SET) that examines benefits individuals and groups perceive themselves as deriving from interactions and relationships in their workplace, and the economic and socio-emotional resources people receive from the organizations where they work. The second area was employee engagement literature, which builds from SET and describes practices and workplace conditions that facilitate engagement at the individual level, workgroup level, and organization-wide. These areas will be elaborated upon in Chapter 2 of the study.

**Assumptions**

Assumptions pertaining to this study are:
1. There has been staff attrition on a number of these workgroups since the 2010 Q12 survey.

2. The assumption of the study is that highly engaged groups in 2010 would remain highly engaged through the data collection process.

**Research Design**

The study used a qualitative research design and is a single-case study (Creswell, 2003, 2007; Merriam, 1998; Patton, 2007; Yin, 2009) using two groups: workgroups and their leaders. Focus groups and interviews were conducted to address the study’s research questions. In addition, an electronic survey was implemented after focus groups and interview sessions to give participants an opportunity to contemplate and comment further on their current levels of engagement at TCH.

The original unit of analysis for the study was the 17 workgroups that participated in the 2010 Gallup Q12 survey at TCH, and were rated in the 75th percentile as being highly engaged employees, and had a self-rated high patient experience index. The patient experience index is comprised of three questions about peoples’ perceptions pertaining to the patient experience at the hospital. Since the 2010 Gallup Q12 results, workgroup attrition had occurred. The attrition rate and the study’s initial requirement to have at least four people and their leader from an original workgroup qualify to participate in the study subsequently reduced the final unit of analysis to seven workgroups and their leaders who work together at TCH. The purposive sampling used for the study is explained in Chapter 3.

Focus group sessions were conducted with members from the seven remaining workgroups at TCH, and interviews were conducted with each of the seven workgroup
leaders. In addition, interviews were conducted with new employees who had joined one of the highly engaged workgroups since 2010. Those interviews provided new employees’ perspectives about engagement within a pre-existing workgroup and within the TCH environment.

Focus group and interview sessions were followed by a request to participants to complete a non-mandatory online survey (Appendix B and C). The data from the Manion surveys were to be triangulated on the survey findings with the information from the interview and focus groups sessions, to uncover deeper meaning in perspectives among workgroup members and their leaders. 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.

Definitions

**Actions:** What is being done or can be done to help employees become more engaged in their work, their workgroups, and in the overall organization (Kular et al., 2008, p. 20). Among other things this could include: events, procedures, and dealings with others.

**Employee Engagement:** Employee engagement is “a persistent, positive affective-motivational state of fulfillment in employees that is characterized by high levels of activation and pleasure” (Maslach, Schaufeli, & Leiter, 2001, p. 417).

**Conditions:** An existing circumstance in the TCH work environment that supports engagement. A condition may include resources, physical environment, organizational structure, training, and resources—human, financial, and physical.
**Modality**: A term used at TCH to denote a functional work area within the larger Radiology department. For example, in the study the Nuclear Medicine modality was one of the functional areas within the Radiology department. It is sometimes referred to as a “work unit” in the study.

**Electronic Medical Record (EMR)**: A system that had been implemented at TCH in late 2011.

**Practices**: Behaviors and feelings demonstrated by leaders or workgroup employees.

**Senior Executive**: A member of the top executive/administrative team at TCH. They include but are not limited to the Chief Executive Officer (CEO), Chief Operating Officer (COO), the Chief Financial Officer (CFO), the Chief Nurse Executive (CNE), and the Chief Medical Officer (CMO).

**Social Exchange Theory (SET)**: Involves a series of interactions that generate exchanges between individuals and the organization. SET provides a framework for observing behavior and relationships in individuals, teams, and organizations. The formula that describes SET is that an individual perceives worth as equal to reward minus the perceived cost.

**Workgroup**: A group of people whose members report directly to a given workgroup leader at TCH. In this study highly engaged workgroups are those that scored greater than the 75th percentile in the 2010 Gallup Q12 healthcare national database for employee engagement.

**Workgroup Leader**: The person responsible for managing, directing, and controlling work at the workgroup level at TCH. People who range in status from the
CEO of the organization to a director, supervisor, or manager may lead workgroups at TCH. The term workgroup leader is used in this study to denote a person who has direct responsibility for a workgroup participating in the study, and whose members report directly to that leader.

**Delimitations**

This study was delimited in the following ways:

1. Delimited to one hospital environment
2. Groups with high-engagement scores on the 2010 Q12 survey.

**Limitations**

This study was limited in the following ways:

1. People would answer the questions honestly.
2. The time gap between the 2010 Q12 survey and the data collection in 2012 may have affected people’s recollections of their 2010 high engagement.

**Setting**

Given this background, the dissertation study took place in the hospital setting where the participants worked. In addition, I sought to understand what characterized high engagement by talking with and listening to the people in the high-engagement workgroups—and to people who were new to those workgroups—to hear their stories and learn about their experiences firsthand. I kept a journal to reflect on the process and what I was learning.
Organization of the Study

The literature review in Chapter 2 provides recent literature, which served as the theoretical basis of this study. Chapter 3 describes the research design, while Chapter 4 addresses workgroup perceptions of high engagement and additional data from the Manion (2009) employee survey. Chapter 5 presents leaders’ perceptions on high engagement, interviews, and responses to the Manion (2009) leader survey. Chapter 6 examines similarities and differences between workgroup and leader responses described in Chapters 4 and 5. Chapter 7 concludes the study and offers recommendations for further research.
CHAPTER TWO

REVIEW OF THE LITERATURE

No problem can be solved from the same consciousness that created it.
We must learn to see the world anew. Albert Einstein

Introduction

Highly engaged employees have been found to be emotionally and psychologically committed to their organizations. Engagement creates a strong sense of ownership and desire to contribute to positive outcomes that result in higher performance. A Gallup longitudinal study of 2,178 business units from 10 companies in six industries found that engagement predicted performance better than performance predicted engagement (Fleming & Asplund, 2007).

In describing behaviors that characterize high employee engagement, Lockwood (2007) noted that engaged employees seem to work harder, be more committed, and are more likely to exceed the requirements of their work. Engaged employees tend to feel that their work positively affects their physical health and their psychological well-being (Crabtree, 2005). Furthermore, emotionally based commitment to a person’s work and the organization where he or she works has been shown to result in higher levels of engagement and commitment based on developmental, financial, or professional rewards (Corporate Leadership Council, 2004).
Social Exchange Theory (SET) and employee engagement literature provide a
conceptual basis for what encourages and helps maintain high-engagement workgroups in
a work setting. Since the 1920s, Social Exchange Theory (SET) researchers have
analyzed characteristics of exchange and laid the foundation for understanding how
specific elements of exchange are manifested in the dependent, independent, and
interdependent transactions among peers, between employees and their leaders, and
within workgroups in organizations.

SET describes what is known and what is still to be learned about why people
choose to engage or disengage in their work and workplaces. It describes people’s
experiences of themselves, their work, and its contexts (Kahn, 1990). In addition, SET
research provides an opportunity to “flesh out the types of factors that are most important
for engagement in different roles” (Saks, 2006, p. 613). SET research identified factors
that underpin contemporary discussions of employee engagement. It provided much of
the scaffolding for the studies on employee engagement that have emerged in the
business marketplace.

Employee engagement literature carries social exchange analyses further by
exploring how positive engagement appears in organizations, how engagement affects the
well-being and job satisfaction of people working in an organization, and the benefits to
businesses of high employee engagement. Furthermore, SET and employee engagement
studies have identified and elaborated upon the specific influences managers have in both
initiating and maintaining employee engagement in the workplace. It describes how
organizational cultures support manager engagement in their work.
It must be noted that the research and details covered in this chapter characterize the progression of thought on the topics of social exchange and employee engagement. The intent is to capture the breadth and depth of knowledge examined, particularly in the primary research cited. While there are a number of excellent meta-analyses and literature reviews on SET and employee engagement that helped inform the chapter, only minimal attempts were made to imitate them by trying to integrate all of this material thematically. Instead, the path taken was to consider and describe literature that would likely have a direct bearing on the research questions.

**Social Exchange Theory**

This section of the review focuses on SET theories including a definition of SET, major rules and norms of social exchange, and a discussion of relationships that emerge in these exchanges. Beyond that, the section provides an in-depth view of the pioneering work of Kahn (1990) and Saks (2006). Kahn (1990) is credited with introducing the concept of employee engagement into the SET literature, and Saks was the first “to test a model of the antecedents and consequences of job and organization engagements based on social exchange theory” (p. 600).

SET matters because it presents a theoretical base for defining what engagement is, developing the research questions, and collecting, analyzing, and reporting the data in the study.

**Definition of Social Exchange Theory**

Social Exchange Theory has been called one of the “most influential conceptual paradigms for understanding workplace behavior” (Cropanzano & Mitchell, 2005,
p. 874). Although there are multiple views of social exchange, its roots can be traced back to the 1920s, bridging such disciplines as anthropology, social psychology, and sociology.

Cropanzano and Mitchell (2005) cite theorists’ agreement that social exchange involves a series of interactions that generate obligations and commitments between people within workgroups and organization-wide. Social exchange theorists emphasize that interdependent transactions have the potential to generate high-quality relationships, which in turn foster high engagement and improve performance in the workplace. In addition, although theorists seem to diverge on the particulars, they appear to be in agreement 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.

Major Rules and Norms of Exchange

In their interdisciplinary review of the foundational ideas of SET, Cropanzano and Mitchell (2005) claimed one of the basic tenets of SET is the belief that relationships evolve over time into trusting, loyal, and mutual commitments. For this to happen, all parties must abide by certain “rules” of exchange (p. 875). Cropanzano and Mitchell divided their examination of such rules into two major categories: reciprocity rules and negotiated rules. Reciprocity or repayment in kind is probably the best-known exchange rule. Reciprocity can occur as independent, dependent, or interdependent exchanges where the outcomes of an exchange are influenced by one’s solo effort, the efforts of someone else, or a combination of efforts among the parties involved.
Cropanzano and Mitchell (2005) cite Molm’s findings that “interdependence reduces risk and encourages cooperation” in the work setting (p. 876). In addition, Molm states: “Consequently, it is easier to establish and maintain mutually beneficial interaction under a structure of interdependence than under a culture of dependence” (Molm, 1994, p. 167). Witt, Kacmar, and Andrews (2001) also found “manager practices that promote perceptions of procedural justice are likely to enhance commitment among employees sensitive to social exchange” (p. 513). These findings are useful because they point to actions and practices that may advance and help maintain employee engagement.

In addition to reciprocity rules of exchange, parties in an exchange may also negotiate rules in the hope of reaching beneficial arrangements. Negotiated agreements between people involved in an exchange “tend to be more explicit and quid pro quo than reciprocal exchanges (Cropanzano & Mitchell, 2005, p. 888). This was especially important to look for in close work relationships, like the workgroups participating in the study, to see if members feel the need to negotiate tasks and responsibilities and, if so, how that has affected their engagement levels at work. The converse of that would be to explore whether reciprocity tends to produce better work relationships than negotiations, because reciprocity allows people to be more trusting of and committed to one another (Molm, Takahashi, & Peterson, 2000). Molm et al. explain the reason for this difference: “In negotiated exchanges, the bargaining process is itself a source of uncertainty; actors’ choices of how hard to bargain, what tactics to use, and so forth all affect the terms of agreements and the likelihood of reaching an agreement” (p. 1401).

Beyond reciprocity and negotiated rules, Meeker (1971) proposed other rules that could affect individuals’ engagement in their workgroups in regard to rules that pertain to
choices made in interpersonal exchanges. According to Meeker, since people do not always function rationally in their work setting it’s necessary to have additional rules of exchange. One is “altruism”—an exchange rule whereby a person may seek to benefit another person even at a cost to oneself. Another is “competition” which as a social exchange can be thought of as the diametric opposite of altruism. Whereas altruism is assisting others even when it potentially hurts oneself, “competition can mean harming others even when it risks one's own earnings (Cropanzano & Mitchell, 2005, p. 879).

Meeker (1971) saw “group gain” as an exchange rule wherein the benefits of an exchange are put into a single common “pot” for all involved. People can take what they need from this common pool regardless of their particular contribution. For example, people in the Healthcare Corporation who accrue sick leave, at the same rate that everyone else does, have been known to contribute some of those days to a larger “pot” in the organization for a colleague who is ill and needs extended leave beyond what the person has accrued.

Finally, Meeker (1971) posited the social exchange rule of “status consistency” which can come into play in a context where the allocation of benefits is affected by one's station within a social group. For example, as a person rises in an organization, he or she may accumulate more financial benefits, staff, and resources based on his or her role, and status of that role, in the organization.

To summarize, much of SET research appears to have focused on reciprocity rules as reasons why employees are engaged or disengaged at work. However, Cropanzano and Mitchell (2005) suggested there is a likelihood that multiple rules like
those described in Meeker’s (1971) research may be occurring simultaneously in employee and workplace transactions.

Relationships That Emerge in Social Exchanges

Social exchange relationships seem to evolve in the workplace when employees perceive their employers are taking care of them, and this in turn creates positive results for the employer or organization. Foa and Foa’s 1974 and 1980 studies described six types of resources that can be involved in social exchange relationships: love, status, information, money, goods, and services (Cropanzano & Mitchell, 2005).

Mutually advantageous and fair transactions between people in the workplace seem to result in effective work behavior and positive employee attitudes. Positive organizational support also appeared to contribute to employees engaging in organizational citizenship behavior demonstrated by higher job performance and reduced absenteeism. Eisenberger et al. (2002) found “the relationship between positive supervisor support (PSS) and positive organizational support (POS) was greater for employees who perceived their supervisors to have high informal status within the organization” (p. 571). In other words, if an employee observed a supervisor who garnered more organizational support or resources than someone else of equal status, such informal status could be perceived as benefitting not only the supervisor but also the person who reports to the supervisor.

In addition, “support from a supervisor who is perceived to strongly embody the organizational ethos is more likely to be taken as organizational support compared to support from a supervisor whom the employee believes, less well represents the organization” (Eisenberger et al., 2002, p. 572). Cropanzano and Mitchell (2005) cited
other research which indicated that adding team support to organizational and leader support can lead to employee commitment and job satisfaction, and that trust figures highly in that equation as well (p. 885).

On the whole, the major ideas prevalent in SET literature appear to indicate two distinct conceptualizations of what a social exchange is and how to interpret it. A relationship might be interpreted as a series of interdependent exchanges, or it might be regarded as the interpersonal attachments, which result from a series of interdependent exchanges. This study watched for exchange elements among workgroups and between the manager and workgroup members.

**Employee Engagement Literature**

This section of the chapter presents Kahn’s work (1990) on the psychological elements that promote engaged employees, and Saks’s (2006) analysis of the antecedents and consequences of employee engagement. This section also presents definitions of engagement by the researchers cited, and briefly describes findings by Maslach et al. (2001) and May, Gilson, and Harter (2004) which built on Kahn’s (1990) research, and laid the foundation for Saks’s work, which followed.

Research by Kahn (1990) and Saks (2006) is described in this section of the literature review because of the breadth and depth of their contributions to social exchange theory, and the link they made between SET and employee engagement studies.

**Kahn’s Contribution**

Kahn’s (1990) groundbreaking work was an empirical analysis of psychological conditions that affect people’s engagement or disengagement in their work lives. He
defined employee engagement as “the harnessing of organization members’ selves to their work roles; in engagement, people employ and express themselves physically, cognitively, and emotionally during role performances” (p. 694).

Kahn (1990) provided a framework for understanding peoples’ emotional reactions to conscious and unconscious phenomena, and the objective properties of their jobs, roles, and work contexts. He emphasized the primacy of how people experience themselves at work and “the depths to which they employ and express or withdraw and defend themselves during role performances” in the workplace (p. 717). His qualitative research was conducted in two stages with two separate groups: counselors in a summer camp and staff in an architectural firm. He set the stage for studies to deeply probe the situations, inter-relationships, and experiences that contributed to people being engaged or disengaged at work. Kahn asserted that such probing relies on looking at “both people’s emotional reactions to conscious and unconscious phenomena, as clinical researchers do, and the objective properties of jobs, roles, and work contexts as nonclinical researchers do—all within the same moments of task performances” (p. 693).

Kahn (1990) realized “a different concept was needed to fit organizational life, which is ongoing, emotionally charged, and psychologically complex” (p. 694). His research focused on people's experiences of themselves, their work, and its contexts. He grouped his findings under several categories: psychological meaningfulness, psychological safety, and psychological availability.

**Psychological Meaningfulness**

Kahn (1990) found that people experienced psychological meaningfulness when “they felt worthwhile, useful, and valuable as though they made a difference and were not
taken for granted. They felt able to give to others and to the work itself in their roles and also were able to receive” (p. 704). He described three factors that influenced psychological meaningfulness: task characteristics, role characteristics, and work interactions. Kahn explained them this way: Task characteristics conveyed psychological meaningfulness when people were doing work that was challenging, clearly delineated, varied, creative, and somewhat autonomous. Role characteristics reflected psychological meaningfulness when people saw a good fit between their talents and skills and what the job required or enjoyed a status which indicated how central to and needed in the organization they were. Work interactions data were identified when people felt their task performances included rewarding interpersonal interactions with co-workers and clients.

**Psychological Safety**

Kahn (1990) claimed people experienced psychological safety when they were able to show and employ themselves without fear of negative consequences to self-image, status, or career. People needed to feel safe in situations and to trust that they would not suffer for their personal engagement. Also, he discovered that to promote trust in people required situations that were predictable, consistent, clear, and nonthreatening. People wanted to be able to understand the boundaries between what was allowed and disallowed at work and to know the potential consequences of their behaviors. He also indicated when situations were “unclear, inconsistent, unpredictable, or threatening, [and] personal engagement was regarded as too risky or unsafe” (p. 708). Kahn reported that in some instances “relationships among people representing hierarchical echelons were potentially more stifling and threatening than relationships with peers” (p. 709).
Additionally, Kahn (1990) found there were characteristics or unacknowledged roles which individuals felt influenced their psychological safety. These would manifest especially in-group or intergroup dynamics; for example, relationships where management styles and processes indicated supportive, resilient, and clarifying management “heightened psychological safety” (p. 711). Both supportive interpersonal relationships and supportive managerial environments allowed people to try and to fail without fear of the consequences. On the other hand, a person’s perception of a lack of safety could be caused by something as simple as the “tone” a manager used with them.

Finally, Kahn (1990) reported psychological safety “corresponded to role performances that were clearly within the boundaries of organizational norms” (p. 712). He described norms as shared expectations about the general behaviors of system members as “deviating from norms and the possibility of doing so presented sources of anxiety and frustration, particularly for people with low status and leverage” (p. 713).

**Psychological Availability**

Kahn (1990) depicted psychological availability as the sense of having the physical, emotional, or psychological resources to personally engage in a particular moment at work. It measured how ready people were to engage, given the distractions they experience as members of social systems. He discovered people were more or less available to place themselves fully into their job role performances depending on how they coped with the various demands of both work and non-work aspects of their lives (p. 714). Kahn described physical energy, emotional energy, and insecurity and outside life as key indicators of psychological availability. He found personal engagement demanded levels of physical energy, strength, and readiness that personal disengagement
did not require (p. 714). Emotional energy, the ability to personally engage, also appeared to influence psychological availability. Furthermore, psychological availability corresponded to how secure people felt about their work and their status. For individuals to express themselves in social systems, people had to feel relatively secure about themselves.

Kahn (1990) observed that insecurity manifested itself as heightened self-consciousness. When people focused on how others perceived and judged them—whether or not such judgment actually occurred—they were too distracted to personally engage. This happened when people “perceived themselves, consciously or not, as actors on stages, surrounded by audiences and critics, rather than as people simply doing their jobs. The self-consciousness preoccupied people, engaging them in the work of managing impressions rather than in the work itself (p. 716). He also observed that people’s outside lives, which had the potential to take them psychologically away from their role performances, appeared to influence their psychological availability at work.

To summarize, Kahn’s (1990) research is key to understanding how social exchange of individuals and workgroups in organizations affects employee engagement. His analysis of psychological meaningfulness, safety, and availability provide a connection for the inquiry in this research.

Additional Contributors to Employee-Engagement Literature

Kahn’s (1990) conceptualization of personal engagement was the only literature on engagement until Maslach et al. (2001) conceptualized burnout—the antithesis to engagement. Their definition of engagement was that it is “a persistent, positive
affective-motivational state of fulfillment in employees that is characterized by high levels of activation and pleasure” (Maslach et al., 2001, p. 417).

Maslach et al. (2001) declared six areas of work-life could lead to either burnout or engagement: workload, control, rewards and recognition, community, and social support, perceived fairness, and values. They asserted that job engagement is associated with a maintainable workload, feelings of choice and control, appropriate recognition and reward, a supportive work community, fairness and justice, and meaningful and valued work.

May et al. (2004) contributed to the SET research base post-Kahn by conducting the first empirical testing of Kahn’s (1990) concepts of meaningfulness, safety, and availability. They found that all three of Kahn’s original domains were “important in determining one’s engagement at work” (p. 30). Following their research, Saks (2006) published his report on the antecedents and consequences of employee engagement. Before Saks, “practitioner literature was the only body of work connecting employee engagement drivers to employee engagement and its consequences” (Shuck & Wollard, 2009, p. 100).

Saks’s Contribution

Saks (2006) noticed that many of the definitions of employee engagement in contemporary journals had a basis in practice, not in research. He made it clear his focus was on the academic research (p. 660). Among the many SET researchers he acknowledged, Saks cited the work of Kahn (1990), Maslach et al. (2001) and May et al. (2004), whose models and theories of employee engagement influenced his research.
Saks (2006) defined 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 is, relationships evolve over time into trusting, loyal, and mutual commitments as long as the parties abide by certain “rules” of exchange. As described earlier in the chapter, rules of exchange usually involve reciprocity or repayment rules such that the actions of one party lead to a response or actions by the other party. Interestingly, Saks claimed “one way for individuals to repay their organization is through their level of engagement” (p. 603).

Saks’s (2006) model of engagement had at its core two types of employee engagement: job and organization engagement. He developed nine distinct hypotheses to examine the antecedents and consequences of employee engagement on the job and in the organization (see Appendix D).

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 role. However, Saks went further to test the consequences of engagement by examining the individual in their work role, and in their role as a member of an organization.

The antecedents of employee engagement which Saks (2006) examined included job characteristics such as: skill variety, task identity, task significance, autonomy, and feedback. In addition, he analyzed perceived organizational support (POS) to employees, and perceived supervisor support (PSS) between managers and their direct reports. Finally, Saks looked at incentives and rewards in the workplace, procedural justice (i.e.,
the perceived fairness of the means and processes used to determine the amount and
distribution of resources), and distributive justice (i.e., an employee’s perception of the
fairness of decision outcomes). The consequences of engagement Saks evaluated were:
job satisfaction, organizational commitment, intention to quit, and organizational
citizenship behavior.

Saks (2006) findings made a number of contributions to the emerging area of
employee engagement. Although he approached engagement as role specific with respect
to one’s job and organization, Saks found that job and organization engagements are
related but distinct constructs: the psychological conditions that lead to job and
organization engagements, as well as the consequences, are not the same. He learned that
a number of factors predict job and organization engagement. For example, positive
organizational support (POS) predicted job and organization engagement, job
characteristics predicted job engagement, and procedural justice predicted organization
engagement.

Moreover, job and organization engagement were clearly related to employees’
attitudes, intentions, and behaviors. In particular, job and organization engagement
predicted job satisfaction, organizational commitment, intention to quit, and
organizational citizenship behavior directed to the organization (OCBO). However, only
organization engagement predicted organizational citizenship behavior directed to the
individual (OCBI). Furthermore, organization engagement was a much stronger predictor
of all of the outcomes than was job engagement.

On the whole, Saks’s (2006) findings suggest employee engagement can be
understood in terms of foundational ideas in SET. He surmised that employees who
perceive higher organizational support are more likely to reciprocate with greater levels of engagement, and employees who are provided with jobs that are high on the job characteristics are more likely to reciprocate with greater job engagement. In addition, employees who have higher perceptions of procedural justice are more likely to reciprocate with greater organization engagement. Saks concluded that engaged employees are also more likely to have a high-quality relationship with their employer, leading them to also have more positive attitudes, intentions, and behaviors at work.

Saks (2006) posed some implications for managers and how they engage with employees. He advised managers on how critical it is for them to understand the importance of social exchange for employee engagement, saying, “Managers should understand that employee engagement is a long-term and on-going process that requires continued interactions over time in order to generate obligations and a state of reciprocal interdependence” (p. 614).

To summarize, Saks’s (2006) findings suggest there is a meaningful distinction between job engagement and organization engagement. He illustrated a number of antecedent variables, which predict job and organization engagement, and found that job and organization engagement are related to individual consequences. Saks’s work is meaningful to the research because it provides a theoretical basis grounded in SET for understanding types of antecedents and consequences of employee engagement in the work setting being explored in the research.

**Engagement Research in the Healthcare Sector**

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. Therefore, this section of the literature review will present the contributions of these researchers pertaining to what encourages and characterizes engagement among workers in healthcare settings.

Mackoff and Triolo: A Study of Nurse Managers

Mackoff and Triolo (2008a, 2008b) collected data from their national qualitative study of 30 outstanding long-time nurse managers in six settings. The first part of their study described dimensions of individual nurse engagement, and the implications for developing and sustaining nurse managers. The second part focused on organizational factors that contributed to engagement of nurse managers, and ways for building cultures of engagement in an organization.

In the report on the first part of their study, Mackoff and Triolo (2008a) categorized their findings under 10 signature behaviors which captured the experiences, capabilities, and attributes of the highly effective long-term individual nurse managers they had interviewed. They found exemplary managers to be motivated and driven to action by a sense of meaningful mission and context. Exemplary managers demonstrated generativity, a capacity to find pleasure and satisfaction in caring for and contributing to the next generation of nurses. In addition, nurse managers showed ardor characterized by a depth and breadth of passion to their job and organization that went beyond job satisfaction.

Also, Mackoff and Triolo (2008a) discovered engaged managers were capable of identifying with the work of others, while still being able to keep a clear line of sight to
the care at the bedside via their staff. Exemplary managers showed boundary clarity, and were able to build strong connections with others without losing their own sense of self. They also had a marked preference for creating and restoring clear boundaries between self and others.

Furthermore, nurse managers indicated the importance of self-reflection in examining their own work experiences, as well as in scanning and learning from relevant cues about oneself and others in workplace situations. They practiced self-regulation, using restraint to keep emotions in check, suspending judgment, and conserving energy. Managers showed attunement, an ability to appreciate a reality different from one’s own, challenging processes, welcoming and initiating change and seeking change through new learning. Finally, Mackoff and Triolo (2008a) found nurse managers manifested an affirmative framework, maintaining resilient behaviors to prevent nursing burnout, and longevity was well established. Their research identified a total of 10 signature behavioral factors with exemplar nurse manager (see Appendix E).

In the second part of their study, Mackoff and Triolo (2008b) captured five signature organizational factors, which they surmised had contributed to the longevity and excellence of the exemplar nurse managers in their study. The organizations that nurse managers belonged to supported employee learning and growth, and provided information and resources necessary to accomplish work. The managers cited being affiliated with a culture of regard, that is, an ability to convey the value of being valued, as a prime driver in their own engagement. Nurses also valued a culture of meaning in their organizations, wherein “meaningfulness” on the job was strongly linked to personal engagement. They prized being part of a generative culture, with signature elements of
generative nursing cultures, defined by a commitment to caring for, and contributing to, the next generation. Finally, nurse exemplars liked being part of a culture of excellence. Their research identified a total of five signature organizational factors with exemplar nurse managers (see Appendix F).

Mackoff and Triolo (2008a) observed that “the engaged nurse managers’ capacity to maintain the line of sight between their management work, patient care, and organizational mission emerged as a critical and previously under documented aspect of long-term nurse manager engagement” (p. 123). They encouraged organizational leaders to be proactive in distinguishing between dispositional elements of an employee (i.e., having to do with a person’s capacity, nature, talents, passion) and those things that are teachable and can be learned and enhanced through various forms of teaching and instruction. Mackoff and Triolo (2008a) felt a combination of these elements and a plan to invest in nurse managers were key drivers of healthy workplace cultures, and would result in an increased tenure of new and experienced nurses (see Appendix G). “It is the influence of successful nurse managers that will develop the next generation of nursing leaders” (p. 123).

Moreover, Mackoff and Triolo (2008b) commented on the connection between nurse manager engagement and how they were transitioned and socialized into their new role. They recommended activities like task assignments to build confidence and interest before assuming the role. Mentorship of nurse managers, exemplars to serve as role models, and approachable senior leadership were also deemed important to engagement.

Mackoff and Triolo (2008b) claimed staff nurses leave managers, not organizations, and managers who feel supported by their organization reciprocate this
support with their staff. In addition, they suggest nurse executives who build cultures of nurse manager engagement “are also cultivating staff nurse longevity and vitality, which translates into high-quality care and patient satisfaction” (p. 170).

This is very similar to Saks’s work on perceived supervisory support. Saks found that when a supervisor cares about an employee’s opinions or cares about their well-being, this enhances employee engagement. Other areas where Saks’s and Mackoff’s research findings are similar are in the area of behaviors directed at being willing to help each other with work-related problems, for example, flexibility with adjusting work schedules and/or assisting with their duties.

Manion: A Culture of Engagement

In her chapter entitled “Creating a Culture of Engagement,” Manion (2009) described a qualitative study she undertook to determine what successful healthcare managers do to create a culture of engagement in healthcare. She used an Appreciative Inquiry (AI) approach in her selection criteria for participants and in her study questions.

Essentially, Manion (2009) asked managers to describe in their own words a culture of engagement. Typical responses included a desire for an environment where: people wanted to stay and to become involved, people’s needs were met, and people felt safe and good about being there. Other characteristics people included were working in a place where people could: trust each other, do a job well, and have others care about them as individuals. Participants wanted their concerns and ideas listened and responded to, and to be treated with respect and high regard. They also wanted to work where appreciation and recognition were liberally expressed. According to Manion, the study “made it clear that the way to create a culture of retention is to first create a culture of
engagement and contribution. It is this type of culture that makes a workplace people want to work in” (p. 131).

Also identified by Saks, and similar to some of Mackoff and Triolo’s (2008a, 2008b) findings on individual and organizational factors that contribute to engagement, Manion (2009) reported five strategies exemplary leaders pursue to create a culture of engagement. They include managers who made their employees the first priority as a way to ensure that the employee would put the patient first. Managers also focused on building strong healthy connections with their employees. Manion found that exemplary managers coach for and expect competence. It is accomplished by setting high standards and expectations, supporting the development of the skills of individual employees, and managing performance by recognizing and rewarding what is positive while dealing with problem behavior the right away.

In addition, Manion (2009) found that these managers focused on results. She discovered managers thought that to maintain credibility among employees and colleagues they had to solve problems, and did so by asking colleagues for input on what needed to be fixed, acting on the input, then giving and seeking feedback on the outcomes. In addition, managers mentioned that to get results it was essential to empower and involve employees in decision-making. Managers also said that providing adequate resources to do the job, in order to provide high-quality service, and providing a pleasant physical environment were essential to people feeling satisfied and successful in their jobs.

Furthermore, Manion (2009) stated that engagement grows when leaders partner with employees to make it happen. Partnering occurs when leaders are visible and present
and seen, and when they jump in and help where needed. In addition, managers thought being accessible and maintaining clear boundaries, as well as open and honest communication, were facets of partnering with employees (pp. 131-152).

Manion (2009) generated an employee engagement survey to be completed by a manager or supervisor of a workgroup or department and simultaneously by employees (see Appendix B, C). She recommended that scores be compared and, where there were discrepancies, there would be opportunities for conversation between employees and managers to help advance the building of a culture of engagement in their organization. Manion’s survey is a way to target the dialogue for the exchange between workgroups and their leader.

In essence, what Manion (2009) proposed was similar to Saks’s and Kahn’s research. She thought that relationships evolve over time into trusting, loyal, and mutual commitments as long as the parties abide by certain “rules” of exchange. As described earlier in the chapter, rules of exchange usually involve reciprocity or repayment rules such that the actions of one party lead to a response or actions by the other party. Interestingly, both Manion and Saks note how “one way for individuals to repay their organization is through their level of engagement” (Saks, 2006, p. 603).

**Summary**

The chapter began with a discussion of Social Exchange Theory (SET), its history and an overview of the seminal work of major SET researchers. Each section in this chapter described researchers and their analyses of what supports, hinders, or helps maintain employee engagement in the context of social exchange.
The literature review acknowledges work by Meeker (1971), Molm (1994), Eisenberger et al. (2002), and Cropanzano and Mitchell (2005), who examined the rules and norms of social exchange, and presented theories and models on how employee perceptions of organizational and supervisor support promote engagement. It then segued to an in-depth analysis of the work by Kahn (1990) and Saks (2006), whose pioneering studies influenced recent exploration of employee engagement in academic, human resources development, and business-consulting literature.

Finally, the chapter explores factors and conditions that healthcare researchers Makoff and Triolo (2008a, 2008b) and Manion (2009) examined regarding what fosters engagement among nurses and nurse managers in hospitals. It described what managers deemed essential to a culture of engagement.

To conclude, the content covered in this chapter provided a progression of thought associated with social exchange and employee engagement research. The cited research provides a foundation for the questions addressed in this study.
CHAPTER THREE

METHODOLOGY

Introduction

Low employee engagement is costing billions of dollars annually to the United States economy. Gallup Research reports that four out of five employees are not delivering their full potential to the organization; the magnitude of this problem is remarkable considering the general consensus in the literature regarding a connection between employee engagement and business results. Hundreds and thousands of interviews conducted by the Gallup organization indicated that when the business unit leader makes connections to the employee, and to the employee’s performance, this results in a culture of engagement (Wagner & Harter, 2006).

Human development researchers are seeking ways to maintain engagement in school, work, and social structures such as churches. Manion (2009) describes the workgroup leader as the chief retention officer who is essential in creating a positive work environment and implementing effective strategies. “We need more than a culture of retention; we need a culture of engagement and contribution. It’s not enough you’ve stayed here for 20 years, it’s about: What are you giving? How are you contributing?” (p. 129). A culture of engagement results from factors such as two-way communication, career development, shared decision-making, trust in leadership, and employees who clearly understand what is expected of them in their work roles. In the 1990s, Gallup
researchers, examining human behavior in the workplace, determined that no organization large or small has only one culture. The locus of a culture is at the local level (Fleming & Asplund, 2007). Facilitating high engagement among individuals, workgroups, and their leaders in organizations is essential to building a high-performing business culture.

The purpose of this dissertation study was to learn from high-engagement workgroup members and their leaders about actions, practices, and workplace conditions that contribute to high engagement.

The research questions driving the study were:

1. How do workgroup member actions, practices, and workplace conditions contribute to high engagement?

2. How do leaders contribute to developing high-engagement workgroups?

3. How are the workgroup member and leader actions and practices similar or different?

This chapter provides an explanation of why qualitative research using a case study using focus groups and interviews was selected. It also describes the setting and population for the study, and discusses the instrumentation that was used including an online survey. In addition, the chapter presents a description of the data collection process—how the participants were recruited and selected, and how the data collection proceeded. It closes with an explanation of the data analysis, and comments on trustworthiness, ethics, and generalizability in the study.

A Procedure Map for the activities described in Chapter 3 is provided in the dissertation’s appendixes (see Appendix H).
Research Design

Qualitative Research

The dissertation study used a qualitative research design utilizing a single-case study with two groups, workgroups and their leaders, and focus groups and interviews to collect data.

Qualitative methods were useful to handle the dissertation inquiry in order to gain an encompassing, integrated overview of what is being studied (Miles & Huberman, 1994). Creswell (2007) proposed that qualitative research is fundamentally interpretive, that is, the researcher should reflect on who she is in the inquiry, and be sensitive to personal biography and how it shapes the study.

Other researchers maintain that qualitative research is oriented toward exploring, describing, and explaining something. Qualitative research can be used as a form of inquiry from which to interpret what the researcher sees, hears, and listens to the people engaged in the inquiry. Creswell (2007) recommended collecting data in the field where the participants experience the issues under study.

Finally, Maxwell’s (2005) interactive model for qualitative studies was used to help guide the process followed in the dissertation case study. His model has five components which he characterized in terms of the concern that each is intended to address: goals, why the study is worth doing; conceptual framework, what is going on with the issues, settings, or people under study; research questions, what the researcher wants to understand by doing the study; methods, what the researcher will actually do in conducting the study; and, validity, allowing for alternative explanations for the research results and conclusions. The premise behind Maxwell’s model is that “design in
qualitative research is an ongoing process that involves ‘tacking’ back and forth between
the different components of the design, assessing the implications of goals, theories (or
conceptual framework), research questions, methods and validity threats for one another”
(p. 3).

Case Study

According to Stake, a “case study is not a methodological choice but a choice of
what is to be studied” (Stake, 1995, as cited in Patton, 2007, p. 447).

Merriman (1998) proposed using qualitative inquiry via case study to understand
why a given situation occurs. She recommended using a case study “to arrive at a
comprehensive understanding of the groups under study” (p. 29). Merriam viewed
qualitative inquiry as an attempt to understand a situation or behavior as a part of a
particular context. The purpose of such inquiry is not to predict what is causing a
particular situation, but to understand why the situation is occurring.

Self as the Research Instrument

Qualitative research is concerned with the process of how people negotiate
meaning rather than simply with outcomes or products (Bogdan & Biklen, 1992). They
learn by understanding what individuals experience, how they interpret their experience,
and how these experiences help them structure their world.

In thinking of the self as an instrument in the study, prior to actually conducting
the study, the process began in my reflections back on what brought me to this point in
my life. Events such as taking the Gallup organization’s Clifton’s StrengthsFinder
assessment and learning about my top five strengths: Maximizer, Strategic, Self-
Assurance, Learner, and Ideation were part of that process. It was interesting to hear that my leading strength is excellence through being a maximizer. Gallup strengths-based literature (Buckingham & Clifton, 2001) reports that maximizers take something good and create excellence through what they have. This strength resonated with me because with over 35 years working in healthcare, I’ve experienced a very positive reputation from patients and employees. I loved my work and had a passion for my healing practice as a nurse. Moreover, I care about people and want to learn how I can create an environment for compassionate healthcare workers to passionately practice.

I also believe the combination of being a maximizer and having self-assurance serves me well in facilitating groups, listening to and observing others, and being an executive performance coach. I have been able to think and act both strategically and operationally in my work.

Moreover, I have always been an ideation person. I gravitate to new ideas in my constant search for learning more about how to be with others and myself in this life’s journey. I seek out and practice generative, holistic ways to integrate well-being from a physical, mental, and spiritual perspective. And, I strongly encourage and open the door for others to pursue their life’s passion and journey.

I bring these same skills for research to this dissertation study. As a servant leader and change agent in organizations, I continually seek to learn, teach, and practice through the transformational dimensions of being a leader. Inspiring others to contribute to a vision and be passionate about one’s contribution is what transformational leadership is all about. Creating an environment where participants can voice their lived experience is a skill I have mastered over the past 15 years of my professional life. Consequently, I
have a passion for learning: what fosters engagement in workgroups, how leaders maximize the potential of people who report to them, and how workplace conditions can either support or hinder engagement. I have discovered that to get to business results leaders must realize that employee engagement is critical. In addition, it’s important for me to note that the study participants do not report to me directly, and do not work at my facility location. With this in mind, I have asked myself if I am the person to assess the workgroups’ experiences and create an environment where they trust me and will be candid and open up with me. I can honestly answer “yes” to that question.

As a qualitative researcher my role was to take the experience that the participants lived in their workgroups and make public what was private information prior to this study. This required producing a description of how the participants lived their experience in their highly engaged workgroups. My years of experience as a nurse, an educator, and an executive working in hospitals, as well as my academic studies in organization and leadership development, prepared me for this undertaking.

To ensure clarity of the description I taped the interview and focus group sessions and had a professional transcriptionist type the transcripts.

By conducting research on workgroup actions, practices, and workplace conditions that drive high employee engagement in a complex hospital environment, I used my talents as a strategic thinker and learner to see patterns of what is creating this high engagement, and to share the findings for future application and research.

**Data Collection Process**

This section of the chapter describes the data collection process that was used. It includes a description of the purposive sampling, sources of data, and procedures.
Purposive Sampling

Because this is a qualitative study, purposive sampling was used. Merriam (1998) noted, “Within every study there probably exist numerous sites that could be visited, events or activities observed, people who could be interviewed” (p. 60). She recommended that non-probabilistic sampling is the method of choice for qualitative researchers because qualitative problems are about “discovering what occurs, the implications of what occurs, and the relationships linking the outcomes” (p. 61). Thus, when the most appropriate sampling strategy is non-probabilistic, the most common form is called “purposive” or “purposeful” sampling (p. 61).

Patton (2007) attested to the power of purposive sampling, saying it “lies in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research” (p. 46). Thus, the size of the sample within the case should be determined by factors relevant to the study’s purpose. Patton goes on to advise the qualitative researcher, “The key issue in selecting and making decisions about the appropriate unit of analysis is to decide what it is you want to be able to say something about at the end of the study” (p. 229).

Site Selection

TCH was chosen as the site for this study. TCH is a member of a non-profit healthcare system. It is a 336-licensed bed acute-care facility that opened in 1979 and is part of an integrated healthcare delivery system. The full spectrum of services covers a wide range of healthcare needs—mind, body, and spirit.
In 2002 TCH was honored for its workplace environment and received state recognition called the “Workplace Excellence” Award Seal of Approval for providing a healthy work environment, and being sensitive to the personal and professional needs of its employees. The president of TCH at the time stated, “Consistent with our mission, it is important for us to remain diligent in creating and maintaining an environment where individuals are able to succeed professionally and maintain a healthy balance between their work and their personal life.”

Population and Sample

Approximately 2,000 leaders and staff at TCH (who took the Gallup Q12 Employee Engagement Survey in 2010) were the population for this study. The unit of study for the dissertation research is high-engagement workgroups at TCH in Valley Town, USA (pseudonym).

The larger population was narrowed down based on the criteria that workgroups had to have taken the Gallup 2010 Q12 survey (Appendix A), and had to have belonged to a workgroup at TCH, which was rated as high engagement (at or above 75%) by the Gallup Q12 healthcare database score. Workgroups also had to have had a high patient experience index score.

The subsequent sample resulted in 186 people comprised of TCH leaders and their workgroups, approximately 9.3% of the employees. The intended sample was subsequently identified as 17 workgroups and their leaders who participated in the 2010 Gallup Q12 survey at TCH and who were rated as highly engaged. As of August 2011, that number was reduced to 12 workgroups and their leaders at TCH, which still retained either in whole or part their original workgroup membership. In October 2011, the
number was again reduced, this time to seven workgroups and their leaders based on the following criteria:

1. Workgroups and their respective leaders were together at the time of the Gallup 2010 Q12 survey, scored in the 75th percentile for employee engagement and on the patient experience index, and were still working together in 2011.

2. There were at least four of the original workgroup members currently working together, and with the same leader as in 2010.

3. Workgroups represented both clinical and non-clinical staff. Clinical workgroups included in the study were: Cardiac Rehab, Clinical Education, Nuclear Medicine, Nursing Administration, and Radiology. Non-Clinical workgroups included Human Resources and Executive Services. Seven workgroups and their leaders were recruited to participate in the study.

Of the seven workgroups, two were non-clinical and five were comprised of clinical staff for a total of 44 workgroup members plus their seven leaders. In addition, nine new employees who joined these high-engagement teams since 2010, and worked with them for at least 3 months, were invited to participate in the study (Appendix H). A total of 60 people were recruited for the study.

Sources of Data

Focus groups and interviews were conducted to address the study’s research questions. After each focus group and interview, participants were asked to complete either an employee or leader survey regarding current levels of engagement in their workgroups. The explanation of each of these methods follows.
Focus Groups

Using focus groups over other qualitative techniques had the advantage of group interactions that allowed me to collect a large amount of data on the topic of interest, and to do so in a limited amount of time. Furthermore, focus groups permitted me to learn participant attitudes and opinions on the given topic (Morgan, 1997). Patton (2007) commented, “The power of the focus group resides in their being focused” (p. 388).

Patton (2007) elaborated on the advantages and disadvantages of using focus groups in qualitative inquiry. Advantages include: the data collection can be done among a number of people for a short period of time; interactions among the participants can provide checks and balances on each other to weed out false or extreme views; it’s possible to assess the shared views or difference fairly quickly; focus groups can be fun and enjoyable social interactions. The disadvantages include: the number of questions has to be restricted due to group size and time limitations; those who feel their viewpoint is controversial or in the minority may refrain from participation; confidentiality cannot be totally assured in focus groups although audiotaped transcriptions where names and other forms of identification are removed can help; focus groups can be beneficial for identification of major themes but less so for analysis of subtle differences; focus groups may take place out of the natural setting where social interactions normally occur (pp. 387-388).

Therefore, focus group sessions were comprised of people who were in the same workgroups and reporting to the same leader from 2010. Initially, the goal was to have four to seven people per focus group. Eventually, that number varied based on the schedule and availability of those who were invited to attend.
Each session was held at TCH. The intent in each focus group was for participants “to hear each other’s responses and to make additional comments beyond their own original responses as they hear what other people have to say” (Patton, 2007, p. 386). People did not have to agree with each other or reach any kind of consensus. Rather, the goal was to get high-quality data in a comfortable context where people could state and consider their own views, and ideally those of others. Each focus group was conducted in a 2-hour session, was electronically recorded and transcribed, and required each participant to sign a consent form to participate in the study.

A Focus Group Guide (Appendix I) contained the study’s sub-questions that linked back to the dissertation’s three general research questions. The common set of sub-questions was used in all the focus groups. The questions were structured to elicit candid open-ended responses from participants of examples and stories pertaining to where, how, and why high engagement had occurred in their workgroups.

Of the existing workgroup members invited to attend a focus group, 41% of the five clinical and two non-clinical workgroup members invited to participate in the TCH research study attended. Two workgroups, Nuclear Medicine and Nursing Administration, had one employee in each of those workgroup sessions. Two other workgroups, Human Resources and Executive Services, had two employees attend a focus session. The Human Resources and Executive Services workgroup sessions were then followed by separate one-on-one sessions with an additional employee from each workgroup. The Focus Group Guide and session format were consistently used for all sessions with workgroup members.
Table 1 presents each workgroup in the study by: (a) the name of the group and whether it was clinical or non-clinical, (b) the type of session, (c) the number of sessions, (d) the number invited, and (e) the number who attended.

**Interviews**

Interviews were conducted with leaders and with new employees.

Leader interviews

“The purpose of qualitative interviewing is to capture how those being interviewed view their world, to learn their terminology and judgments, and to capture the complexities of their individual perceptions and experiences” (Patton, 2007, p. 348).

To that end, a 90-minute interview was conducted with each of the seven workgroup leaders. Each interview was electronically recorded and transcribed. Each interviewee signed the TCH Consent Form before the interview began.

A Leader Interview Guide was used in the leader sessions (Appendix J). It contained the study’s sub-questions, which linked back to the dissertation’s two general research questions. As in the focus groups, the questions were structured to elicit candid open-ended responses. Leaders were asked about their experiences working with high-engagement groups. The guide was developed and sequenced in a way that allowed me to make decisions about what information to pursue in greater depth within the time and resources available.

I alternated interviews between leaders and focus workgroups to reduce the possibility of facilitator bias. By alternating sessions, I was able to look at both
perspectives throughout the entire study. All sessions were based on availability of participants to attend.

One hundred percent of the workgroup leaders who were invited to participate in the study did so. Each leader met in a separate one-on-one interview with me. The Interview Guide and session format remained constant across all leader interview sessions.

Table 1

Workgroups Used in the Study

<table>
<thead>
<tr>
<th>Workgroup Name</th>
<th>Type of Session</th>
<th>No. Sessions</th>
<th>No. Invited</th>
<th>No. Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Workgroup</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td>Focus Group</td>
<td>1</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Clinical Education</td>
<td>Focus Group</td>
<td>1</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>One-on-One session</td>
<td>1</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Nursing Administration</td>
<td>One-on-One session</td>
<td>1</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Radiology</td>
<td>Focus Group</td>
<td>1</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td><strong>Non-Clinical Workgroup</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Services</td>
<td>Focus Group</td>
<td>1</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>One-on-One session</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Human Resources</td>
<td>Focus Group</td>
<td>1</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>One-on-One session</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td></td>
<td>9</td>
<td>44</td>
<td>18</td>
</tr>
</tbody>
</table>

*Note.* 41% participation. Non-clinical workgroup participants were invited to both a focus group and a one-on-one session.
New employee interviews

In addition to the seven workgroups and their leaders, I sought one-on-one interviews with the new staff members who had been hired into one of the seven workgroups since October 2010. The reason for the new employee interviews was to garner their perceptions on what it was like for a new person to have joined a high-engagement team. The criteria for the new employee selection was that the person must have been hired since October 2010, have worked with their current workgroup for at least 3 months as of October 7, 2011, and have the willingness, time, and availability to be interviewed.

Ninety-minute interviews were conducted with the new employees from the seven workgroups. Nine new employees were identified as having been hired into some of the seven workgroups between October 2010 and October 7, 2011. Two were from Clinical Education, three were from Human Resources, two were from Radiology, and two were from Nuclear Medicine. Three agreed to participate. The three who participated were from Clinical Education, Radiology, and Nuclear Medicine departments. A New Employee Interview Guide was used to gather participants’ perceptions about employee engagement within their workgroup and at TCH (Appendix K). They too had to sign a Consent Form to participate in an interview.

Thirty-three percent of the new employees invited to participate in the study attended a one-on-one session. Each new employee who participated came from a clinical workgroup. The New Employee Interview Guide and session format remained constant across all new employee interview sessions.
Researcher Journal

This study made use of a journal—a place where I wrote about what was seen, heard, and felt in the study. It was used as a basis from which to continually re-examine and shape the ongoing research process. The journal was the place where I used self as the instrument through a personal dialogue about feelings, insights, assumptions, biases, and ongoing ideas regarding the method.

Researchers believe maintaining a journal is essential to qualitative studies (Bogdan & Biklen, 1992; Ely, Anzul, Friedman, Garner, & McCormack-Steinmetz, 1993; Ely, Vinz, Downing, & Anzul, 1997).

Manion Survey

The invitation to participate in the study explained that there were two parts to the study. The first part consisted of participation in either a focus group or an interview. The second part consisted of a request to all participants to complete a non-mandatory electronic survey pertaining to either leader or employee engagement.

At the end of each focus group or interview, participants were given instructions on how to link to and complete one of the electronic surveys pertaining to a Culture of Engagement developed by Dr. Jo Manion. Manion had given her permission to use the surveys and adapt it for purposes of the study. One survey was for the workgroup member (Appendix B); the other survey was for the workgroup leader (Appendix C). Twenty-one employees and new employees were invited to complete a survey. Fourteen of the 21 completed the survey, which resulted in a 66% participation rate. Seven leaders were invited and four of the seven participated in the survey, which resulted in a 57% completion rate.
Procedures

This procedure section includes the discussion of the formative committee, recruitment and selection process, the consent form developed for the study, and how confidentiality matters were handled.

Formative Committee

Prior to conducting the focus groups and interviews, a formative committee comprised of four people at the executive, supervisor, and staff levels met with me in a pre-meeting to confer on the general scope of the study, the recruitment and selection process for participants, the logistics and timing for conducting the study, and giving me permission to recruit staff. I selected the formative committee members and the TCH Vice President of Human Resources based on who the committee thought could best address the study needs. All committee members had participated in the 2010 Gallup Q12 survey, had demonstrated an enthusiasm for high employee engagement at TCH, and were knowledgeable about the behaviors of engagement, and what high engagement looked like in a hospital.

Recruitment

Participants were recruited via an email invitation from myself (Appendices L, I). The invitation described the purpose, timeframe, and use of focus groups, interviews, and surveys in the study. In addition, potential participants were informed about why they were recruited for participation, the risks and benefits, and how confidentiality would be maintained.
The email invitation to participants explained that the focus group sessions and interviews would be audiotaped and transcribed. The individuals being recruited for the study could decline to be audiotaped; if a person did decline she or he was not selected for participation in the study. In addition, each individual was asked to complete a TCH Consent Form which included an explanation of the audiotape and transcription services that were used in the study. People brought and signed their consent form before their focus group or interview session. Their signature indicated they understood and agreed to the terms for participation (Appendix M).

All data were managed by a project assistant who stored the data on a secured and limited-access drive to ensure confidentiality was maintained throughout the data collection and analysis process. Those files were password protected. Several people involved in the logistics, editing, and storing of the data signed TCH Conflict of Interest and Disclosure Statements, assuring participants that any of the data collected and maintained for the study would be held in confidence (Appendix N).

**Data Analysis**

Miles and Huberman (1994) stated, “There may be a situation where the researcher wants to capture data on the perceptions of local actors from the ‘inside’ through a process of attentiveness, empathy and bracketing of preconceptions about the topic under discussion” (p. 6).

Bogdan and Biklin (1992) offered practical suggestions on how to code information in a systematic way throughout the qualitative data collection and analysis process. Their suggestions included categorizing the data by: peoples’ perspectives such as their orientation to a given topic; processes such as ongoing workflows that may
change over time; *activities* such as regularly occurring kinds of tasks in the workplace; *events* such as special activities that occur separate from their daily routine; and, *strategies* such as specific approaches people use to accomplish something.

With those suggestions in mind, data analysis began once the audio files were transcribed. The data analysis followed a process similar to what Creswell (2003) proposed, which involved moving deeper and deeper into understanding the data, representing the data, and making an interpretation of the larger meaning of the data (p. 190).

The initial phase of data analysis consisted of reading transcripts broadly to look for indicators of activities, conditions, events, practices, and processes that facilitated high engagement. After the first reading of the transcripts, a list of 23 codes was developed to drill down deeper into the content and context of the material. Then the codes were used to mark narrative segments in the transcripts, and look for trends in the data. Subsequently, codes were clustered into major groupings, associated with the study’s research questions.

The next phase of data analysis was to develop two Excel workbooks: one for clinical and one for non-clinical workgroups and leaders. The purpose of using Excel was to organize and categorize information in a way that was visually accessible for deeper analysis and reporting. The narrative text from the transcripts was transposed into columns in the separate workbooks, on separate standardized worksheets per workgroup and leaders in unique columns:

1. Group or leader name (e.g., Human Resources)
2. Participant initials (The one exception was the Clinical Education group. Because of the number of participants, and the fact that the workbook process was not yet in place, names of respondents were not caught for transcription.)

3. Facilitator questions/comments (in order of occurrence in the session)

4. The page where a given comment appeared in the transcript

5. The specific comment

6. My researcher notes copied from the transcript

7. A column for other notes on any recurring themes or patterns that emerged in the group

8. Separate columns for each of the codes used for labeling the comments in the transcript.

Once done, the data could be sorted by question, workgroup, leader, comment, and code to take a deeper look into the patterns that emerged about employee engagement at TCH. A high-level tabulation was run on the separate codes for each worksheet, and then tallied by code across worksheets to get a picture of what workgroup members and leaders appeared to be most focused on in their discussions. The code which predominated a particular segment in the transcript was counted first. Then secondary codes in a segment were counted. The purpose of counting was to search for major recurring patterns within the transcripts. The counting was not done for purposes of statistical analysis, but rather to assist in “selecting, focusing, simplifying, abstracting, and transforming the ‘raw data’ in a way that that linked most directly to the research questions” (Miles & Huberman, 1984, p. 21).
Codes were then clustered by what appeared to be similar or related topics (Appendix O). Four themes emerged. They were: (a) Teams Contribute to High Engagement, (b) Valuing Patients Contributes to High Engagement, (c) Workplace Conditions Contribute to High Engagement, and (d) Leaders Contribute to High Engagement.

In the final phase of data analysis, the results collected from the employee and leader surveys (Manion, 2009) were reviewed and collated to see how those participants who elected to take the online survey responded to questions regarding a culture of engagement at TCH. Once tabulated, the results were analyzed in light of the same theme categories that had emerged during the transcript analysis. Each item in the surveys was then placed into one of three major focus areas for examination: team, workplace, or leader. Patient-specific questions were not in the survey. Subsequently, two tables were developed to illustrate those findings. One table pertained to workgroup members. The other table was for the workgroup leader (see Appendix P).

**Trustworthiness**

Patton (2007) proposed alternative sets of criteria for judging the quality and credibility of qualitative inquiry. Among those are social construction and constructivist criteria pertaining to trustworthiness. In effect, the discussion around trustworthiness for judging findings occurs when the analyst “owns and is reflective about her own voice and perspective; a credible voice conveys authenticity and trustworthiness” (p. 494). Patton asserts that “the researcher’s focus becomes balance—understanding and depicting the world authentically in all its complexity when being self-analytical, politically aware, and reflexive in consciousness” (pp. 494-495).
In the dissertation study I kept a journal that contained my self-reflections on what I was seeing, hearing, and feeling particularly in the focus and interview sessions. I started out with some ideas to help me think through and write my reflections. Some of the reflections contained responses to questions such as: Where did the meeting occur? What were the circumstances? What stood out about the session or the state the person was in when first arriving to, or during the session? Were people being authentic and forthright in their responses? Was there any undercurrent of things not said—that is, what people were reluctant or unwilling to talk about? What was missing that I would have liked to hear more about? How did I feel about the session overall?

The thoroughness of these reflections, the sense of authenticity in my voice, and the representations of the voices of the participants contributed to the perceptions of trustworthiness of the data. Since all data collection processes and analyses are described in the dissertation chapters, and all original data were recorded and transcribed and transparent, it would be possible to review the data for its authenticity from its inception to its conclusion.

The purpose of audiotaping was so that I could accurately record, transcribe, and analyze the data. Research subjects were recorded in order to maintain the integrity of the data by being true to what people actually said in their session. If I did not have the tapes to refer back to, there was no way to go back and check the facts; this increased the possibility that the interpretation would be flawed. It would negatively impact the research. Moreover, using an alternative approach like having an additional person in the room to take notes and document the discussions would likely have been disruptive and
provide less accuracy to the process. Adding another human being into the process would likely have disturbed the flow of the interview or focus group conversation.

Within interpretative research, validation is “a judgment of the trustworthiness or goodness of a piece of research” (Creswell, 2007, p. 205). Ethical validation requires researchers to question their “underlying moral assumptions, political and ethical implications and the equitable treatment of diverse voices” (p. 205). Self-reflection, as described in the segment on trustworthiness, contributes to the validation of the work. In addition, the documented chain of interpretations that occur in the study provides a means for others to judge the trustworthiness of the meanings arrived at. As described earlier in this chapter, great effort was made to accurately transcribe what occurred in the data collection sessions, keep the treatment of diverse voices equitable and heard, and transparently document the chain of interpretations in the study. Self-reflection was also part of the process.

*The Standards for Evaluation of Educational Programs, Projects and Materials* (The Joint Committee on Standards for Educational Evaluation, 1981) caution researchers to monitor for personal, professional, and political agendas and conflicts of interest in conducting a study. The conflict of interest standard was dealt with openly and honestly and documented on a TCH disclosure form prior to the study, so that it didn’t compromise the research processes and results. Other processes implemented to retain congruency included triangulating the narrative content in Chapters 4 and 5 with data provided in the Manion surveys. While these data were not a one-to-one match in terms of numbers of people participating in the interviews and focus groups and those taking the surveys, it clearly provided information that enhances the discussion on what people
perceived as supporting or hindering engagement. It helped me to challenge my own thinking about whether what I heard in the workgroup and leader sessions was “true,” that is, that I accurately reflected the situation. Using the Manion survey added further support to the findings, yet also opened up other avenues for consideration that may have not been discussed in the study earlier. Akin to Patton (2007), the goal of triangulation in this study was not necessarily to arrive at consistency across data sources or approaches. Instead, the additional information was viewed as an opportunity to uncover deeper meaning in perspectives among workgroup members and their leaders. The similarities and differences in the transcript information and the survey data provided the foundation for that comparison.

**Generalizability**

Generalizability from a qualitative research dissertation standpoint, where the findings are often heavily context dependent, could be ascribed to pre-specified criteria agreed to by the dissertation committee and researcher, links drawn to SET or employee engagement research, or by the reader developing generalities from their conclusions after reviewing the findings (Krathwohl & Smith, 2005, p. 139). In this study, generalizability links to comparison of similarities and differences between the two groups (workgroups and leaders) participating in the study. It draws comparisons between those two groups and links the findings to the theoretical framework based in SET research, and the research of people who have conducted studies in the areas pertinent to maintaining a culture of engagement in healthcare settings.
Ethics Issues

Hospital leadership granted approval for the study and its Institutional Review Board.

No apparent conflict of interest presented itself in the design of this study. No financial or other benefits such as a promotion, increased salary, or bonus were promised to me; and, no promises were made to senior executives who offered permission to conduct the study. There was no reporting relationship between me and anyone who worked at TCH. Furthermore, senior executives had no input into my performance reviews or salary. In addition, respondents’ comments were not presented in a way that would identify them in the data analysis or final report.

To ensure further ethical safeguards, prior to conducting the study, rigorous Andrews University and the Healthcare Corporation Internal Review Board processes were followed to protect against potential sources of conflict of interest (financial, social, political).

With regard to the study participants, Krathwohl (1993) outlined a number of ethics considerations for the researcher. Based on those considerations, I did establish a clear and fair agreement with participants. This was done by sending an email to invite participation, which included in the invitation a clarification of the obligations and responsibilities of the researcher and participant. Also, the participant was notified that I respected his or her right to decline or withdraw at any stage in the study. In addition, a consent form was provided to the participant, outlining the purpose of the study, how its findings would be reported, and plans for protecting confidentiality. If a recruited or selected participant was uncomfortable with any part of the information presented in the
study’s Consent Agreement, he or she could opt out of the study at any time without penalty or future ramifications. No one chose to do so.

In addition, all names of persons participating in the study, or spoken about in the study, were removed from the write-up of the findings. All original data sources, be they audiotapes or transcriptions, will be destroyed 3 years after the study is reported and defended to the Andrews University dissertation committee.

Summary

This chapter provided an explanation of why qualitative research using a case study with two groups, leaders and workgroups, and focus groups and interviews as the primary source of data was selected to answer the research questions. It also described the setting and population for the study, and discussed the instrumentation that was used including an online survey. In addition, the chapter provided a description of the data collection process—how the participants were recruited and selected, and how the data collection proceeded. It closed with a description of how the trustworthiness, ethics, and generalizability of the study were maintained.
CHAPTER FOUR

WORKGROUP PERCEPTIONS ON HIGH ENGAGEMENT

Chapter 4 was designed to address the research question: “How do workgroup member actions and practices contribute to workplace conditions that facilitate high engagement?” The chapter uses peoples’ own words and perceptions, as captured in the ebb and flow of conversations with workgroup members. Content was clustered under the major themes, which emerged out of those conversations. The themes pertain to how: (a) Teams Contribute to High Engagement, (b) Valuing Patients Contributes to High Engagement, (c) Workplace Conditions Contribute to High Engagement, and (d) Leaders Contribute to High Engagement. In addition, results from the Manion employee survey provided further insight from the workgroup respondents on what contributes to high engagement.

Teams Contribute to High Engagement

The first theme examines how participants characterized team work—what it meant to them as individuals, within their workgroups, and hospital-wide. The content in this section was divided into subtopics to capture flow of the conversations with workgroup members. The subtopics for the Teams section are: (a) Shared Values and a Passion for Their Work, (b) Cohesiveness Matters, (c) Balancing Professionalism With
Having Fun, (d) Support for Each Other, (e) Demonstrating Care for Each Other, and (f) Appreciating and Acknowledging Each Other.

Shared Values and a Passion for Their Work

Overall, clinical, non-clinical, and new employees were proud of their workgroups and passionate about their work. Clinical and non-clinical staff explained how having a passion for their work, shared values, and common goals are fundamental to their high engagement. Among Clinical Education staff there appeared to be mutual agreement about how “we all feel proud to be associated each other, and when you have someone on the team who does not represent our values, it is not comfortable because we represent our department no matter where we are.” Something similar appeared to be true for the Nuclear Medicine workgroup. The new employee in that group praised her workgroup leader because the leader “does her best to put a good team together. She won’t let somebody else in who won’t be a team player.”

Human Resources staff also believed that shared values fueled high engagement. They agreed that people must be passionate, focused, and purpose-driven in their work. One person commented, “Being a part of the team that I am excites me, because the people I work with inspire me, they energize me.” In responding to the question, “There is a strong sense of connection, of community, among people in the department,” 64% of staff responding to the survey strongly agreed, 36% agreed sometimes, and no one disagreed.

A new Clinical Education employee felt engagement is based upon common goals, patient satisfaction, and good patient care. He felt that “good patient care is feeling good about what you have done for the patients. Having them say thank you. But
knowing in your heart when you leave, you have given them the best care you could.”

The new employee went on to explain why sharing a common goal is integral to his workgroup’s engagement. For him, it meant “making the education process for the hospital as smooth as possible and making it pertinent; what the staff perceives they need, and then measure that against the practice of the hospital.” The new Clinical Education employee also addressed how cultivating friendships with coworkers and having some commonalities among them fostered engagement. He stated, “If you have commonalities, you can work better together. Then you can develop a bond. Age, hobbies, things in common. Without the commonalities, you end up working in a silo.”

Workgroup members talked a lot about the necessity of having a common work ethic. The Nurse Administration participant voiced that her workgroup members “are in it for the right reason. Every one of my colleagues, I think, is passionate about good patient care here at this hospital, and what can they do to make that happen.”

Cohesiveness Matters

There was considerable discussion on how group cohesiveness helped teams take on new challenges, and in turn, how cohesiveness helped people trust each other, resulting in their wanting to do more for each other. For example, the new Nuclear Medicine employee felt that what characterized her engaged team was people working together: “We will always work together, it doesn’t single anybody out, doesn’t throw anybody under the bus.” She went on to say that a cohesive team is one where “you have a problem, you can solve it as a team. People you feel comfortable with all the time.”

Likewise, an Executive Services employee spoke about why trust is important, and how it contributes to collegiality. She stated, “I think you need to have a cohesive
team that you trust.” The employee went on to describe how trust and collegiality open the door to feeling free to voice opinions and to problem solve with each other. “If you have that collegiality, you can say ‘I think the path you are going down is wrong, and here is why,’ and try to problem solve.” She added that in a collegial environment, “you are free to express your opinions and aren’t excluded because of it.” In responding to the question, “When an employee is having problems, other people in the department rally around and help in constructive ways,” staff 64% strongly agreed, 36% agreed sometimes, and no one disagreed.

On the other hand, the Nurse Administration workgroup member gave an example of how a lack of trust among colleagues eroded team cohesiveness. She described a colleague who did not fit in well with the Nurse Administration workgroup, saying:

This is such a cohesive group, he just stood out. We operate on the same values and principles, and when he didn’t it was just glaring that he didn’t. He was very much full of himself and his position. I think all of the others . . . may have a title, but they love doing the role, not just having a title and they work hard at it.

Workgroup members from other departments talked about how cohesiveness evolved through participation in volunteer activities together, covering for each other at work, and focusing on keeping patients happy and engaged. Cardiac Rehab employees described volunteer activities they engaged in after work hours, “like the heart walk, bariatric walk, love your heart, health expos and health fairs, vascular screenings,” and how those activities were important to the workgroup. “Because of our cohesiveness, if one person is going to participate in an event, we sort of all feel like we all do it as a group, because we are used to doing things as a group.” Another person said, “That is just what we do, we volunteer as a group, we work as a group.” Similarly, Nuclear Medicine staff cited volunteer activities they engaged in together, like preparing special meals for
colleagues in the Radiology Department during Nuclear Medicine Week. They saw such activity as a way to promote more cohesion across functional lines within the department.

Cardiac Rehab employees also provided insight on why they felt cohesiveness was easier to achieve during night hours than on daytime shifts. A staff member said, “It was much easier for us at night to be a cohesive group than it was when I worked on the day time, because we had just each other to rely on, because there were not a lot of external people there. In the day time you are going a bunch of different ways.” The person also mentioned how patient satisfaction fostered even more cohesiveness among staff, saying, “Our patients don’t have to come to us. They tell us sometimes, ‘I really don’t like coming here, I don’t like this exercise, but it is fun to be here with you all, you are all friendly and happy.’”

Balancing Professionalism With Having Fun

Workgroup members spoke enthusiastically about the importance of balancing hard work with fun, even in a potential crisis situation. They were mindful of maintaining professional decorum, and never spoke of fun in a flippant manner. Instead, people addressed ways in which their social interactions lightened the intensity of their work.

A Cardiac Rehab employee explained, “Sometimes you get overwhelmed at work, you have a lot of stress going on,” but when “you can joke about it this really engages you a lot. It is definitely where I want to be. It actually helps you get out of that rut and helps you through working.” Likewise, the Nuclear Medicine employee offered, “If I observed a team member having a bad day, I would make a joke with them, and ask what is going on with them. It makes them lighten up some.”
In addition, several Clinical Education staff mentioned how job sharing and overlapping each other across shifts helped eliminate some of the stress on their team. They recalled the stressful situation of having to help train people on the hospital’s new Electronic Medical Record (EMR) system, how the whole team pulled together to get it done, and how they celebrated afterwards. “We had our delayed Christmas party, since we were doing [installation] at the time. This was a good decision, because we were just fried in December. Everybody was engaged and having a good time. Like a family.”

Some workgroups used ongoing celebrations in order to maintain engagement. One Nuclear Medicine person said, “If we have a day where we don’t have a patient assessment, we might try to go together for lunch. We almost always all sit down together and eat, like a family.” Also, “We always have birthday parties, not parties necessarily, but celebrate birthdays, weddings, and babies. It is really important to us.” When asked whether employees “enjoy spontaneous fun as well as planned fun together on a regular basis,” 71% strongly agreed, and 29% agreed sometimes; no one disagreed.

Fun also occurred on a different scale and within a different context in a large project sponsored by the Radiology department called “Adopt a Spot.” This project engaged the whole department of approximately 103 people. The project brought people together to resolve the cleanliness problems in the department. The Radiology employee described how “we broke it up into teams, and it was a competition. We were graded and awards were handed out. We scrubbed floors, we scrubbed toilets, and we scrubbed doors.” The group that took the project helm was able to maintain awareness about cleanliness, use fun-filled competition, and promote everyone taking ownership and helping out for almost 18 months.
Engagement in between the Nuclear Medicine modality and the larger Radiology department was also fostered by an event called Nuclear Medicine Week. Nuclear Medicine staff used the weeklong activities to fix breakfast, lunch, and dinner as a way to say “thank you, thank you” to their colleagues within the department. The new Nuclear Medicine employee noted, “As serious as we have to be, there are those times to have fun as well. That is kind of team promoting. I thought that was great because this is the only place I have been that actually wants to celebrate what they do, and I think that is important.”

Finally, a weather-based emergency revealed to the Nurse Administration workgroup how professionalism and having fun can intersect even in a crisis situation. The Nurse Administration employee recounted how we had a blizzard 3 years ago . . . where everyone was pitching in to the best of their ability. We were all under stress and fatigued, but we learned to have a sense of humor about it. We got to know things about one another that we didn’t necessarily know outside of work. Things are still kind of a joke 2 years later [laughs]. Well, I know that about you! But it was, and we all agreed, that was a true bonding experience.

The Nursing Administration member felt the bonding happened because you are all sleeping in scrubs in recliners, sharing a room. It was really good, and we had to be there for one another and no one wanted to be the one to leave. You wanted to be there for your group and be supportive. No one tried to tell anyone else . . . it was all come together, mutual, problem solve. We all had the same problem and we put our heads together around it to get to a solution. It was a great experience, as painful as it was. I look back on it and think it was one of the greatest experiences as a team that we ever had.

Support for Each Other

People elaborated on how support from team members fueled their engagement in a fast-paced environment. They described this support in multiple ways. Some viewed
support as a colleague or leader showing the flexibility to cover another’s tasks—and felt this was made easier when there were seamless work practices in place. Other people viewed support as pitching in to help out wherever and whenever needed—including taking the time to bring new staff up to speed or figuring out ways to alleviate stress.

In response to the question, “We work hard at keeping scheduling in our department as flexible as possible in order to meet both customers’ and employees’ needs,” 79% of staff strongly agreed and 21% agreed sometimes.

Nuclear Medicine and Cardiac Rehab staff felt flexibility among staff members was essential to maintaining engagement. The new Nuclear Medicine employee commented, “The thing I think about, we have set shifts. You come in. Any time one of us needs to come in late or needs to get off, you always know somebody within the team will switch shifts with you or cover for you. It is never a problem.” Offering a different example of flexibility among colleagues, the Cardiac Rehab staff termed flexibility as a professional behavior that doesn’t “hold a line between us and what our titles are.” This group of nurses and exercise physiologists stated, “The thing that is actually cool about it is that it looks seamless.” Bolstering this notion further, the Cardiac Rehab group reported how seamless work practices helped in “feeding off each other” to the extent that “if one can’t answer a question or provide what they need, perhaps the other person can.”

Similarly, an Executive Services employee appreciated how a supportive workgroup can “just be completely involved to the point that we all know what each of us are doing and we make sure that everybody else is aware.” Further, as one Clinical Education employee put it, support occurs when “everyone pitches in” to help each other
out. One example was given by a Clinical Education member who had to run a staff development day and was overwhelmed by the task. She said, “I arrived early to make sure everything was done,” and to her surprise, “the rest of the team members arrived early to help, too.” The clinical educator was spurred on by this experience to run 22 individual events hospital-wide over the next 6 months. Likewise, another Clinical Education employee recalled what it was like to have support to hit the ground running once in the new job. He said, “It was daunting at first, knowing the responsibilities ahead,” so he appreciated “being part of a team that brings people up to speed, getting them to a high level of function.”

Supporting each other in stressful situations, where problems have to be dealt with right away, was another characteristic of highly engaged workgroups. A Human Resources employee recalled a situation where a colleague, instead of buckling under the strain of trying to pack and move an entire department in a short period of time, elicited team spirit by “going around and being a real cheer leader about getting it done . . . a little bit at a time.” Because of the person’s upbeat attitude, others rolled up their sleeves and helped out.

In addition to these examples, an Executive Services member explained why supporting others in a hospital environment is central to engagement. “Collectively as a team, the harder the issues that we are dealing with, we reach out and we make sure that the one person isn’t just stuck with dealing with it themselves. We are really aware of what’s on everybody’s plate.” Another Executive Service member echoed how team support is the groundwork for being able to “focus on specific tasks that contribute to the institution’s overall goals.”
On a different note, people in the Radiology department said they were more restricted in how they can support each other task-wise in their department. This is because “they cannot do each other’s jobs.” “We all have specific licenses, just like a nursing license, each of our modalities, we cannot cross.” Consequently, when the Radiology workgroup members talked about what supported their engagement, given all the ebbs and flows that occur in their department, participants concurred that “seeing improvement and feeling like you can maintain it” is a motivating factor. In addition, one Radiology employee stated, “When the patient comes to Radiology they rarely come to one modality. They will probably come to three out of five. That is just how it works now. So, if we cannot work well as a team, and know how to help each other be successful, the patient experience will be lost.”

Like the earlier shared-values discussion in this chapter, people mentioned challenges a group faces when someone doesn’t appear to want to be part of a team, or fails to carry a fair share of the workload. An Executive Services employee observed that there is less engagement “if a team member feels excluded or not trusted.” He reflected, “I have seen it apply to other people where they will start to feel like they need to go elsewhere if their opinion isn’t valued or they are not included in certain conversations.” On the other hand, the Nursing Administration group member cited how a colleague who was seen as not doing his share of the work affected her whole workgroup. She said, “You don’t mind taking on a heavy load or carrying a lot of the water if everyone is in with you, but when you have one who is kind of putzing around and not really engaged, then that does rock the boat.”
The Nuclear Medicine employee also reported what happened when colleagues are not supportive of each other. He noticed how sometimes within the larger Radiology department, it was like “everyone plays their own instrument.” Because of this, people in his workgroup as well as patients found themselves having to sort through confusion created by others. The Nuclear Medicine employee felt such silos and disconnects could be bridged if everyone placed patient welfare above all else in the department.

Demonstrating Care for Each Other

There was general agreement in the focus groups and interviews on the need for compassion for one’s self and for others in the workplace. This agreement also appeared in the Manion survey responses. Asked if “there is a strong sense of connection, of community, among people in the department,” 64% strongly agreed and 36% agreed sometimes. Also, in the workgroup discussions, participants gave multiple examples of how they demonstrated compassion both on and off the job. One person observed how caring grows through deeper connections made over time. Another gave examples of how his colleagues practiced “I Care” moments both inside and outside of work.

A Human Resource workgroup member noted how in her department “we all enjoy each other and we care about each other, and are always asking you ‘How’s your family?’” In addition, Human Resource members conveyed how “a strong sense of professional respect for one another has been a constant, which has helped us grow and work through many challenges and difficulties on the job.”

A Cardiac Rehab employee reported that workgroup colleagues reached out to her during a family crisis and how this had affected her. “The kindness of some of the words that people said to me were so amazing to me . . . sending me texts all day, checking on
me and on my brother . . . Does that really happen to people? It’s just really cool.”

Further, a staff member in the Clinical Education department spoke about how her colleagues supported each other even when “they are at low ebb or having an issue, coworkers gather around to cheer and lift up.”

The new Clinical Education employee attested to a similar type of camaraderie, and added his observation that friendships are necessary for engagement. “You can work with someone that you don’t like, but you are trying to just get the day over.” On the other hand, colleagues who are friends ask, “Is there anything I can do for you? Have you had lunch? The ‘I Care’ moments. How is it going? What can I do for you?”

Appreciating and Acknowledging Each Other

The general sense conveyed in this conversation was that workgroup colleagues appreciated the people with whom they worked. Several people among the different workgroups spoke about how good it is to be able to recognize one’s own skills, to acknowledge those of their colleagues, and to be appreciated by others.

Cardiac Rehab members portrayed themselves as “knowing what you’re good at and appreciating and recognizing what others are good at,” thereby building on each other’s strengths and differences. One example of this was a Cardiac Rehab staff member who recalled learning a new exercise skill from a colleague, which she in turn taught to her patients.

In addition, an Executive Services employee reflected on how good it felt to have her skills acknowledged. She enjoyed “feeling appreciated and being allowed to do what you are good at. Feeling very much a part of the team, and being allowed to share insights and having those insights and opinions taken seriously.” Further, the new
Nuclear Medicine employee recounted behaviors indicative of her workgroup’s strengths, saying, “In our work we don’t take criticism as a bad thing. Our shared goal is to make our team better and improve patient satisfaction.”

The Executive Services member, who ran the installation of the new Electronic Medical Record (EMR) hospital-wide, said she was pleased when she overheard a colleague telling someone “if she says something is of concern, you had better listen.” The Executive Services employee recalled how “I felt complimented by the statement, and felt I had earned that reputation, because I don’t squawk about everything and I am a good listener.”

Probably more than any other workgroup, the Clinical Education group talked at length about each other’s strengths. In an almost call-and-response fashion, members called out a colleague’s unique strengths, and others responded with additional praise. One person was acknowledged for being the team’s “organizer, she sets the bar, is clear in her expectations with staff and they know what they need to do.” Another was recognized as being “an excellent teacher. Staff gets it. She is thorough and has the knowledge to present the subject.” A third person was cited for “patience and tolerance” while another was described as “very collaborative.” The team was enthusiastic about one colleague for being “very knowledgeable, able to understand patient care.” They noted that “because she was so good at the nursing role, people are not afraid to ask her a question. Nurses are able to progress because of no fear.” Moreover, the Clinical Education workgroup felt their high engagement spills over into being engaged in the larger organization as well because “by having a supporting group you can move along together for the same mission.” Overall, the discussion among workgroup members
regarding appreciation and acknowledgment was consistent with responses to the survey. Of the employees who participated, 71% strongly agreed and 29% agreed sometimes that “employees in my department regularly recognize each other and participate enthusiastically in any department recognition events.”

Valuing Patients Contributes to High Engagement

Discussions on valuing patients are presented under three major subtopics to capture the flow of the conversations: (a) Staff Cohesiveness and Its Effect on Patients, (b) Patient Experience, Feedback, and Empathy, and (c) Regulatory and Human Performance Concerns.

This section presents how workgroup members described actions and practices in valuing patients: what is integral to a satisfying patient experience, and how staff connects with patients to provide them with safe effective care. In the Teams Contribute to High Engagement section of the findings, many of the workgroups spoke in terms about their passion for providing good patient care and achieving patient satisfaction. In looking closer at the outpatient Cardiac Rehab and Nuclear Medicine workgroups (and to some degree, Radiology) spoke most directly and extensively about the patient as priority. They gave multiple examples of how this is manifested in their interactions with patients throughout the workday, and how such interactions led to both patient satisfaction and their own high engagement.

Staff Cohesiveness and Its Effect on Patients

Cardiac Rehab workgroup members gave examples of the consistency required in their continuous interaction with patients, and described how such interactions are the
best part of the job. One staff member recollected how after many years of nursing practice she was seeing sicker patients coming into the hospital with shorter hospital stays. She said she saw patients “going home so sick that they did not have a chance to be impacted by some of the educational things you said to them, because they were so worried about coping with going home with still being sick.” Subsequently, for her an attraction of working in Cardiac Rehab was to “finally be able to see the other side of what happened when they got home; to be able to build on the knowledge in the hospital; to be able to educate them, to teach them.”

Another Cardiac Rehab employee observed the effect of the individual and the team dynamic in achieving patient goals. “It starts with the employee. The patients see us and feed off of us.” To keep patients engaged, Cardiac Rehab staff mentioned that the first contact starts in the inpatient area prior to their going into outpatient services. “We continue our interaction on the floor as they are exercising, always talking with them to keep them engaged.” One workgroup member felt it was critical to get to know the patient, and what motivates the patient to achieve his or her health goals. Further, Cardiac Rehab staff explained how they keep the patient engaged by reviewing and reevaluating goals with them every month. Staff also noted how patient engagement in setting and achieving their health and lifestyle goals was augmented by involving families in helping patients achieve their health-related goals.

In addition, the Cardiac Rehab staff spoke of engaging patients on a social level to keep them coming back for their rehab therapy. For example:

We try to do fun things with them like its heart month, so we had activities and giveaways. One day was going Red and they had to wear red. Next Friday we are having Mardi Gras day so we take pictures and post them on the board. We have
educational boards. We try to engage them and keep them feeling like they are part of what is going on here.

Overall, Cardiac Rehab staff appeared to take pride in the care they delivered, and liked how the procedures they followed integrated with patients and their families.

Patient Experience, Feedback, and Empathy

The Nuclear Medicine workgroup and their working supervisor—who is part of the functional supervisor workgroup in the Radiology department—gave numerous examples of how empathy and feedback improve the patient experience and motivated their own engagement. She and the Nuclear Medicine staff spoke to the importance of: (a) practicing empathy by putting yourself in the patient’s shoes, so you can truly see it from the patient’s perspective; (b) being ready to make the patient the first priority even in the face of conflicting demands; (c) keeping communication open with a patient from the time they enter the department until the moment they leave; (d) and being a champion for the patient within and outside the department even when administrative tasks and work schedules pressure you to do otherwise.

The Nuclear Medicine employee felt every hospital employee should ask, “How would I want to be treated if I were a patient here?” He felt it was his job to acknowledge up front to a patient how coming to the department for tests is scary, and then “engaging the patient and finding out how they are feeling, to determine how thorough one needs to be in describing procedures or sharing information.” However, the Nuclear Medicine employee consistently faced performance reviews from his workgroup leader that differed from his priorities. The employee wanted “to make the patient feel comfortable” and not cut “the patient experience short, just so I can stay on schedule.” The workgroup
leader, however, wanted the employee to stay on schedule and complete administrative tasks in addition to his direct patient care activities. Interestingly, 14% of employee respondents strongly disagreed that their leaders wanted to know “what’s important to you?” However, 21% strongly agreed, and 64% agreed sometimes that their leader did want to know. One possible explanation for this response variation is that clinical people, like the Nuclear Medicine employee, face competing priorities. They want to do what’s best for the patient, yet have administrative tasks that their managers also want them to complete while staying within the expectations of performance.

Another concern of the Nuclear Medicine employee was the ratio of patients to staff. He explained how throughout the hospital “people are overwhelmed with patients.” He felt the ratio of patients to staff is too high. He voiced the concern that the issue was not so much about how many patients someone sees everyday but rather about “the amount of time you get with the patient.”

The new Nuclear Medicine employee described how she was always looking for ways to be more efficient without compromising patient care. She noted, “We try to cluster the patient care by improving communication between departments, allowing multiple services to be provided consecutively.” Like her senior colleague in the Nuclear Medicine workgroup, the new employee concurred, “It’s important to step back and view things from the patient’s perspective. All patients need to feel that they are a ‘top priority.’ The satisfaction from the patients keeps you engaged.” She went on to say, “You can be having a rough day. You can be unhappy coming in the morning, but you put on that happy face as much as possible to take care of the patient. Then when they
thank you, or even if they don’t thank you, you can feel like you helped someone that
day.”

In addressing what he viewed as distinctive in the Nuclear Medicine group’s
interactions with patients versus what he had noticed with other departments, the Nuclear
Medicine employee noted how within Nuclear Medicine

inpatients are greeted right away. Any delay in service is communicated immediately.
While walking patients back to the department, communication begins, and this is
when you get a sense on what kind of patient you will be caring for. Personalizing
interactions with patients makes the process less mechanical and more engaging.

The Nuclear Medicine employee did not feel that putting the patient first was a
common practice across other hospital departments.

For the working supervisor on the highly engaged Radiology workgroup, there
was the dual role of being both the supervisor of and a clinician and administrator within
the Nuclear Medicine modality. As a working supervisor she described “having to plan
ahead, gathering as much information as possible, to bring patients to their department
floor.” She had responsibility for tasks, which required “planning and communication
with involved staff essential to processing all aspects of a patient’s procedure and care
within scheduled times.” In addition to scheduling, a working supervisor had to work
closely with people in other departments to ensure “protocols and preps that the nurses
need to do before the patient even arrives in the Radiology department” are completed.
Yet, even amidst the planning and scheduling challenges, like her Nuclear Medicine
colleagues, this person was a champion of patient care as the first and foremost priority.
The working supervisor noted that “many patients are frightened and in need of
assurance. Age and language can compound the anxiety. Small gestures of assurance: a
simple hand-holding or rubbing of the brow can make a large difference.”
While talking about the administrative aspects of their work, Cardiac Rehab staff relayed how patient feedback was valuable to their high engagement. They said it “keeps us attuned to identifying weaknesses and changing our programs into something better.” One person mentioned, “Sometimes you think patients may not be paying attention, but they do, they pay a lot of attention.”

Other workgroups like the Clinical Education staff mentioned they have staff members who work directly with patients, but for the most part they provide a different range of services. These include conducting training in best practices to both clinical patient and outpatient staff across the hospital. This Clinical Education workgroup indicated that one of their major goals was “helping speed up recovery of the patient so they can move on.”

Regulatory and Human Performance Concerns

Members from several workgroups commented on the patient experience in the context of a regulatory environment and work performance. Speaking on the topic of patient safety, an Executive Services person noted, “Our team is incredibly impacted by all the mandates that come down, a lot of it is regulatory, either state or federal, that come through. I think the goal of all these things is patient safety or better care, so all that is good.” On the other hand, another Executive Services member reported a big challenge at the hospital is “our work force is very diverse, people who come from all over the world. Some of the basic stuff that you would expect people to know when taking care of patients and families, they don’t get.” She mentioned “things like talking on the cell phone, dressing appropriately, not talking about patients when other patients can hear them, these are just basic respect things.” The staff member allowed how “part of that
just comes with maturity. You slow down. You are still able to be polite even though you are completely consumed with work.”

The Nursing Administration workgroup has the unique position of having clinical expertise, and also being responsible for running the hospital’s clinical staff. As such, they have the tasks of: (a) implementing and monitoring regulatory mandates and standards; and (b) hiring, supervising, and identifying resources necessary for staff to do their jobs. One concern raised by the Nursing Administration employee was that she had to collect numerous metrics on engagement and patient care. “We cannot do well collecting all 30 of those presently required. . . . Right now we are under more stress than ever, because of all the outcomes and measures and metrics and everything people are working on.” The Nursing Administration member went on, “It is crazy because we are up to our eyeballs in data and statistics and audits and answering to them, and at the same time you have to turn around and not brow-beat staff, because they are the ones who have to perform.” She added how, in any event, “that patients are safe is the number one priority.”

For the most part, both the Human Resources and Executive Services non-clinical workgroups influenced patient care on a more indirect level by providing and monitoring the operational functions of the hospital as well as providing staff, budget resources, and equipment for people to be able to do their jobs.

**Workplace Conditions Contribute to High Engagement**

This section presents how workgroup participants described conditions that facilitated their high engagement and some that did not. These included:

(a) Opportunities for Continuous Learning; (b) Involvement in Recruiting, Selecting,
Hiring, Orienting and Retaining Staff; (c) Work-based Communication Practices; and (d) Work Environment: Workspace, Equipment, and Attire.

Opportunities for Continuous Learning

Workgroup members spoke of continuous learning as both a goal and value in their workplace. People mentioned how learning events and various forms of professional development helped build collegiality and respect among staff. It also allowed people a break from the day-to-day grind.

There appeared to be general agreement among Human Resources staff regarding the benefits of having team-building sessions not only from the learning standpoint, but also because it built collegiality and respect among workgroup members. One person commented:

You can get out of the day-to-day grind, and you really get a renewed appreciation for each person as an individual and it is fun. It just renews your whole sense of understanding about one another, and that we are all different, but we all add value in different ways. We have different personalities and different strengths. And where there are weaknesses, others help to build up; when one is down the other can help to build that person up. . . . The main thing is just to really have respect for one another.

In addition, workgroup members described various ways learning took place through activities like planned retreats, departmental education sessions, problem-solving meetings, and guest speakers. In the clinical arena Cardiac Rehab staff praised their department’s ongoing monthly educational sessions on topics relevant to the staff, often given by fellow Cardiac Rehab staff.

Further examples of ongoing learning included one from a Radiology employee who mentioned how her director sometimes paid to bring in a speaker for a learning event. The speaker was videotaped for others who could not be there. She also mentioned
how the director “encourages us to continually learn.” She had recently heard that he named her to be the Radiology Safety Officer (RSO), the coordinator in training. “If I pass, I will be the RSO. This is usually a physician’s job. I will be the first of my peers.”

Clinical Education staff reflected on how their job invoked a passion for learning, and how they shared that learning with other clinical staff in the hospital. One member commented, “Passion for lifelong learning is probably why we all came together. Some nurses just don’t have that passion, and they aren’t interested in journals and articles and best practices. Everyone in this department has that passion and drive for learning and best practices.”

Like the experience recounted by Cardiac Rehab and Radiology workgroup members, people in the non-clinical Executive Services department also described group meetings as a source of ongoing learning. One person mentioned how at their weekly meetings “we talk about the here and now and what is going on. If somebody has a bad outcome, they are unhappy that it happened, but they are comfortable enough to realize it is not a reflection on them, but how do we fix it.”

On another topic, several workgroup members cited the connection between continuous learning and performance outcomes. The Nurse Administration employee repeated a motto she learned from her boss that “what you accept is what you teach.” The employee reflected on how “the behavior that you accept sets the culture.” For her that meant, “Let’s not just say something has to be done, but what is the best way to be done.”

A recurring problem that emerged in the conversation regarding work and performance outcomes pertained to difficulties with the new EMR system recently implemented in the hospital. Workgroup members talked about how it troubled them that
the training was not sufficient for employees to really come up to speed. Nor did they feel prepared to translate the new system to use at the bedside.

Some workgroup members described how they found themselves enmeshed in helping with the EMR system implementation, while still also trying to do their full-time jobs. For example, the new Clinical Education employee recalled the training problems associated with the new EMR and how it affected his work. “It is such a complex and in-depth system, and it is hard to learn the full capabilities without having the time to play with it.” However, having that time can’t happen, “because you can’t play with live patients, and the training environment does not reflect what is going on in the live environment.” Further, the same employee reported how the lack of training across different menu options in the EMR, and the lack of standard processes, resulted in great frustration. He said these problems “put a cramp in our services” especially for fast-paced services like the Emergency Department. “There is no doubt. When we went live with the new EMR, it just tanked our workflow. It shined a big spotlight on processes, and we are still ironing those out.”

On the same topic, the Nurse Administration employee explained how she’d like to have seen learning activities associated with the EMR more readily incorporated into the daily routine. She felt the EMR should have been more fully integrated with the daily workflow, processes, and procedures that occur on any given day in the hospital. She commented, “I think it is imperative that we don’t forget the staff at the patients’ bedsides. We have to make sure that meaning is attached to changes and processes so that all involved understand the importance of the new procedures.” In general, the feelings
about the EMR conveyed a sense that more had to be done so staff could feel comfortable using it at the bedside.

Responding to questions pertaining to learning and development of employees in the Manion survey, two sets of responses emerged. When asked if “development of employees is a key goal in this department,” 50% of staff strongly agreed and 50% agreed sometimes. Yet, when asked if their leaders were concerned about “what are you interested in learning?” and “What opportunities are you interested in?” 43% strongly agreed, 43% agreed sometimes, and 14% strongly disagreed that leaders were concerned with these matters. The differences in responses may have occurred because the clinical participants were steeped in implementing a new electronic medical record (EMR) system, and what they regarded to be insufficient employee training on the EMR. On the other hand, non-clinical workgroup members in the study did not have to learn the new EMR system so may have been more in agreement that development was a key goal of their departments.

Involvement in Recruiting, Selecting, Hiring, Orienting, and Retaining Staff

The implication of bringing new staff into the organization and its impact on engagement among workgroup members was talked about at length in the focus and interview sessions. Most workgroup members indicated they had some involvement in selecting new staff and in orienting new members, but mostly in orienting new members. The amount of involvement varied. This pattern was also apparent in a response to the question, “Department employees are involved actively in the hiring and selection process of new employees,” where 57% strongly agreed, 29% agreed sometimes, and
14% strongly disagreed that employees are actively involved in selection and hiring practices.

One workgroup that is heavily involved is the Human Resources workgroup. Members spoke about working with internal customers in the hospital departments to recruit and hire staff. A Human Resources staff member remarked, “The key is to have that strong partnership where they [department leads and managers] develop: the trust that they respect your judgment, they trust the candidates you screen and the ones you send to them, and they trust your judgment on other issues.” Furthermore, she stated it was an ongoing challenge to “just keep the partnership going and work together.” She noted that some high-stress areas, like the Emergency Department, have high vacancy. Subsequently, the task became “to think about strategies for that area and just meet and talk about it.”

In addition, Human Resources staff explained how in hiring for their own department they “do a group panel interview,” and then “debrief later about the qualities of the candidate, and the fit, and the reasons why we feel they are a good fit or not a good fit.” Consequently, “when we interview we are just looking for the same type of values and work ethics and compassion for the job; and, when they come, we always want to make people to feel part of the team.”

Human Resources group members described the department’s purpose as being to serve the employee and take care of their needs. For the larger Human Resource team it would be the hiring, the orientation process, to show that first good impression of us, to create a nice warm environment for those new people coming in who are probably anxious, to show them that this is a place they would want to work.

The sentiment among Human Resource staff was, “You have to want to be where you are to make a difference. To be engaged.” People talked about how engagement
starts from the top, and how it “trickles all the way down, which makes a huge
difference.” They also felt that each individual person who is being considered for a job
has to “have the drive, the motivation, and the focus. They have to want to be here.”

However, while talking about turnover as a recurring problem for the hospital,
Human Resource staff said they’ve had difficulty retaining staff in their own department.
This included a 33% turnover in their workgroup since they participated in the Gallup
2010 employee engagement survey. Group members felt they could do a better job at retaining staff, but it required providing clearer expectations for all involved. One person said, “It is important that everyone be held to the same standard. If expectations are there, and are not being fulfilled, it is management’s responsibility to counsel and hold accountable individuals who are not compliant.”

Other workgroups also described being affected by the selecting, hiring, orientation, and turnover of staff. Cardiac Rehab staff talked about how they have experienced a number of staff leaving, and what it felt like to be the ones trying to hold things together. “As our facility expanded, we had two new employees come, but over the past couple of years, we have more people leave than before. And that was challenging.” The people interviewed noted that “we are the two of the people who have been there the longest now, and we have actually discussed how sometimes that has been stressful for us.” In talking further regarding the staff departures, one person explained:

It’s like if you lost two of your family members, and they went away and never came back. That emotion along with the emotion of what was going on. So we feel like we had recovered from all of that and this year we lost a couple other employees. . . . It was just because they got new jobs at the same time, so we were like really, are we going to go through this again?
On the topic of hiring new employees and finding the right fit for their workgroup, the Cardiac Rehab staff recounted their unique interview process. Job candidates are required to spend an unpaid day shadowing in daily schedules. Candidates are then evaluated on how well they interacted with patients and other employees. Moreover, the Cardiac Rehab department also appeared to have a consistent, standardized approach to orienting the new employee. “We have the binder that has all the orientation stuff, competencies, checklists and stuff.” New employees get to shadow their primary lead, be that a nurse or physiologist, and also to shadow the secondary lead, “to get a much more rounded approach.” Once hired, “we have some sort of party going on that week so it helps with their engagement; they think ‘OMG is that how it is going to be? I really love this place.’” Furthermore, staff members were clear that while they don’t know that anybody ever says it, “there is not the option of not being part of the team.”

Clinical Education workgroup members described bringing new members onto their team by helping to integrate them into the group as well as to the hospital—whether the person is new to the job, or new to the role. Team members recognized it is not easy for a new person to come into a fully integrated team, and cited the importance of providing the support necessary to help the person to acclimate.

Asked about how the Nuclear Medicine modality incorporates new people into the group, the workgroup member responded, “We have students that do rotations. They are from the community college program.” He explained that “when a new student comes in to observe, we all serve as mentors to the students, shaping them into what we are all about at TCH. If we have an opening, and they have shown the potential to be hired in our department, they have a head start on procedures.” The Nuclear Medicine employee
added, “I feel like when they are done with their rotation here, if they were licensed technologists, they could work here. That rotation is a semester long, about twelve weeks, working here four days a week.”

The Nurse Administration workgroup is also involved in the selection and hiring of new staff. “A Nurse Administration candidate would interview with the recruiter, and then interview with us, and also with other senior executives. Then they would have a panel interview with other directors. So we would meet maybe five of us in a room, and talk with the person for about an hour.” Traits the workgroup looked for in a new member included “wanting the role, rather than the title, so someone who really has a healthy respect for the amount of work involved in doing it well.” The Nurse Administration person looked for “a team member, and not someone with a personal agenda.” Other desirable traits she listed included: “Being a contributor, exhibiting strong interpersonal skills, and demonstrating a solid work ethic.”

On the whole, except for Human Resources and Cardiac Rehab staff, there was little conversation among other workgroups about employee retention or turnover and its effect on workgroup morale or engagement. Instead, most of the workgroup conversations focused around finding the right fit between current staff and new hires, or the interview process itself. In response to the survey, “When interviewing job applicants for this department, we consider the personality and ‘fit’ of the applicant a priority for hiring,” 79% strongly agreed to the importance of an appropriate fit, 21% agreed, and no one disagreed.
Work-based Communication Practices

This section describes workgroup members’ perceptions regarding the constant need for good communication within their departments, and ways in which it was occurring or not occurring. People spoke about how media—like email or cell phones—could either support or hinder communication among staff. They described problems which arose when there was a lack of procedural consistency in working remotely, or when people failed to check in when doing evening or weekend coverage.

Opening up the conversation, a Cardiac Rehab employee spoke of good communication as being essential in any workplace. She said, “I would make sure people are on the same page, keeping your communication lines open in the right way, going to the right person if there is an issue, don’t assume things or take things for granted.” The question this raised for another Cardiac Rehab employee was whether it was possible for people to really feel comfortable “opening up to whatever we have to say to the manager or to our higher ups.” Interestingly, this was less a concern for the survey respondents, because 71% strongly agreed that at TCH, “employees are comfortable giving managers direct feedback,” 29% agreed sometimes, and no one disagreed.

Further on, workgroup members expressed various points of view about meetings they had to attend. Cardiac Rehab staff liked having agenda-driven weekly staff meetings and bi-weekly department meetings, where they rotated the role of running the meetings, and “people are able to share with each other.” Cardiac Rehab staff members recalled how “everyone was overwhelmed at different points” during the implementation of the new EMR, and how they were able to “hang together” in spite of the tension by allowing each other to operate as a team who “do not take venting as complaining, but as a safe
environment to decompress and gain team support.” Cardiac group members also acknowledged one of the things they learned in installing such a huge innovation was being able to accept help from others. Part of their adjustment included addressing how to deal with conflict. People had to recognize that “conflict resolution is important. You have some successes and some failures.”

A Radiology employee called their workgroup meetings “the best staff meetings ever. They are very well organized.” She applauded their leader who “builds the agenda with objectives he wants to accomplish.” In addition to regular functional-area meetings within the department, the whole department, consisting of over 100 people, had on average three meetings per month. “We have one for the weekend staff, and we have two on designated days so we can get all shifts. So when we do the weekend Radiology meeting, all of leadership comes in to cover for the staff so they can attend the meeting. We do that voluntarily.” Similarly, 100% of the workgroup respondents strongly agreed in the Manion survey that “we have regular department or staff meetings that include active dialogue on current issues and concerns.”

Conversely, the Nuclear Medicine employee did not find meetings productive, saying, “There is a lot of wasted time in meetings.” He complained, “The facilitator is not always able to keep things on track,” and too frequently meetings interfere with being “able to do what I need to for the patient.”

The Nurse Administration employee spoke about having frequent meetings with her workgroup colleagues and their director. “We have those once a month. We have a nursing director meeting, and we have nursing leadership meeting once a month. At nursing leadership are nursing directors, managers, educators, and then we are having the
managers of Respiratory and Radiology attend.” She spoke about the importance of this kind of communication, and how it fostered respect among her workgroup colleagues, and the staff whom they manage. She explained, “It can’t just be a job. If I look at all my peers, they are all in the game, they are here to play, and they are invested.” All (100%) leader respondents strongly agreed, “We have multiple methods of communicating important information within the department.”

In addition to discussing the value of meetings in fostering communication, workgroup members spoke about the advantages of communication tools like email and voicemail to enhance workplace communications. They also spoke of how some of these tools could be improved to advance their intra-departmental communication.

Clinical Education staff liked using email as the primary means for communication, and using Vocera, which is a portable phone that works in-house and allows them to locate and communicate with other staff members. The Nuclear Medicine employee also appreciated having Vocera for coordinating patient care as well as for fostering engagement with other workgroup members. In contrast, a problem the Radiology employee experienced with both email and voicemail pertained to people working from home, working after regular work hours, or being on call after hours. She explained that problems occurred in coverage, because people had not checked their messages. She stated, “There has to be better communication, because most of the time when there is a break in the operation, people say, “No one told me.” So, “we have to find ways to get it across to them, especially those who are here after hours.” She maintained that one obstacle to improving the situation is “the average employee does not log in after hours at home.”
Work Environment: Workspace, Equipment, and Attire

Workspace, equipment, and attire all contributed to how people viewed their work environment. Starting out, some workgroup members spoke about the advantages of working in a centralized area with each other, and the camaraderie and communication benefits that resulted. Yet, others spoke of the disadvantages of being allocated to a workspace separate from the hospital, and how certain departments lacked the space or equipment important to providing quality patient care.

Human Resource staff began by describing how happy they were about a recent move to a new workspace, and not having to be housed in a trailer anymore. They were excited because “it will be a fresh start” in a location where they could feel safe and secure while at work.

The Nuclear Medicine employee also liked his workspace and explained why.

We have the main control area and scan rooms. They each have their own doorway into the hall. When you come into the scan room that is your room. So you feel private and have the space to go over everything with the patient, and you don’t feel you are being watched. You can control the lighting, put on some music, and quietly walk in the department. It is quiet for them, not like they are in the hubbub.

Nevertheless, the Radiology workgroup member who also supervises the Nuclear Medicine modality felt there was still much to do to improve the quality of the Radiology department workspace for both employees and patients. She said, “It is so antiquated. The flow is not functional to the needs of the patients that we have. None of the bathrooms can fit a wheelchair. No private space. Lounge is really small. We have been on the radar for construction for several years.” However, even given the restrictions of the Radiology department workspace, the employee felt it was important to overcome such obstacles. She said this could be done by “being neat, organized, on time, professional,
communicating, having the dynamics of in motion, readiness, having the equipment that we need, that it functions well, the supplies and it all comes together.”

The Clinical Education staff members attested to the advantages of being together as a centralized department saying, “Everyone used to be in their own silo. There was competition before, hoarding of information, not sharing work done. The benefit of the new space is the positive reinforcement for self, and drawing from other experts, and expanding your own knowledge.”

Cardiac Rehab staff commented they too have a common workspace. “We are in a close environment and at the same times of the day. When you have groups that are all spread out, it is much more of a challenge.” On the other hand, being located in a building separate from the rest of the hospital, as Cardiac Rehab is, was seen as a challenge. To address this concern, Cardiac Rehab staff got uniform “jackets with logos on them” so patients and other staff would recognize who they are.

On the topic of equipment, Cardiac Rehab employees were frustrated when equipment didn’t work. Consequently, when invited to join discussions about acquiring new equipment, they readily jumped in. They liked it when qualified staff were given the charge of selecting appropriate equipment/materials. They felt establishing such support networks built feelings of respect and competency, and more evenly divided tasks among the affected departments.

Different from the Cardiac Rehab perspective on uniform attire, the Radiology workgroup member said she was troubled about having to accept common uniform attire based on the department. She also didn’t like the way the decision was handed down to employees with little or no employee feedback. While the Radiology workgroup member
appreciated how wearing uniform clothing and colors could help patients recognize someone by department, she preferred wearing a white coat, which she felt better connoted professionalism to the patient.

On the whole, Human Resources workgroup members provided a good summation regarding what supports or challenges communication within workgroups, with internal clients and patients, and hospital-wide. Workgroup members proposed, “The dynamics of a team may change in many different ways, and through all of those changes, you don’t want to lose sight of your organization’s purpose.” In addition, they felt “expectations need to remain focused, and efficient communication must be ongoing.” Finally, they suggested that “opportunities to meet as a staff reinforce why we are here, and provide the opportunity for valuable interaction between administration and staff.”

The theme area pertaining to work environment included questions addressing such things as equipment and the physical environment of the department. Workgroup members showed 77% were in strong agreement in the Manion survey that “the physical environment of our department is clean, organized, and pleasing.” Further, when asked if “employees are authorized to obtain adequate supplies and equipment, even in the manager’s absence,” 86% strongly agreed that they had such authorization. Because operations of a hospital are 24 hours daily, this response likely reflects the confidence workgroup members have in being able to procure what is necessary to do their jobs.

Leaders Contribute to High Engagement

This section presents how workgroup members described leader contributions in developing a high-engagement workgroup. The section is organized under two subtopics:
Leader Characteristics That Foster High Engagement

Workgroup members described personal and professional traits that they admired in their workgroup leaders. People liked having leaders who had clinical expertise, who were on the floor with them, accessible, and who asked staff to do things they themselves would do to meet the job demands. Some leaders (50%) strongly agreed that “I jump in and help out employees with their work on a regular basis” and 50% agreed sometimes. No one disagreed.

The Nuclear Medicine employee spoke of his group leader as having been in the field a long time, saying, “She knows things inside and out, and is very technical and knows all the regulations. You give her a task, she is very thorough and almost nitpicky on things, but it is all for a reason. She wants to have the best department. She has extremely high standards.” Basically all the workgroup respondents to the Manion survey agreed (93% strongly, 7% agreed sometimes) that “the standards for performance are very high” in their departments.

Likewise, the Radiology department employee appreciated when her leader is on the floor with them and when “the leader has a clinical role and works along beside us.” Clinical Education staff also said they “have a good leader and they respect her. She has balance with the job—patient contact and education make great personal satisfaction.” The new Clinical Education staff member said he’d like to see more leaders who have a combination of clinical expertise and management skills. He thought this would be a winning combination for a workgroup leader.
In a different conversation, a Human Resources employee respected her group leader because when she was working on holidays and staying late she saw the “leader doing the same thing.” An Executive Services staff member acknowledged how her leader supported the need for flexibility to accommodate a very demanding job. She explained, “When necessary I would make up missed hours elsewhere in the schedule. I appreciated the trust of my administrator and the support of my co-workers. Everyone knew that the work got done.” Similarly, 100% of Manion survey respondents strongly agreed that “management believes that I am an honorable person, and if I tell my manager I need something, he or she believes me.”

Another Executive Services group member felt their team’s successful engagement was due in part to the leader creating a safe environment where, if problems arose, people felt comfortable talking in front of each other, and having a broader discussion of what “might work in another situation.” The Executive Services employee commended the leader for the trust he places in his staff, and how “he is exciting to work for, because he accepts people for who they are. He understands the talents that he has tapped into to make up this team, so it is not a cookie-cutter approach; it is ‘I need all of you.’”

Describing traits of her workgroup leader that keep her engaged, the new Nuclear Medicine employee declared, “I like my team, and the leader is great. She is what makes our team. She is what keeps us together, keeps us rolling. She is a leader that will always stand behind you if you have a problem. She will never throw the team under the bus.”

The Nursing Administration group member spoke of her group leader, the Chief Nursing Executive (CNE) for the hospital, as one who “really shows fairness and equal
respect for everybody.” She said he manifested this behavior by letting the Nursing Administration workgroup “own our expertise and our professional practice, and he allows us to be leaders among our group so he doesn’t try to own everything and give directives.”

Cardiac Rehab group members recognized their leader as being supportive in giving them ongoing feedback, asking for their input, and congratulating them when they do a good job. Staff also enjoyed receiving a personal note, email, or meal card from their leader, because it “also helps keep us engaged.” They valued when their leader approached “you as an individual; being able to just come up and talk with you and engage you, and asking you if there is anything she can do for you.”

The new Clinical Education employee exclaimed, “I have one of the best bosses in the hospital,” because “she is so supporting, knowledgeable and cares. I don’t know where she gets her energy, but she is really good. Anytime you need her, she is there. If she is busy, she will make time for you. Above all, she cares.” He stated that his boss demonstrated her caring “just by being there and kind words. She can make corrections to what you are doing without making you feel like you are being stepped on.”

Other characteristics cited as indicative of good leadership were open communication and involving staff in decision-making. The Nursing Administration employee said her leader “comes to us, as a group of nursing directors, as the leaders of nursing, asking how do you think we should go about this, and, how should we put this together?” Essentially, “he allows us to be the person who owns it and presents it to our peers. And he just kind of facilitates that being able to happen.”
Likewise, the Radiology workgroup member described her department leader as able “to present things to them, and give them options on how to resolve things, and how to inform others in the department about those solutions.” She recounted, “We spend a lot of time going over and over scenarios. I don’t feel like there is a stone unturned. We get the information from him, we go back and go over it with our team members, and then he again goes over it with the whole department, twice a month, so there is a lot of communication.” The Radiology employee wondered, “When I step outside of Radiology, I want to know, do the other directors not do this? Why are there always these breakdowns in communication, when I step outside of Radiology?”

The Radiology group members also applauded their leader for being an innovator trying to improve things (like cleanliness) that are good for the hospital as well as good for the department. One employee said, “He must be the luckiest director in the hospital, because people who work directly underneath him, we pretty much buy into this every time.” She gave as an example the “Adopt a Spot” project within Radiology to improve the work environment, and marveled at the leader’s ability “to get things done.” Even amidst some negativity and naysayers, the leader was “able to still lead and get people to buy into it, and they did it for a long time. We have hundreds of pictures of people scrubbing the floors, the walls. We bought things with our own money to decorate.” In talking about why people engaged around this activity, which wasn’t part of their clinical job, the Radiology employee said, “The biggest thing that must engage staff is that they want to be recognized for being very good at what they do, and they want the patients to feel good about the environment that they are in.” Likewise, the majority (77%) strongly
agreed in their survey responses that “the manager works to ensure that the physical environment of our department is clean, organized, and pleasing.”

Overall, while the Radiology leader was cited because he “does not threaten people,” and “he is very genuine when he approaches you about anything,” a workgroup member cited a recurring situation where the leader was not successful in dealing with physicians’ negative behaviors toward the Radiology staff. She commented how most of the time the physicians are “very negative, they are outspoken, they are inappropriate, they are very condescending, and demoralizing.” She felt a more concerted and consistent effort among hospital officials was needed to address issues with physicians if anything was going to change.

How Leaders Role Model Behaviors Conducive to Fostering High Engagement

In conversations about leaders as models for the behaviors wanted in the workplace, people spoke about how their leaders promoted goal setting, learning, good communication, and shared decision-making among their workgroups, and how this led to higher employee engagement.

As mentioned earlier in the chapter, people appreciated leaders who were flexible in providing coverage when someone needed it, and who treated them professionally—looking at all sides of a problem before considering how to resolve it. The new Nuclear Medicine employee described the feedback mechanism her workgroup leader provided to staff. “She always sets goals for us. If she sees something that we are okay at, the goal for the upcoming year would be to improve, and she sets the steps on how you can improve.” In addition, the new employee admired her workgroup leader because “she will switch
her shift with you. As a leader she won’t ask you to do anything she won’t do herself. I think that is what makes it comfortable so that you know you can approach them about anything.” The survey responses indicated that all of the employees agreed (71% strongly agreed and 29% sometimes), “The manager believes that one of his or her most important jobs as a leader is to facilitate the work of our employees.”

Moreover, the new Nuclear Medicine employee valued her leader for taking time to walk her through protocols and regulations she needed to know; not assuming that it was something the new employee could pick up elsewhere. The employee commented, “If there is stuff that we get, are not very familiar with doing and never did as a student, I can ask her to walk me through the study. She will say ‘of course.’” Also, the leader walked the new employee through the department while pointing out “where all the laws and regulations are” for all areas of the hospital. Further, the new Nuclear Medicine employee noted how the workgroup leader “always makes herself available—no matter if it is 1:00 in the morning or 1:00 in the afternoon. She always says to call her if we are here by ourselves and have a question. And there were many times in the beginning when I would call her.”

The Nursing Administration employee said her group leader models team building and learning by fostering the group’s shared decision-making and shared governance. He does this by engaging group members in handling matters at hand, and by encouraging “a very healthy discussion” about whatever comes up. She mentioned how the leader’s behavior is consistent even when thorny situations arise. For example, when there was an “issue with a couple directors trying to undermine the team and implement things on their own,” the Nursing Administration leader didn’t hesitate to rein
it in by saying, “Let’s have some consistency, and make sure everyone’s voice is heard, and that it is a team decision.” “So he is very good at supporting us as a team.” Survey responses appeared to be consistent with the experience of the Nursing Administration employee. Basically, all of the workgroup respondents (93%) strongly agreed that “our manager models the behavior he or she expects to see in employees and colleagues.”

Many workgroups admired how their leader modeled the behavior of “following through on what they say they will do.” Moreover, several commented how outside of their workgroup, they felt it is important for leadership huddles to include staff organization-wide. “Huddles involving executive leadership and staff are important for real-time problem solving and sharing success stories.”

An Executive Services group member mentioned how her group leader has “been working really hard with us to feel empowered” to fix problems. In other words, to feel “empowered to take care of a wrong that you see, a behavior problem, the breaking of the rules,” and “to make it right.”

Likewise, the new Nuclear Medicine employee remembered her group leader saying, if a question or problem arises while we’re on the job, “she would rather we call than something goes wrong.” Furthermore, “if something needs to be changed, she [the leader] approaches it right away. She doesn’t let it get worse, and she gives you that chance to change, even if minimal.” Also, she said the leader asks people their opinion. “We will sit in the office and brainstorm, or she will send it out in an email and then run it by everybody else to see if that is what they want to do.”

The new Nuclear Medicine employee also liked how her group leader modeled the behavior she preached. She gave an example of how the leader supported her when a
supervisor in another part of the hospital complained about the new employee’s work. The workgroup leader’s behavior was to ask “what your side of the story is; and, she considers both sides. And if it was that I was doing something wrong she will address me, but she will speak to me privately. She won’t call me out in front of anybody.” Further, the new Nuclear Medicine employee appreciated when her group leader “sees something that is not going correctly, she does something to fix it as soon as possible.”

The Nursing Administration interviewee provided a list of behaviors she feels her workgroup leader models. She liked that her leader: (a) is “accessible” with an open-door policy, (b) is “not a micro manager,” (c) “has faith that he has the right person in the right seat, and he knows that I will do my job and he does not have to hover over me,” (d) will “give you guidance” but is not “going to tell you how to do it,” and (e) pays “the highest compliment to an employee by asking you for your advice.”

It must be noted that some actions and practices identified in Manion’s survey showed a wider variation in staff responses than some previously cited. In the questions regarding putting the employee first, and questions related to leaders partnering with employees, the greater majority of the staff either disagreed or agreed only sometimes.” For example, in response to the question, “My manager puts the employee first when making decisions and solving problems,” 46% agreed sometimes and 8% strongly disagreed. On the topic of leaders partnering with employees, 14% strongly disagreed and 43% agreed sometimes that “our managers regularly help out employees with their work on a regular basis.” The fact that these responses varied indicates that employees don’t necessarily feel their leaders are consistently putting them first or partnering with them on things that matter to employees.
Summary

In conclusion, for the most part the workgroups viewed their high-engagement teams as being passionate, cohesive, balancing professionalism with having fun, supporting each other, caring and being appreciative of each other. Workgroup members had a problem with those who expressed an unwillingness to work in support of each other. Clinical staff in particular emphasized the importance of valuing patients. Their empathy with their patients had an inspiriting effect on new workgroup members.

All of the high-engagement workgroups spoke of the pros and cons of their work conditions. Furthermore, they had a common resilience of looking to each other for support with mutual respect and trust. Indeed, workgroup members faced head-on the day-to-day working conditions over which they may have had little influence or control. These highly engaged teams were able to both handle challenging workplace conditions and still celebrate their successes.

Group members valued open discussion with their leaders and the ability to talk about what was working or not working in their department, or hospital-wide. Many of the people acknowledged and appreciated how hard their leaders worked. They cited ways in which their leaders covered for them or cleared the path for them to be able to do their own jobs.

On many occasions, an esprit d' corps extended out from the workgroups to their leaders. People enjoyed their interactions with their leaders in both professional and personal circumstances, while watching and learning from them.
Chapter 5 is designed to address the research question: “How do leaders contribute to developing high-engagement workgroups?” It uses words and perceptions captured in the ebb and flow of conversations with leaders. The organizing themes for presenting this material are the same ones used in Chapter 4. This is because common themes emerged during the larger analysis of the entire transcript data collected from both workgroup members and the workgroup leaders. Those themes pertain to how: (a) Teams Contribute to High Engagement, (b) Valuing Patients Contributes to High Engagement, (c) Workplace Conditions Contribute to High Engagement, and (d) Leaders Contribute to High Engagement. Some of the subtopics under each theme may vary from those used in Chapter 4. Again, the goal was to capture the flow and details of those conversations. Four of the seven leaders involved in the study (51%) completed the Manion survey. Their responses are integrated into the theme sections. The goal of incorporating the survey information was to enhance the readers’ understanding of actions and practices high-engagement leaders used to contribute to developing high engagement in their workgroups.
Teams Contribute to High Engagement

The leader-related Team theme section examines how workgroup leaders characterized teamwork and described actions and behaviors they felt contributed to developing high engagement. The content is segmented into the following subtopics to capture the flow and details of those conversations: (a) Shared Values and a Passion for Their Work, (b) Cohesiveness Matters, (c) Balancing Professionalism With Having Fun, (d) Support for Each Other, and (e) Appreciating and Acknowledging Each Other.

Shared Values and a Passion for Their Work

Clinical and non-clinical leaders described how having a passion for their work and shared values are fundamental to developing high engagement. Workgroup leaders spoke about the importance of finding people who have a passion for their work and who have shared values. A couple of leaders mentioned they are reassured they have the right people on their teams when colleagues from other departments give them that feedback.

The leader of the Cardiac Rehab workgroup, who since the Gallup 2010 survey has also expanded her role of leadership to multiple departments, was promoted to the Director of Cardiology and Ancillary Services at TCH. Her opinion was, “You have to find people who have passion, and want to do the best by the customer patient. I see this through the staff being dedicated to their work and the patient. I think they feel they have a passion to improve their own outcomes and the patient’s outcomes.”

The leader of the Clinical Education workgroup proposed that employee engagement requires the following actions and behaviors: (a) commitment to the team on an individual basis; each individual has to see the sum of its parts, (b) everyone has a stake in outcomes and objectives they want to meet, (c) everyone contributes their talent,
and (d) we all work together. The Clinical Education leader said her workgroup was unique because it is “a multidisciplinary team where you see strengths in other people and pull them in. It is neat to be able to have a stake in how a hospital-wide process goes, and to partner with a variety of people.” The leader liked “all the different stakeholders around the table with a common goal, and then working on it together.”

The Radiology leader, who has a number of working supervisors running the functional areas in his department, discussed developing high engagement this way:

I find tremendous pleasure in seeing the growth in the team members. I think about, I talk about trust. I really rely on them. Going back to the makeup of our department, and how susceptible we are to being islands, it is impossible for me to be the subject matter expert on every imaging modality. So I do need to rely on my workgroup to help me oversee and run those.

The leader of the Nursing Administration workgroup, who is also Vice President of Patient Care and Chief Nurse Executive (CNE) at TCH, commented on how he has received “feedback . . . validating I have the right team, and that the members of my team are really fully engaged and giving it their best.”

Most leaders viewed their workgroups as separate from themselves. The major exception was the Human Resource leader, who saw himself and the workgroup almost as one. For example, the Human Resources leader thought his job was to help his workgroup members achieve to the level that reflects their best use of talents, knowledge, and skills. The leader did not differentiate between himself and his team. He claimed, “The team is the team. There is not I and the team.” The Human Resources leader noted that when someone left his workgroup, he conscientiously took action to replace the person with someone who has similar skills and talents. For the Human Resources leader, “it is just a matter of time where they will be right where the other one was that left.”
The Executive Services leader, who is also the hospital President, summed up what he looks for in a team. “There is this congenial good-natured feeling where people just like being with you. There is a sense of comfort.” He went on to say, “What I am looking for in a team, if I can find it, is the chemistry, but I have to deliver the skills. I have to deliver the operational performance.”

Cohesiveness Matters

Leaders spoke of cohesion and common goals necessary for developing high engagement. The Clinical Education leader noted how “I have had in the last 2 to 3 months people come up and say, ‘I love your team. I love your group.’” She reported this happened because the Clinical Education workgroup is known for pulling together to solve problems even under tough circumstances. The example the leader gave to illustrate this practice pertained to the Clinical Education team taking on the challenge of planning how to train staff on the new Electronic Medical Record (EMR) to be implemented hospital-wide. The year prior to the EMR installation, the team came to her proactively and said, “You know we are going to have the EMR at the end of the year, and everything is going to be focused on that.” Subsequently, because they planned almost a year out, the Clinical Education workgroup was prepared to act, and as a result 950 nurses and 200 technicians were trained in 6 months. For the Clinical Education staff it meant holding training sessions during the workday, in the evenings, and on weekends. As a team, they came together and completed the task. The leader recalled how her team members “did not complain, or gripe. They were in it.”

Some leaders talked about how a leader must provide clearly articulated expectations and desired outcomes for staff. Others addressed how workgroup members
had a stake in helping to formulate expectations and outcomes, and why it was important for leaders to not micromanage staff. The Clinical Education leader explained why having common goals is integral to engagement. She said it’s all about having clearly articulated expectations, and the space to do it. And not being told. . . . It’s like saying here’s our destination, you guys have to get there. It’s about letting staff know, “You are smart, talented but get there. Figure it out and enjoy the journey.”

Like the Clinical Education leader, the Radiology department leader addressed the importance of allowing people the space and autonomy to perform the jobs they were hired to do. In addition, the Radiology leader recalled how he encouraged his workgroup’s creative brainstorming, and how they subsequently came up with initiatives to improve the work environment for patients and staff. The example the leader offered was an 18-month project, called “Adopt a Spot,” that his workgroup undertook to promote cleanliness in the hospital. The leader described his philosophy that set the stage for the initiative. He reflected how “the best ideas are in the minds of our team members, and you just have to mine it and bring it out.” The leader explained how the staff not only came up with the new initiative, but also how they made a contest out of it. He said staff “became so engaged and excited and enthusiastic, and some of the things they came up with to improve the appearance of the department—I was just amazed.” The leader also recalled how the Radiology department received recognition hospital-wide for the success of this initiative. Seventy-five percent of leaders strongly agreed and 25% agreed sometimes that “most of the improvements in our department over the past year have come from ideas and concerns shared by employees.”
Balancing Professionalism With Having Fun

In talking about the mixture of professionalism and having fun, leaders thought professionalism and fun could be a healthy mix. However, for the most part the leaders agreed that professionalism matters more. For example, the Cardiac Rehab leader said, “We will show that we are professionals most importantly; this is number one. If I am here to advocate for you, you need to tell me the truth with exact facts. I think the respect will be gained by them acting professionally.” She then went on to mention how her workgroup also has fun, and “celebrates birthdays, celebrates recognitions.”

Similarly, the Clinical Education leader spoke about having professionalism first, and having fun second. She stated:

Basically, our overarching goal for the department as a team, which we all decided on together, is to facilitate an environment of clinical inquiry among the staff. We are a very strong team that works together. We all have our separate skills and areas of knowledge, but we come together for bigger projects.

In addition, the Clinical Education leader mentioned, “We celebrate together too, and it feels really good to be part of the synergies that are more than a sum of our parts.”

The Human Resources leader took a different tack in addressing the balance between professionalism and having fun at work. He addressed multiple ways to have fun, and emphasized how people benefit. He said, “It is okay to have fun at work. If you look at it, we spend more time with our employees as a group than with our own families.” Thus, whether it is a team-building exercise as basic as dinner or bowling, having lunch, or talking about things other than work, the Human Resources leader appeared to care about establishing a work environment where “it’s okay to laugh; it’s okay to share a joke; it’s okay to let your hair down.” The leader referred to other work environments he’d been in where it was not okay to laugh, to be a human. His opinion
was that such environments cast a hue of “doom and gloom like a cloud that hung over that environment.” The leader did mention that having fun is okay, “as long as it stays within the appropriate guidelines.” All leader respondents (100%) strongly agreed that “we enjoy spontaneous fun as well as planned fun together on a regular basis.”

Support for Each Other

Leaders recalled how they supported staff through their transparency, open-door policies. They coached trust and commitment from staff to do the best job possible, and acted with candor and honesty if staff met obstacles along the way. One leader emphasized that employee engagement underpinned everything for her. She indicated that her job was to get to high-employee engagement. This meant providing the best equipment, clean space, and best environment possible.

The Cardiac Rehab leader spoke of how in her workgroup “we all support each other and we are like family.” This may include coaching moments with staff, especially because “I think to build a team is to build people up.” In addition, the Cardiac Rehab leader reported how “time spent on recognition averages about 10 minutes at each meeting. I like that workgroup members want to participate. I want respect, but I want them to know I am here to support them.” All leaders agreed in the Manion survey that “employees feel supported by management.”

The Clinical Education leader emphasized ways in which she supported her workgroup members in achieving their goals. “It’s giving them the space to get there and acknowledging in the end that they did it; that it was their work.” She viewed creating space for people to do their jobs was especially paramount for people “with an advanced
practice or people with a profession where they are very proud of their profession—to have that autonomy of practice where they can do it without being micromanaged.”

The Clinical Education leader also elaborated on how supportive her group members are of each other and what makes them so amazing. She noted, “They really work well together and as a team. They have the strength to go off and do what they need to do. They also have respect for one another.” The leader applauded how her team can identify strengths in themselves and others and tap into them in a respectful way. She also commended their mutual commitment to the department goals.

Like the Clinical Education leader, the Cardiac Rehab leader noted that having autonomy to do a job is a measure of support and trust on a team. She recognized that she leads “a group of licensed, professional people who would not have their jobs if they weren’t.” Therefore, the Clinical Education leader felt it prudent to give the staff autonomy to do their job, and let them do what they do best. In return, the leader had to trust them that it would be done right.

In addition, the Cardiac Rehab leader reported that every workgroup member matters on her team. She gave an example of how she differed from other hospital directors in regarding her executive assistant as a full-fledged member of the Cardiac Rehab team, and subsequently gave the assistant the opportunity to work closely with other workgroup members on projects to help achieve team goals. She indicated this was not a common practice of other hospital leaders.

The Nuclear Medicine leader also spoke about trust and respect. She intimated that it’s a two-way street in her department. To achieve trust and respect, the leader intentionally looked for technologists who are focused on the team approach to working
together. She wanted people on her team who are grounded, and who want to be part of the organization for a long time. In addition, the Nuclear Medicine leader explained how her role was to keep her work team’s focus “on the patient experience, safety and well-being. Employees should always be looking out for others in the hospital.”

The Executive Services leader also described how he supports those whom he hires to work on his team. He said, “If I pick somebody, I am also going to commit to their individual goals where I can.” He clearly wanted staff who have an ownership of their work, and who care about their own performance. The leader maintained, “There is an internal motivation to their good work,” so when he can help staff perform well in their own work, he also helps the workgroup perform in achieving the organization’s goals.

Similarly, the Nursing Administration workgroup leader talked about being mindful and attuned to what is going on in the world of those who reported to him. To do that, he often checked in with them and asked, “What would keep you really engaged beyond just the humdrum of coming into the hospital, doing your staffing, doing your evaluations, making sure there is continuity of care?” The leader felt “all those routine things become very routine unless you have other irons in the fire.” Therefore, to foster engagement, the leader did things like asking the head of the Medical Surgery unit “to step up and be the one to modulate our involvement in the ‘falls’ collaborative,” an initiative to reduce the amount of falls among patients. He noted how the Med Surge person agreed to fill in a slot left vacant by someone else, and moved out of her own comfort zone to do so.
Similarly, the Nursing Administration leader acknowledged that while each of his workgroup members had their day jobs, he wanted them to also take on what he called “additional day jobs”—things which kept them networking and engaged with other leaders across the state. The leader championed this practice, because “the collaborative has offered an enormous amount of creative ways to make your job and the patient experience interesting.”

Appreciating and Acknowledging Each Other

All leaders were consistent in their attitudes of wanting to acknowledge and reward the successes of their workgroups. Some leaders built that formally into their regular meetings; others liked to do it more on the spot.

The Nuclear Medicine leader relayed how to earn the confidence of their patients and for staff to “feel a part of a winning team. I don’t want them to ever dread getting up and coming to work. They may dread the commute, but at least when they get here they know they are part of a team and recognized for being successful.” This point of view was confirmed by 100% of leader respondents to the survey statement, “Employees in this department enjoy coming to work.”

The Executive Services leader spoke of celebrating success by reaching milestones along the way, such as “when we successfully achieve a Joint Commission certification or we are working toward a Center of Excellence with some of our service lines.” In effect, he used such celebrations to acknowledge how “people are putting their efforts toward that. Let them all point to something that means something, which is validating to the organization, and validating to those people who are part of something that individually they wouldn’t have achieved.” Furthermore, the leader explained:
There is too little time, it is too easily overlooked. . . . Celebrating successes is an important part of this work. . . . We need to help people feel good about their choices of working in our organization where there is real opportunity. I mean genuine opportunity. . . . We are not taking for granted for their good work. . . . We have a responsibility to refill peoples’ tanks when we can.

On the other hand, the Human Resources leader spoke of a time where his workgroup members indicated they were not feeling recognized for their accomplishments. Consequently, the leader responded by making “recognition a standing monthly agenda item on our staff meeting. Once a month we go around the table, and ask if anyone has any recognition to offer. He noted, “Something as simple as that contributed to the difference of where we were, to where we got to,” in the department’s employee engagement scores.

On a somewhat different tack, the Radiology department leader mentioned that while he might acknowledge accomplishments during a formal meeting, he “tries to give feedback on the spot, just saying how much I appreciate what they have done. I couldn’t run that department without my group.”

The Clinical Education leader, who had cited her workgroup’s efforts in implementing the new EMR, mentioned she was pleased when the Chief Nurse Executive (CNE) spoke to her workgroup about what they had achieved, and offered to take them out to breakfast.

It made me feel happy that it was acknowledged. I felt really good for them that someone observed it; that, I did not have to ask for their recognition. I was happy for them that it was an observation for them that leaders saw.

The Nuclear Medicine leader also declared she publically acknowledged and rewarded success both within her workgroup and within the larger Radiology department where they work. The leader mentioned posting awards on her department’s success
board, including an award from the department of Radiology “for our cleanliness and patient experience.” The Nuclear Medicine leader also brought in treats, randomly purchased lunch for her department, and also held huge events, such as Nurses Week, Apple Fest for the Radiology staff, and National Nuclear Medicine week.

One example the Nuclear Medicine leader mentioned went above and beyond the acts of recognition cited by the other leaders. She used her bonus reward to take her workgroup out to dinner, because she felt they shared in making her successful. The leader felt it was important for her to demonstrate, “I don’t want you to give me anything. I want to give back to you and say thank you. Because if it weren’t for your teamwork and support in moving patients or getting patients, answering the phone, sitting with my patient,” success wouldn’t happen.

Overall, the Nuclear Medicine week of celebrations and fun-filled activity that this leader and her workgroup collaborated on, was a way to acknowledge and celebrate the interdependencies among all the workgroups within the Radiology department. The Nuclear Medicine leader had intentionally led her team in bringing fun and joy and awareness to the contributions of others. Analogous to the interviews, 100% of the leader respondents to the Manion survey strongly agreed that “employees regularly recognize each other and participate enthusiastically in any department recognition events.”

Valuing Patients Contributes to High Engagement

The Patient theme section describes workgroup leaders’ actions on behalf of patients. Leaders talked about patients in terms related to length of stay, treatment planning, and care coordination. Subtopics in this section pertain to: (a) Patient as
Priority; (b) Patient Experience, Feedback, and Empathy; and (c) Regulatory and Human Performance Concerns.

Patient as Priority

Both clinical and non-clinical leaders described how the patient is a priority for them and their workgroups. Leaders spoke about the patient as priority from both a business and clinical perspective. From the business perspective there were discussions about value-based services, which revolve 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 for what the patient faces in navigating the departments and services in the hospital. Some people talked about this prioritization mostly from a business perspective; others spoke more from a clinical or patient-care perspective.

The Executive Services leader, who is also the hospital’s President, explained why he had to focus on both the business and the caregiver aspects of patient care. He said, “We are going to reduce the length of stay (LOS) by improving treatment planning and care coordination. That is most appealing to a set of caregivers.” He added, “A finance person’s interest in reduced LOS is how much money is saved. Both correct, both important, but we have to be sure we are paying attention to those who are actually providing the care.”

In another conversation, which had an eye on business as well as patient care, the leader of the Nursing Administration workgroup, who is also the Chief Nurse Executive, spoke about the impact of healthcare reform, and what he called value-based purchasing. He asked:
How do you interpret what is going on in healthcare reform, both at the national and the state level, digest it and present it to your leaders for consumption in a way that doesn’t overwhelm them? I will give you a few examples. As you know nationally . . . all the pressure is around readmissions; the avoidance of readmissions; and what the potentially preventable complications are. Everything sort of rolls up to ‘Value-Based Purchasing.’ The consumer component of healthcare is emerging very powerfully.

The Nurse Administration leader also noted how people who come to the hospital are using internet services like Google and Medscape to research their condition, and to set expectations for the kind of treatment they want. He allowed that this type of pre-education presents a different type of patient-care expectation from what hospital staff has been used to in the past.

Taking a different tack in the conversation about patient care, the Radiology department leader spoke of wanting to “reenergize our department toward our patient advocacy scores.” He linked the scores to what they imply regarding quality patient care, and commended his team for coming up with another initiative to improve patient care. As in the case of the “Adopt the Spot” project, which his team had implemented in the department for almost 18 months, the leader wanted to tap into the ideas of those with whom he works. He spoke of a new project called the 3C’s: Communication, Comfort, and Cleanliness. The Radiology leader commented how department staff “selected three captains, and those captains in turn recruited or asked for volunteers to be part of that team; the whole purpose of that team was to mine those ideas.” As a result of the planning sessions, “the team came up with actions that we can put into place that will help us improve communication, improve patient comfort and improve cleanliness.” The leader was amazed by the enthusiasm, and the ideas that people came up with. He also noted, though still in its early stages, the staff already seem energized by the project.
Seventy-five percent of leaders strongly agreed in the survey that “most of the improvements in our department over the past year have come from ideas and concerns shared by employees,” and 25% agreed sometimes.

Furthermore, the Radiology leader reported how such initiatives help patients. He reported how his staff deals with a wide range of people—from the highly educated to the less informed patients. Therefore, they must be on their toes to communicate with their customers about radiation in ways that best serve individual needs. The Radiology leader was aware that all patients have anxiety coming into his department, so the department’s 3C’s project shines a light on staff determining “the best way to ensure a great experience to handle those anxieties and concerns.”

Overall, the Radiology leader wanted a broader awareness of the patient experience hospital-wide. Like his workgroup colleagues in Nuclear Medicine and other areas of the Radiology department, the leader addressed the importance of putting himself in the patient’s shoes. He understood how a patient might be confounded at having to interface with multiple departments on a visit to the hospital. Therefore, the Radiology leader felt it was incumbent on everyone in the Radiology department to remind people across the organization:

If you are trying to improve that patient experience you are all going to have to come together to make it appear seamless. If you are operating as an island, you will never have the coordinated care that you will need to provide a great patient experience.

The Radiology leader understood his challenge was “to foster that kind of environment where we are all working together.” He considered the challenge to be a journey where “there is opportunity for us to make improvements.” He was optimistic because “the good thing is that we are recognizing it and working to improve it.”
On a different front, the Clinical Education leader said she tells staff, “You own that patient.” She elaborated, “We have ability to have an influence on how care is provided in the hospital. We need people to step up to the plate and do it.” Expanding on this further, the leader declared, “Basically I and members of my team touch many areas throughout the hospital. I really like that and . . . how patients receive care. There is a lot of quality and safety combined.” She went on to describe the continuum of care she and her workgroup had developed.

Two years ago my team decided that we wanted to take education to the bedside, so we would have that relationship and partnership with bedside nurses to elevate their practice in real time instead of just having them come to a classroom.

Consequently, what the clinical educators did was move to areas of designated specialty. The result was “they are rarely in their offices anymore. They make rounds on their units.” In addition, educators meet with their charge nurses, and ask a series of questions regarding patient conditions, such as, “Do you have any patients with the following: chest tubes; surgical drains, pressure ulcers.” Then, the educators ask the nurses if they have any problems with a specific procedure or situation, and follow up with any information that may be needed. When asked in the survey, all leaders strongly agreed (100%) that “when an employee is having problems, other people in the department rally around and help in constructive ways.”

In addition to this innovative approach to rounding on patients and providing clinical inquiry to nurses at the bedside, the Clinical Education leader partnered with the hospital’s Vice President of Patient Care/Chief Nurse Executive to champion the use of clinical nurse specialists in the Clinical Education group. She explained why this was done:
In being closer to the bedside, our overarching goal is to create an environment of clinical inquiry. By having educators and clinical specialists circulating and talking to the nursing staff at the bedside, they are prompting questions requiring critical thinking, and trying to get staff to inquire why a patient presents a certain way.

Teaching is one means the Nuclear Medicine leader used to inspire staff to stay conscious of the ‘patient as priority’ mission of their work. The Nuclear Medicine leader said she constantly reminds staff and trainees, “We have to touch the patient. There is a whole lot more involved than just getting your paycheck. You really have to take care of the patient.” The leader said she announced up front, “I am going to teach you when you push that button what actually happens in that machine, and how do we get that picture on the screen . . . because when the patient asks you how you got that there, I want you to be able to explain it to them.” Further, the Nuclear Medicine leader advised, “When you get the word technologist at the end of your title, that is someone who understands the anatomy and the physiology associated with nuclear life, and you have to be able to explain it back to the patient.” She declared, “If you are not interested in that, it is probably not going to work out for you.”

Patient Experience, Feedback, and Empathy

In the interviews the leaders talked about how patient experience, feedback, and empathy were the best form of recognition ever received. For example, the Nuclear Medicine leader recalled the best recognition she ever received from a patient. The leader spoke about a cancer patient whom she had taken care of.

All I did was take care of the patient. It is the same way I take care of every patient. She was just so impressed by the people who touched her life when going through cancer treatment . . . that she would even say thank you. That was really an impressive thing to do.
As it turned out, the Nuclear Medicine leader was asked to be a part of a photo shoot with the team and the patient, and found out later that the photo appeared on a Metro Bus and Metro Station in the larger metropolitan area. The Nuclear Medicine leader appreciated the patient’s acknowledgment of the care she had received, saying, “That was a really nice thing she did. She left a lasting impression.”

Regulatory and Human Performance Concerns

Workgroup leaders, who often held other leadership roles in the hospital, addressed the need for hospital staff to be informed about changes in healthcare practices and regulations at local, state, and national levels. Regulatory audits are a fact of life for hospitals. The Radiology and Nuclear Medicine leaders were mindful of both the risks to patients and staff, and the professional standards and criteria necessary for people to work in their fields. All leaders strongly agreed (100%), “The standards for performance are very high in this department.”

The Nuclear Medicine leader explained how she and her workgroup aspired to greater standing in state audits, and achieved a 100% audit rating over a 5-year period of time. Talking about regulations and audits, which directly related to patient safety and care, the leader said, “When I took the job there was a list of things that had to be fixed.” There were many issues she had to address; “I remember working 16 hours a day for many months just to get up to ‘sea level.’” The Nuclear Medicine leader went on to explain:

An auditor can show up at any time. I may be on vacation and I want my department to achieve that same standard even if I am not here. The only way that can be accomplished is with transparency: no secrets. The staff must know how to run the department, and my boss must be equally well informed.
Furthermore, the leader described how after her team got the first “state perfect audit,” auditors showed up 3 years later, and “we got the second straight perfect audit.” From there another audit was conducted 2 months later on another license and they received a perfect audit on that. The Nuclear Medicine leader was pleased to have achieved three perfect state audits in 5 years because “that just does not happen in Nuclear Medicine.” The leader felt this success reflected well on her workgroup especially because it indicated a clear line of sight between the work they do and the quality care they provide to patients.

The Nuclear Medicine leader offered advice about the kinds of actions and behaviors critical to handling such matters. They included:

Follow the rules. Don’t cover things up. Do what they tell you to do. Teach your staff to do things properly. Explain to them why you do it this way, don’t take a shortcut because if you take a shortcut when you think someone is not looking, you will take that shortcut in front of an audit and it won’t be good and we will get in trouble.

In a non-clinical context, the Human Resources leader candidly described his experience regarding what happened to his employee-engagement scores when he took over that department. He recalled:

My first evaluation scores “tanked” compared to my predecessor. I had expected there would be a drop, and considered this my “baseline.”

As I began to work with the staff, I went out of my way to include myself in tasks: modeling not only to ‘do as I say,’ but to ‘do as I do’: roll up your sleeves and get involved. When staff saw that my actions matched my philosophy, I think it helped bring them along. My evaluation the following year reflected marked improvement.

The Human Resources leader attributed the raised engagement scores to the actions he took to make his staff feel comfortable. People recognized that “I supported them in what they did on a daily basis. I was there for them.” Moreover, the leader observed, “it is possible to engage employees, and the responses on surveys kind of go
hand-in-hand. If they [the employees] feel good about themselves, who they work for, the
department they work in, it all ties together.” This sentiment was confirmed in the
response of leaders (100%) that “the employees in this department know they have been
heard when they see action taken on their issues and concerns.”

**Workplace Conditions Contribute to High Engagement**

The following section presents how workgroup leaders described conditions that
facilitated high engagement and some conditions that did not. Leaders described actions
and practices in the workplace that contribute to developing high engagement among
workgroups including: (a) Opportunities for Continuous Learning; (b) Recruiting,
Selecting, Hiring, Orienting, and Retaining Staff; (c) Work-based Communication:
Meetings and Processes; and (d) Work Environment: Workspace, Equipment, and
Resources.

**Opportunities for Continuous Learning**

On the whole, all leaders spoke about how learning is facilitated in the workplace.
They spoke of the need for continuous learning for both practical and philosophical
reasons. The practical perspective addressed the necessity of having people stay current
in best practices in their fields. This was especially the case for clinical staff who have
ongoing credentialing and certification requirements.

The Clinical Education leader spoke about the influence of Stephen Covey’s
book, *The 7 Habits of Highly Effective People*, on her life, and how she had used his
principles in ongoing learning with her workgroup. She noted, “Most everyone read the
book. Every month we would go over a new principle. Now . . . a couple of years later some speak the lingo. They are using his principles.”

Furthermore, the Clinical Education leader explained how her staff conducted a Staff Development Day which approximately 80 nurses attended. The leader was proud of her workgroup because “it did not matter what area the nurses or educators worked in . . . they were all on the team and interacting. It was a huge job, but they did it.” The leader who said her workgroup is known for its proactive planning was pleased how “over the last 2 years we have been able to build an environment, and we are definitely getting there.” On the other hand, the Clinical Education leader was somewhat concerned that time and budget restrictions had reduced the kind of work-related retreats where her workgroup’s proactive planning had typically occurred.

The Radiology leader spoke of his commitment to continuous learning, and acknowledged he is very much a reader, especially of management literature. He reported that as he read and learned new things, he liked to share his learning with his leadership group and challenge them to expand their own thinking about management practices. In addition, the leader mentioned that one of his practices was to bring in guest experts to talk with his staff so that they could stay current and receive their Continuing Education Units (CEUs). The Radiology leader recorded the sessions for staff that worked on different shifts, and couldn’t attend the live presentation. He mentioned, “We have weekend team meetings and will play it for them, and it will be available.” Likewise, in the Manion survey all leaders strongly agreed (100%), “We have regular department or staff meetings that include active dialogue on current issues and concerns.”
In addition, the Radiology leader stressed to his highly engaged group, who are working supervisors for the various Radiology department modalities, the importance of their being engaged in continuous learning. He said:

We can't be satisfied as a leader if you are not trying to learn how to be a better leader. If you are not taking a class; if you are not reading a book; if you are not looking for articles, you are stagnant. It will be reflected in your team and reflected in the metrics by which you are measured. I strive to lead by example and ignite a passion to learn in my leadership group.

The Nuclear Medicine leader spoke of continuous learning in connection with the career ladder available to people in her profession. She explained how for those who aspire to management or supervisory positions, she coached them, “Lead me down the path they want to go.” In turn, she tells them the training and experience required to get there. As a matter of fact, she said, “I just had someone who completed that goal, and is off running his own Nuclear Med department elsewhere.” All leaders strongly agreed to a Manion question, “Development of employees is a key goal in this department.” Some leaders (50%), however, were aware that they did not continually ask their staff, “What are you interested in learning?” and “What opportunities are you interested in?”

As a training expert and coach in her field, the Nuclear Medicine leader addressed a problem, which her workgroup had also reported in their interview sessions. That is, “we are all licensed specifically for our skills,” so people trained in one area of specialization can’t work in other aspects of the field. Typically they don’t have a license or cross-training to do so. Consequently, the Nuclear Medicine leader had recently found herself “encouraging everyone to get cross trained within our own work environment.” She declared why this was no simple matter: It requires multiple days of training, and testing, and shadowing professionals, before being certified to work in a different
modality. “Every employee would have to have so much training and exams, and you have to take a couple classes at the university. . . . Once they sign off, you can sit in front of the board and take the exam. If you pass, you would be credentialed.”

Linking upcoming changes in the Nuclear Medicine modality with training challenges, the Nuclear Medicine leader described one initiative currently underway.

The hospital is moving forward to purchase a [CT] machine, and I will be in charge of it. When that happens for our new cancer center, we have to be trained. So, I will be responsible for preparing my staff. . . . That will be a big responsibility.

However, the leader emphasized how good the news is:

Everybody I have in my department currently is looking for cross-training. They want more. It is like a reward to get the cross-training, and learn something new, and at the end of it, there may be an opportunity for you to do something additional. It is much higher technology than the base-level stuff.

Recruiting, Selecting, Hiring, Orienting, and Retaining Staff

Leaders also spoke at length about how they and their workgroup members interviewed, selected, and hired new staff onto their teams, while keeping an eye to finding the best fit for all involved. The leaders talked extensively about the steps they followed in moving from hiring and selection into orientation and retention. Further, leaders 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. For one leader in particular, employee satisfaction was essential to retention.

The Nuclear Medicine leader indicated that because her field is rated as a high-risk profession, highly advanced and highly credentialed people are required to work in
it. Consequently, she was very careful about whom she hired. She declared, “My interviewing process is very long compared to other people.” It involved both her and her workgroup members. The procedure the leader identified for the hiring process included almost a dozen well-laid-out steps. In consisted of everything from first reviewing and rating potential job candidates, to observing the candidate shadow a staff member in-house, to extending an offer, then hiring the person and having the person spend 1 month at TCH and rotating among the leader and other workgroup members. After 30 days the new employee would be given the green light to work with patients.

The Nuclear Medicine leader also explained how, when possible, she hired students into her department—many of whom she had trained. She said the field of Nuclear Medicine requires a difficult training and certification process, and typically there is a high failure rate. However, for those who make it, the leader saw her role as one of outlining the stepping-stones to get students and new employees where they want to go in the profession. The Nuclear Medicine leader said it takes about 5 years to go from being a student to being a leader in this highly technical field. Moreover, she stated, “I don’t really have turnover. I have a lot of people trying to get jobs here.” The Nuclear Medicine leader mentioned again the two staff members who left to take leadership positions, because of the training and mentoring she provided them. She also mentioned having to let one person go, because the person’s value system was not in line with hers. “It came down to patient safety constantly being compromised.”

In a similar manner, the Clinical Education leader also made it clear she looked for people who are in sync with the clinical-inquiry direction the department is taking. In an interview with potential candidates, the leader asks “a lot of questions around critical
thinking, but also the social intelligence questions. I would not hire someone who did not have the ability to function on a team.” She explained, “When I hire for my department, I want to hire people who ask questions rather than just black and white. It is that clinical inquiry” that she is looking for. Similarly, 100% strongly agreed, “When interviewing job applicants, I consider the personality and ‘fit’ of the applicant a priority for hiring.” In addition, the Clinical Education leader went on to describe how she had new employees shadow colleagues to become familiar with how the department operated. The leader commented, “I usually have a lot of interaction with new hires in the beginning. If I had a larger group, I would have to assign someone to be their preceptor or their buddy. But my group members tend to be caretakers. I try to hook up new employees with a couple of people to show them the ropes—their go-to people.” Seventy-five percent of leaders strongly agreed in the survey that “department employees are involved actively in the hiring and selection process of new employees,” and 25% agreed sometimes.

The Clinical Education leader also felt her values in interviewing and hiring were consistent and transparent, and described how they even played a role in her being hired into her current position. The leader told the story of her interview for her current job at TCH. She mentioned how she had to address the concerns one of the educators had about potential favoritism with someone who was already on the staff, and a good friend. The Clinical Education leader reported that she responded to this concern by saying, “I have a set of principles that are core to who I am and follow those principles no matter the situation or who I work with. You will understand when you get to know me that those principles stay true. And I don’t use different sets for different people.” Apparently, the person who had originally voiced the concern about favoritism later told the Clinical
Education leader, “You know, I was worried, but you are steady and true to your principles.”

The Nursing Administration leader reported a bit different approach to hiring staff. He indicated his hiring practices relied on using core requisites relative to performance. The leader reported how “I look at those competencies that cover everything from emotional intelligence to financial acumen for doing the budget, and things like that, and use those as a backdrop. And I can gauge the strength of people with that as a benchmark.”

The Cardiac Rehab leader described her high level of involvement in acquiring new staff. Her personal involvement ranged from being involved in the interviews to personally greeting new hires. Like the Clinical Education leader, the Cardiac Rehab leader appeared to have a fairly systematic set of procedures, including the use of checklists, to guide staff from the interviewing through orientation process. The leader was proud of the fact that she accompanied every new employee on a tour, and took the time “to check in with them and make sure they hear my expectations as well.” She noted how she had conversations with new employees regarding patient satisfaction being “the most important aspect of our jobs.”

Similar to the Cardiac Rehab leader, the Radiology workgroup leader described his personal approach to making the new employee on board successful. He said, “First impressions for a new employee are very important. I try to express as the director of the department how happy we are that you have decided to join our department, and we want to make sure that your work experience with us is very satisfactory, enjoyable and as
pleasant as it can be.” Further, the Radiology leader encouraged new employees to feel free to reach out to him, anytime.

The Executive Services leader said workgroup engagement required that new people integrate well into his team. To that end, he made sure that candidates whom they’re considering are aware of TCH’s organizational goals and objectives. On the other hand, the Executive Services leader also recognized people have a set of their own individual goals and aspirations, and felt it was important for him to “understand who they are, and find ways to leverage their strengths to do the most we can for the organization.” In addition, the Executive Services leader felt that “you need to give them [the new hire] a space to just come in and get to know people, set up meetings. . . . It is the relationship focus. A lot of what I do, to be honest with you, is based on relationship.”

On the topic of staff retention, the Clinical Education leader explained she had to let several people go, because “they were not a good match for the role. What was expected was more engagement with the staff and being out on the unit and it just wasn’t working.” To handle these matters, the leader “worked with them along the way so there were no surprises. I just told them how they were not meeting the whole goals and expectations of the role, and that it required more presence.”

On the other hand, the Nursing Administration leader was happy that his workgroup had faced little turnover. He reported:

Fortunately my immediate leadership team has been pretty consistent. There has not been much turnover. We had a change in leadership, so rather than go outside, I looked at the current team to see if anyone had the bandwidth to absorb these areas. On some levels it is succession planning, and in some cases it is a retention strategy, because you are building and advancing people’s careers from within. If they feel the ceiling has been moved a little higher for them, they will be more likely to stay.
As one final point, the Human Resources leader explained how new people are mentored in his department. He said, “We are a small enough department that orientation could be one-on-one. Recently we hired an HR assistant. One of the staff took that person under their wings to be their mentor and preceptor, until they feel that new person is ready to move on their own.”

Work-based Communication: Meetings and Processes

Discussions pertaining to meetings, intra and inter-departmental communications, workspace, equipment, and other resources highlighted what leaders felt both supported or hindered staff engagement. Among other things, leaders viewed meetings as a good venue for communication.

The Cardiac Rehab leader detailed a process she used for planning and running meetings.

Everyone has a part in the staff meeting. Everyone needs to be prepared to present the information. Staff present from committees they are representing. Just because you are a staff member, I always try to raise the bar higher. I ask staff what committees they would like to be part of. To engage everyone.

In describing other communication behaviors, the Cardiac Rehab leader mentioned practices that affected not only her Cardiac Rehab group, but also the Cardiology and Ancillary Services workgroups that report to her. She said:

I have an open-door process. We have boxes for comments... I committed to having huddles every morning at 7:00 a.m. Each discipline would report their volume. We could shift resources to help get the work done. Whatever it was, so we could all pitch in to help. Made us a team instead of isolated disciplines.

The Cardiac Rehab leader also noted how she used posted notices, phones, and email to communicate with her staff. Regarding collaboration at the inter-departmental
level, the Cardiac Rehab leader mentioned, “One goal of mine is to make our voice be heard, but also make us work seamlessly with nursing.”

The Nuclear Medicine leader described her process of attending leadership meetings, and then coming back and going over everything with the staff immediately. “If not that evening before we leave, then the next day.” She added, “Things that I need feedback on, I will say what I need and RSVP.”

In the Radiology department, the leader had weekly meetings with his workgroup, but liked to be accessible whenever needed. He said, “You can’t be distant from your team, you have to be visible.” Furthermore, the Radiology leader encouraged “all of our modalities to attend the monthly team meetings, even though there may be things presented there that are not pertinent to their specific modality.” He explained to them, “We just don’t allow you to be an island unto yourself. It just doesn’t work.” This sentiment also rang true for Radiology’s involvement with others at the inter-departmental level. The Radiology leader’s opinion was, “This is a real opportunity for improvement for our hospital. . . . The temptations for the departments to be islands unto themselves is also a pretty great, and you are not going to reap the goals of the hospital by operating that way.” The Radiology leader went on to describe how he kept his workgroup informed about higher-level meetings at the hospital and shared “what is given to me at our hospital leadership meetings, so they are all informed and on the same page. We try to give them examples of how the care they are providing everyday can contribute to the overall goal of the department and the hospital.”

The head of Executive Services spoke of having weekly or bi-weekly meetings with his workgroup, but noted he is just as likely to communicate more informally;
I might just stop in and say hi. I have daily little mini conversations, people stop in my office, I stop in their office, try to be respectful that they are trying to get work done, but I think it keeps the barriers down by having that frequency. . . . I don’t need to add more stress by having people question or feel nervous about being around me.

Like the Executive Services leader, the Human Resources leader mentioned that while he has monthly staff meetings where workgroup members take responsibility for the agenda, what he mostly preferred were

daily conversations with people that work in my department. . . . It could be anything from ‘What did you do this weekend? How is your family doing? Is there anything I can do for you?’ to work-related questions on projects or getting their input on how we can better serve the needs of the organization.

Similar to what several of the other leaders had mentioned, the Human Resources leader wanted an environment “where we are open to suggestions; we are open to hearing from our employees about what is working well, what is not working well. Even though we can’t fix everything, from a simple point of view, that we have asked them is truly what keeps an employee engaged.” This perception appears in alignment with the Manion survey findings where all (100%) leaders agreed that “people rally around and help in a constructive way when an employee is having a problem in their team.”

Work Environment: Workspace, Equipment, and Resources

Leaders discussed how workspace, equipment, and other resources either supported or hindered staff engagement. One leader made the direct link between employee satisfaction and the need to have consistently functioning equipment, sufficient updated technology, and proper workspace for people to do their jobs well.

On the topic of workspace, the Cardiac Rehab leader spoke of having to temporarily relocate her workgroup while the hospital was constructing a new space for them near the Emergency department. The leader was pleased the construction was
underway, saying, “We have a nice design for the new department. I have been part of that and it is so exciting.” She said she was “happy to get the green light to go ahead. I was so used to having the construction sidelined. We have a very high volume center. There are a lot of nice features, and we’ll look like a Rehab center.”

On the other hand, the Radiology workspace is not in the shape the department leader would like it to be. He commented that although “some of our lead technologists are getting an office for the very first time,” for the most part “they have been . . . working under less than ideal conditions. . . . It is challenging to find a place to have a private conversation, where you can sit down privately with an employee. . . . So we have shared and managed to get along.”

Whereas the Radiology leader tolerated the current workspace, the Nuclear Medicine leader had a different view. She felt there was still much to do to improve the quality of the Radiology department workspace for both employees and patients. She said, “It is so antiquated. The flow is not functional to the needs of the patients that we have. None of the bathrooms can fit a wheelchair.” She noted how currently in Radiology there are seven bathrooms, starting from the waiting room back. Only one is handicap accessible. We have so many handicap patients that come in and see us and we can’t get the wheelchair in the door. You can’t do the job. It just does not make sense. The bathrooms, the work environment is so outdated. It becomes a morale issue.

Moreover, the Nuclear Medicine leader cataloged other workspace problems that included “no private space. Lounge is really small. We have been on the radar for construction for several years.”

The Nuclear Medicine leader spoke about what is essential to her workgroup’s high engagement and employee satisfaction. She said,
You have to have equipment that functions consistently. You want to be up to date with technology. Unfortunately, the budgets that we have to run our entire Radiology department do not meet the needs of technology. Not even one department. Everything we use within Radiology is extraordinarily expensive. You have to have the proper workspace. You have to have a clean workspace. You have to have a workspace that’s user friendly for the patient’s needs.

Ultimately, the leader explained how it was her job to ensure that workgroup members “have everything to do their job properly.” She felt it was her responsibility to make sure the work environment is organized, structured, and clean, and the equipment is working. “If I can provide all of that to my department, the rest just comes natural.” The Nuclear Medicine leader went on to link concerns about the employee environment to the patient environment. “You have to give the employee the environment that will make them successful, friendly and nice. If the patient sees the environment we are proud of, they will tell everyone to come here because it is so nice. If I were a patient that was wheelchair bound, I would expect you to be able to accommodate me.”

While several leaders mentioned functioning under less than optimal work conditions, the Human Resources workgroup leader was happy to report on a workspace, which was previously poor, but steadily improving. He explained how,

when I first came in 2007, our office was in dire need of a face lift. . . . I think the simple thing of putting in new carpet and painting changed the environment from what the employees had worked in for years. A new coat of paint on the walls, new carpet, new smell, freshness. It does wonders.

The HR leader was pleased that the workspace looked better. In addition, the department had recently opened up the reception area, and repositioned the computers for things like applicant testing. People who used Human Resources in the new space enjoyed the new work environment.
Similar to the sentiment expressed by the Nuclear Medicine leader, the Human Resource leader said that it is fundamentally important that staff have the right tools and the right processes and systems to do the job. He said:

When systems don’t work well, or processes are changed, again, without getting their involvement . . . I can see engagement truly being impacted because . . . if the employee is not happy or they are frustrated because something is constantly broken or is not working well . . . that really does impact an employee’s engagement.

**Leaders Contribute to High Engagement**

This section presents discussion on leader contributions in developing high-engagement workgroups. It describes what workgroup leaders said about their bosses and their peers, as well as how they practiced leadership with their workgroup members.

The material in this section is organized under the following subtopics: (a) How Leaders Support Leaders, (b) Leader Characteristics That Foster High Engagement, and (c) How Leaders Role Model Behaviors Conducive to Fostering High Engagement.

**How Leaders Support Leaders**

Workgroup leaders were people who often had broader responsibilities in the hospital, so sometimes spoke about their specific high-engagement workgroup, and sometimes reflected out loud about more inter-departmental or hospital-wide concerns they were engaged in.

What was distinct about these leaders was how often they mentioned peer-to-peer relationships among leaders as well as how their own leaders (or bosses, if you will) had affected their high engagement. The workgroup leaders recalled the satisfaction they derived from peer-to-peer relationships with other leaders. They spoke of 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.

The highly engaged workgroup leaders liked and enjoyed good working relationships with their boss. Actions and behaviors they liked about their own leaders 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 a tough work or personnel situation, having their leader’s trust and confidence, and the autonomy to do their job.

The Cardiac Rehab leader commented how all of her peers “are best buds and are so great and supporting.” The “best buds” she referred to are the nursing directors who cover similar units in the hospital. The leader mentioned the support that her peer leaders provided each other through such activities as weekly huddles with each other, and in regular problem-solving sessions with the hospital’s senior executives. In addition, the Cardiac Rehab leader spoke about how important it is to her to have a boss who is a leader she can depend on. What she liked about her boss was being able to “have clear expectations set for me, and for me to be able to convey those” to her staff.

The Clinical Education workgroup leader spoke of the effect that her previous and current bosses had on how she managed and led others. She noted how the previous CNE she worked for was a bully, who made her life miserable. She commented, “It built character and stamina, and that I will not leave an organization that I have been part of for 20 years because this person does not like me.” Furthermore, having persevered and survived in her job under tough circumstances, the Clinical Education leader declared, “I promised to never ever to do that to a human being.”
Fortunately, the Clinical Education leader found her new boss, the hospital’s current CNE, to be someone who was “very supportive and has respect for my ability to do my job.” She liked that her boss “does not micromanage me. I feel I am being treated as a professional. I can go to him when I have a problem. I can call him on his cell phone if I need to.” This leader also liked her boss’s open-door policy, and said he “is always a respectful listener, and listens to what I have to say, and promotes what I want to do unless he has a different goal.” Such experiences have taught the Clinical Education leader it’s important to “lead by example” and to have “respect and consideration of your staff.” All leader respondents strongly agreed that they are continually aware they must model the behavior they expect to see in their employees and colleagues.

The Radiology department workgroup leader commented on having had a number of different bosses over the past few years. Most recently he reported to the new Vice President of Operations. The leader described how the people he has reported to “have always been persons of high character that I could admire and look up to; and, like I said, I have learned from each and every one.” Asked what regenerates him as a leader, the Radiology leader said:

I like to feel trusted. That is demonstrated in many ways. I like, as everybody does, to be told, “Good job.” . . . Trust is critical. I do appreciate being told “good job,” or in the performance of your department “that’s really great.” One of the things I really like about [his current boss] is that she seems to have a lot of confidence in you. This is the perception that I walk away with: that she really knows me.

The Radiology leader went on to explain how tough it was to be a leader in the organization:

Well at a director level, you often feel you have to give so much of yourself and you have to. It crosses over into your personal life at times, but as much as I feel that, I know for our executives, it is much more magnified. So I think that the expectations and performance metrics the executives are held to, if you are not meeting those
expectations or if you are doing well, oftentimes you are recruited to go to other systems. So it just seems like that all lends itself to a relatively short tenure.

Several leaders spoke of leader-staff and peer-to-peer encounters that were uncomfortable to initiate, and how a boss coached them through the situation. Both the Clinical Education and Radiology leaders mentioned how it was important to them to be “honest and straightforward” in having crucial conversations with staff, and doing so in a respectful way. The Radiology leader recalled how his practice of dealing with problems had been less direct in the past. He said he had been more of a caretaker in dealing with problematic personnel situations, and he recounted the negative impact his avoidance had on himself and his team. The leader described a situation he had with two disgruntled employees, who were technically highly qualified, yet undermined him and their peers in the work setting. Based on stories from her own experience, the Radiology leader’s new boss coached him on how to deal with such conflicts more immediately and directly. He did and was grateful for the advice, and determined not to let future personnel problems fester to the point of toxicity within his workgroup. The Radiology leader also clarified why the support of colleagues is important to him. “I think it is important to have networks that you can confide in and seek comfort.” Leader stories aligned with all the leaders strongly agreeing in the Manion survey, “When employees bring me problems of an interpersonal conflict, I use my judgment about whether they should resolve the problem or whether I should intervene.”

To sum it up, the Radiology leader described what he learned about handling difficult situations.

The only way to have that difficult conversation with an employee is to tie in their behavior to the overall goals of the department, and the hospital and how that helps us achieve what we need to achieve. It takes the pressure off you as a leader when you
have that conversation, and don’t get mired in some of the trivial things that you can get mired in.

Reporting on an entirely different matter, the Cardiac Rehab and Clinical Education leaders spoke of challenges they had to face with a peer in the Emergency department. The Clinical Education leader was coached by her boss on how to address the person’s behavior, rather than having the problem linger for staff to deal with or moving it up the hospital’s chain of command. The Cardiac Rehab leader described how she knew that avoiding a troublesome person wasn’t going to do anyone any good, so she took it upon herself to speak directly to the person regarding a matter of joint interest—and came away relatively unscathed from the encounter. In both cases, the leaders sounded relieved to have faced the surrounding issues head on.

Leader Characteristics That Foster High Engagement

Workgroup leaders explained how they set goals and expectations with their workgroups, and how they best communicated with their staff. Some liked more formal communication, while others liked more informal contact.

The Cardiac Rehab leader indicated she spent one-on-one time with her direct reports. In addition, she used staff meetings to discuss goals and convey information, while also promoting having fun. “I take the time to meet with them as a group, make it fun, and order in food. Also I start every staff meeting with recognition.”

The Clinical Education leader said she wanted staff to think beyond their departmental view of work, toward an inter-departmental perspective regarding how best to work with colleagues and patients hospital-wide. The leader indicated she had “a heightened awareness of who does what and who are good at certain things. I like to key
in on people strengths, and say, “You know what, you are really good at communication.’
So I pull them to the table.” Moreover, she commented, “I really think [leadership is]
tapping into people’s interests and skills and highlighting that and recognizing that for them.” In addition, this leader noted that a goal for her workgroup was to have a global view of healthcare. She wanted staff to be conversant in current best practices in healthcare, then “connect those dots where you take it to a bedside nurse, because we are trying to elevate practice at the bedside.” The Clinical Education leader felt in doing so “you really acknowledge and highlight that this was a bedside nurse, and now it is a system-wide protocol.”

In describing how to build trust, the Clinical Education leader stated: “I am who I am. I don’t manipulate people. I have expectations, but they are the same for everyone. I operate on mutual respect. I won’t undermine you, but you have to prove yourself.” She continued,

I don’t micromanage. I have respect for my team that they are professionals, and they have knowledge, and that they are self-directed and self-motivated. They come to me if they need support. I will be in the background with support.

The Clinical Education leader gave an example of how she worked with a new employee. “I coached her on communication skills, and how to network and get to know people.” In addition, the leader spoke about what she did when a nurse and physician were butting heads. She said the physician
did become confrontational, with his hand on [the staff member’s shoulder] like he was shoving her. The patient’s mother had witnessed it, and apologized [to the staff member], but the staff member said, “That’s ok, my boss was there.” I felt like, for me personally, that was a time that I was really there for one of my employees.

From there, “we spoke with the CNE, wrote a report and it went to the President of the Medical Staff.”
How Leaders Role Model Behaviors Conducive to Fostering High Engagement

Leaders felt that to promote employee engagement they had to model the actions and behaviors they wanted to see in others. A couple of leaders used the stage as a metaphor for how they felt they had to behave with patients and staff—extending the analogy to having to put on a happy face when that wasn’t necessarily how they were feeling. In conversations with leaders about serving as models for the behaviors they wanted to see in the workplace, people spoke of goal setting, learning, good communication, and shared decision-making among their workgroups, and how this led to higher employee engagement.

The Human Resources leader felt that in order to promote engagement it was essential for leaders to “walk the talk.” He commented, “What impacts employee engagement is seeing leaders don’t do as I say, they see leaders doing the opposite.” Furthermore, he maintained this even carries over into “pay for performance, or lack thereof.” He explained that when employees see co-workers or even leaders getting a pay increase or bonus across the board, and it is not directly linked to performance, over time it disengages them because “the incentive is taken away.”

The Radiology department leader spoke of working with a Radiology physician to implement a national program called TeamStepps to address problematic physician behaviors. The impetus for the initiative occurred because “there comes a point when you have to hold them [physicians] accountable for their behavior, otherwise it does begin to impact the morale, the efficiency and the outcomes you are relying on your staff to produce.”
Consequently, the Radiology leader reported, “We are beginning to hold our Radiologists accountable for their behavior.” The leader allowed, however, that “without a physician champion to partner with, you are dead in the water with TeamStepps. You have to have the physician as well as the technologist collaboration working together. We are excited about that.” Furthermore, the Radiology leader said he was initially inspired to undertake the TeamStepps initiative, because a leader in the Neonatal unit at TCH shared her TeamStepps experience with him. The Neonatal unit he modeled his program on is now “one of the shining examples at TCH in terms of patient satisfaction.”

On a different topic, the Radiology and Cardiac Rehab leaders spoke of being on the stage with employees and patients, and about what’s needed to help staff be engaged. The Radiology leader talked about modeling engagement this way:

I think that I need to demonstrate to my team that I have faith and confidence and trust in them. I have to be very transparent as a leader. I know that I have to conduct myself in a certain way. They say you are all on stage everyday for your patients, but you are on stage every day for your employees as well.

He extended the stage metaphor further, saying:

If I am pensive, if I am, my mind is elsewhere, I see it directly reflected in the leadership that reports to me in my department, and then by the team members that report to my leadership group. So whether you feel like it or not, you have to put on that smile.

I certainly believe as a leader you have to be a person of integrity, you have to be, have a high moral ethic standard. You are watched so carefully. I have learned that over the years. People have to have faith and confidence in their leader and you want to respect that and not give them any reason to be disappointed or dismayed.

In a similar manner, the Cardiac Rehab leader said:

I feel like as soon as we hit the workplace, we are on stage. We need to leave everything that is upsetting aside. If I see there is some frustration with a staff member, I will stop them and ask them what is going on. I ask that they get themselves together before they go see patients. I show/model behavior. Positivity and enthusiasm is a big thing for me.
Similar to the Human Resources leader, the Nursing Administration workgroup leader also spoke about ‘walking the talk’ with staff. The leader conceded, “If I am looking for a team that is punctual, something as primitive as that, then I need to show up on time to my leadership meetings, to my one-on-one meeting, to be respectful of their time. Those kinds of role-modeled behaviors speak louder and more voluminous than anything at times.” He went on to say, “We are in healthcare reform, and there are tremendous financial pressures on us, but with all that said, it requires that we establish and adhere to what I would call the basics of chain of command.”

On the other hand, the Nurse Administration leader also claimed an interest in shared leadership in certain situations. He stated, “I am a real proponent of shared leadership, but you still need some structure. So I find that with some decisions I am a little more prescriptive and put up guardrails on the decisions.” He used as an example his asking the Nursing Administration workgroup to make decisions about how uniformity in attire would be selected and implemented hospital-wide. They did so, although the shared decision-making process did not appear to have consistently occurred down the line between the Nursing Administration workgroup members and the staff who reported to them.

The leader also voiced a dilemma regarding his role as a servant-leader in the organization. He noted that shared leadership is “the core of servant leadership,” and how “I feel most empowered, most engaged when I am serving them [the employees].” On the other hand, the leader was resigned to a position where “there are times of non-negotiable and some prescriptive things that I will put out. . . . So that flow of what I call up-managing is important for me to be able to serve them.”
Leaders discussed the stress placed on them and senior executives to meet performance targets, and the frustration of having to constantly collect metrics often without getting feedback on how they were being used. Leaders wanted more responsiveness and accountability in such matters, particularly from centralized services that were supposed to be provided to hospital staff within the larger healthcare system they were a part of.

In a discussion of modeling accountability for the staff, the Executive Services leader felt that staff have to be engaged with their leader on defining what performance looks like. He said:

It doesn’t make sense to hold people accountable when they may not even know what they are accountable for. That is just frustration, which is a lack of leadership. So I think the first thing is to be sure there is clarity and what it is we are asked to do and then having a very clear set of metrics that I can keep track of whether we are meeting the performance and measurements that we have put up and that we have agreed to. . . . I think part of what we have done is we have agreed together as to what that performance should look like.

The Executive Services leader felt if performance does not meet expectations, it was incumbent on the leader to bring that to the table and “just being honest to say this is not working. How do we fix this together? But it is done in a way that tries to be honoring and not humiliating people.”

The Cardiac Rehab leader also addressed the issue of accountability. As a leader who practiced being accountable to those with whom she interacts, she wanted centralized support services at TCH’s parent organization to be accountable as well. She stated, “I would love to see accountability being enforced everywhere, and when you are depending on key services like Accounting or HR. It is frustrating when you are trying to recruit, and you are feeling they are not being held to the same level of accountability.”
She explained, “Sometimes I don’t know who is in charge and have to find out. It is the time that you spend that is frustrating.”

The Clinical Education leader would also like to see more accountability among hospital leaders. She stated:

I would really like to see the leadership as a whole have the courage to take on . . . there are lot of metrics we are held to. It is up to the front line people to deliver. As leaders, we continually skirt around the issue of resources to get it done, like staffing. . . . I think we have a really good leadership team in place at TCH, but I think they still dance around really having the vision and the faith that if we make this investment up front. I just don’t know how you get there by laying more and more on people.

Likewise, the Nuclear Medicine leader wanted accountability from others up the chain of command in the organization. She said, “Over the years we have been submitting this information up the chain. What did the chain do with it?”

We do audits every week. I am an auditor and have to submit my audits weekly. I understand you have set the standard, and you have told us what we need to do. Now I want to know the numbers. Because we have been doing this for over a year. I want the feedback numbers. Did we achieve our goal? If we did, you need to tell the people. From an organization level, you need to hear the information from us. We are the first line. Patients talk to us and we see things. Higher up they don’t see it.

The Executive Services leader, who is the hospital President, drew attention to a number of challenges coming down the pike in healthcare. Like the many leaders who voiced metric, safety, regulatory, and performance concerns earlier in this report, the Executive Services leader cited why leaders and workgroups must be conversant with what is going on at the local, state, and national levels regarding healthcare policies and practices. He summed it up this way:

I think that it is incumbent on systems to . . . have an awareness of the agenda that is being set at different levels of the organization and being sure that we are trying to integrate as much as possible to control the pace.

The increasing uncertainty of the healthcare landscape and the higher demand for driving results faster and the changing transparency for information. My point is the
drive [for results] and the . . . strain on our ability to keep delivering high performance [requires] staying in tune and pacing. We need to keep ratcheting up performance, but as you are ratcheting up performance, you’ve got to have an intuition or a mind toward the pacing of that work and almost a sense of what it is doing to the organization. . . . If we are not careful, we just become a sweat shop.

Summary

Workgroup leaders spoke about how important it was for them to find people who have a passion for their work and shared values—and how this lends to engagement. Leaders spoke of a need to avoid micromanaging staff, and the importance of allowing people the space and autonomy to perform the jobs they were hired to do. They also recalled how they supported staff through transparency, open-door policies, coaching activities, and by advocating for them when problems arise. In turn, leaders expected trust and commitment. This exchange is a great example of how leader actions ensue in building trust in relationships. The outcome is that the employee exchanges engagement and passion in the workplace.

Leaders thought that professionalism and fun could be a healthy mix. However, for the most part they agreed that professionalism matters more. All leaders were consistent in their attitudes to acknowledge and reward the successes of their workgroups. Some people built that formally into their regular meetings; others did it more on the spot.

Leaders spoke of patients as a priority from both the business and clinical perspective—and the need to keep both perspectives at the forefront of decision-making. They spoke of how workplace conditions—like the quality of a common workspace or providing people the tools and resources to do their jobs—were essential to workgroup engagement.
Leaders talked about their own leaders and how their bosses as well as peer-to-peer relationships fostered their own engagement at work. Finally, leaders spoke about the chain of command at TCH and how they wanted to see more accountability and feedback up the line from people who are supposed to be supporting those who work at the front line of patient care. In addition, they challenged the need for so many metrics that draw employees from their primary task of patient care. They wondered how they and their workgroups could continue to maintain engagement when more demands were constantly being placed on them by those up the chain of command.
CHAPTER SIX

SIMILARITIES AND DIFFERENCES BETWEEN WORKGROUP MEMBER AND LEADER ACTIONS AND PRACTICES

Chapter 6 is designed to address the research question: “How are the workgroup member and leader actions and practices similar or different?” The organizing themes for presenting this material are the same ones used in Chapters 4 and 5. They are the common themes that emerged during the larger data analysis. Those themes pertain to how: (a) Teams Contribute to High Engagement, (b) Valuing Patients Contributes to High Engagement, (c) Workplace Conditions Contribute to High Engagement, and (d) Leaders Contribute to High Engagement. Two of the subtopics under the Team theme, Cohesiveness Matters and Support for Each Other, were combined for easier comparison. Otherwise, subtopics match the pattern of Chapters 4 and 5.

Every section in the chapter has an introduction to what is covered in that section. References to the Manion survey are cited throughout the chapter as they support or differ from the workgroup and leader conversations. A summary at the end of the chapter explains major points of intersection across the case study.

Teams Contribute to High Engagement

Both workgroups and leaders discussed the importance of teams building relationships through shared values and a passion for their work, the need for
cohesiveness and support on their teams, and why having fun and showing appreciation mattered to their high engagement. In some cases the viewpoints of leaders and workgroup members mirrored each other. In other cases they did not. This section will identify what was similar and different in the leaders’ and workgroups’ perspectives.

Shared Values and a Passion for Their Work

Workgroup members spoke about shared values from their view inside the department. They described actions and behaviors they considered fundamental to working together. Group members described how essential it is to really get to know each other, and how critical it was to hold each other to shared values and standards. In addition, workgroup members talked about valuing the collective pride they have in doing a good job for the patients. Further, it was not the norm for group members to have an attitude of “it’s not my job” on the highly engaged teams.

In a similar vein, leaders spoke about how they liked to have good feelings, comfort, and chemistry between themselves and staff. Both workgroups and leaders spoke about finding people who would be a good fit for their teams. For the workgroups it was more imperative to find a good match of shared values with new staff. Perhaps this was because employees were the ones who were going to have day-to-day interactions with the new employee, and they perceived their engagement and the quality of patient care as dependent on their shared values. For the leader, the good fit implied people who had a stake in the objectives and outcomes of the work unit, rather than people whose shared values most closely matched those of the workgroup. Good fit also meant to both workgroups and leaders having the technical and interpersonal skills to be part of their teams.
Cohesiveness Matters and Support for Each Other

Both leaders and workgroup members observed it was essential to work with people who know what they’re good at, and to support colleagues in bringing their talents and strengths to bear in their workgroups and in their patient care; an “our patient” versus “my patient” mentality. Some workgroup members viewed support as a colleague or leader allowing a flexible work schedule. Others saw it as showing the flexibility to cover another’s tasks—and felt this was made easier when there were seamless work practices in place. Still others spoke of support as pitching in to help each other wherever and whenever needed—including taking the time to help a new staff member quickly come up to speed.

Group members and leaders also agreed that team cohesiveness hinged upon everybody being willing to help each other out to ensure goals are achieved. For them, everybody counts, and knowledge and expertise were not to be used as a power struggle. Team members described conflicts that arose when someone came onto the team who did not have that common perspective.

Workgroup cohesiveness also appeared to spur group members into feeling free to voice opinions, learn new skills, and work across modalities (work units) in a department. Leaders echoed their support for workgroup cohesiveness, and mentioned additional responsibilities they bore for contributing to team cohesiveness. Leaders mentioned they supported staff by being transparent, keeping open-door policies, conducting coaching activities, avoiding micromanaging, and advocating for staff when problems arose. In turn, leaders expected trust and commitment from staff to do the best job possible, and candor and honesty if they met obstacles along the way. Leaders commented that their
workgroup members were advanced professionals, who must have the autonomy and space to do their jobs. One leader was emphatic that employee satisfaction underpinned everything for her. She indicated that her job was to provide the best equipment, clean space, and best environment to get to employee satisfaction. Both leader and workgroup respondents to a Manion survey agreed that employees feel supported by management.

Balancing Professionalism With Having Fun

Leaders and workgroups spoke about how they function as professionals yet still have fun in the workplace. All the workgroup members and leaders who responded to a Manion survey agreed that they enjoy spontaneous fun and planned fun on a regular basis. However, in the interviews and focus groups, leaders spoke about fun as more of a planned occasion; workgroup members talked about fun more as spontaneous day-to-day interactions vital to their sense of well-being in the workplace.

Leaders valued having celebrations with staff but typically they were during planned events like meetings or team retreats. Sometimes leaders saw fun as a by-product of other initiatives like the “Adopt a Spot” and “3Cs projects” where there were competitive fun activities to encourage staff involvement. When speaking of more spontaneous fun, like that which occurred during a weather-based emergency, the leaders involved almost seemed surprised at what a good time they had laughing and telling stories even though there was a crisis going on at the time.

On the other hand, workgroup members spoke easily about creating an atmosphere of humor and fun to lighten things up, and doing fun things to help “blow off steam.” They regularly held birthday and holiday celebrations, had lunch together, or texted the occasional joke to one another. Even though group members explained that
sometimes they felt overwhelmed at work, having fun definitely was indispensable to alleviating their stress.

Demonstrating Care for Each Other

Demonstrating care for each other was a topic that workgroup members spoke about, but was not one that directly arose in leader interviews. There was general agreement among workgroup members on the need for compassion for one’s self and others in the workplace. Group members gave examples of how they demonstrated compassion—be that through electronic media like voicemail or texting, or in personal exchanges with each other—and how compassion is practiced in both professional and personal matters. One person observed how such caring grows through deeper connections made over time. Another gave the example of how his colleagues used “I Care” moments, like having lunch or checking in on someone who is having a bad day, and practiced these both inside and outside of work. Overall, people thought demonstrating compassion was integral to the cohesiveness of their teams.

Appreciating and Acknowledging Each Other

The leaders of the highly engaged teams as well as their workgroup members agreed that they acknowledged and appreciated each other, and they described different actions and practices they used in doing so. Workgroup members spoke about their actions in personal and workgroup terms. For example, they thought it was important to recognize one’s own skills, and to acknowledge those of their colleagues. The general sense that workgroup members conveyed was that although they appreciated the knowledge and skills of the people with whom they worked, they mostly did so in
informal ways like sending a text message, having flexibility in covering them at work, or celebrating a special occasion together. One example that differed from this pattern was when the Nuclear Medicine leader and her workgroup held an entire week of celebratory activities for staff outside of their immediate workgroup. They prepared meals, held education sessions, and provided treats for other members of the Radiology department. The Nuclear Medicine workgroup did this to show their appreciation to colleagues working for other modalities within the department. They also wanted to acknowledge the interconnectedness among the modalities in the workplace.

On a different note, it was the workgroup leaders who appeared to more frequently recognize individual and collective contributions of their workgroups at both informal and public forums. Some leaders built recognition events formally into their regular meetings. Others preferred to do it more on the spot. One leader went above and beyond and used her bonus check to take her workgroup out to dinner; she felt they had shared in making her successful. Another leader, the CNE, acknowledged the Clinical Education staff for the work they did on the EMR installation by taking them out to lunch. The Clinical Education leader was especially pleased because this brought positive feedback and recognition to her staff at a hospital-wide level.

In summary, it’s interesting to note that leader respondents to the Manion survey strongly agreed that employees in their departments regularly recognized each other and participated enthusiastically in any department recognition events. The majority of employees (79%) also agreed.
Valuing Patients Contributes to High Engagement

Workgroup members and their leaders valued their patients, and were committed to the mission of providing them with an excellent patient experience. Clinical leaders who had dual functions at the hospital (both clinical and administrative) had perspectives similar to clinical workgroup members about what it takes to provide excellent patient care. They also had additional responsibilities hospital-wide that sometimes conflicted with this primary objective. Non-clinical workgroups and their leaders recognized that their contributions to patient care were different from the clinical ones. This section describes how clinical and non-clinical people talked about the patients.

Staff Cohesiveness and Its Effect on Patients

The high-engagement clinical workgroup members had more direct experience with patients than did non-clinical workgroup members. Clinical workgroups described their experiences with patients as their primary mission in the hospital. They spoke of the consistency and continuity required in their interactions with patients, and considered such interactions to be the best part of their job.

Clinical workgroups and their leaders recounted specific examples of what they did to put the patient first. Their actions ranged from teaching patients how to improve their health and lifestyle, to training new staff on how to best interact with patients who were concerned about a medical procedure and required more support.

The two non-clinical workgroups and their leaders acknowledged they are not on the front line with patients like the clinical groups, nor do they directly engage in patient care. However, the non-clinical people saw their mission and workgroup cohesiveness as instrumental to patient care, because they assisted clinical departments with the hiring
and performance reviews of staff, helped them prepare their budgets, and worked with finance to get the tools, space, and equipment important to staff who supply good patient care.

Patient Experience, Feedback, and Empathy

Clinical people also spoke of engaging patients’ families in achieving health-related goals, and even having fun activities for them to keep them engaged. Two outpatient clinical workgroups, Cardiac Rehab and Nuclear Medicine, talked at length about why it was important to really get to know the patient. They thought it was essential to have empathy for the patient and put oneself in the patient’s shoes. For these workgroups, it was important to understand and address the fears patients were experiencing. Clinicians wanted to help motivate each patient to achieve his or her health-related goals. They did so by conducting regular reviews with their patients on whether they were meeting the goals they had set for themselves, reevaluating and removing any stumbling blocks that got in the way.

Regulatory and Human Performance Concerns

At the operational level, many clinical workgroup members seemed to take pride in patient-care delivery especially when it appeared seamless to the patient. Yet, several clinical staff and their leaders cited the challenge of wanting to take care of patients, but having to balance that priority with competing administrative and regulatory tasks. Employees and leaders referred to the strain of having to juggle the implementation and monitoring of regulatory mandates and standards with the competing demands of providing quality patient care.
For clinical leaders this challenge was even tougher, because with dual roles in the organization, they had to provide staff with resources necessary to do their jobs, while keeping an eye out on patient safety and care metrics. Interestingly, while all employee respondents to the Manion survey agreed that they had the necessary equipment and supplies to do their jobs, interview and focus group conversations did not always share this perception. In fact, clinical staff reported issues about the outdated physical plant at the hospital, and how it was not always conducive to good patient care (e.g., the number and access to bathrooms, and the visibility of the patient to the clinician).

Another challenge for clinical leaders was trying to maintain the focus on patient care, while having to do so through the lens of hospital-wide value-based purchasing objectives. Value-based purchasing is a national healthcare alignment of financial incentives for quality and patient experience outcomes. Clinical leaders were required to meet quality and patient experience metrics to help increase the market share and the hospital’s financial security. The strain was most apparent at the forefront of patient care where clinical staff were being asked to do administrative tasks in addition to providing direct patient care.

Clinical employees cited the tension in their workgroups that resulted because of conflicting messages from their leaders on what was the priority. One example was given by a man who had a reputation for providing excellent patient care, and who was clearly passionate about keeping patient care as his first concern. His workgroup leader and fellow team members had acknowledged him for his service to patients. Yet, he had received a negative performance review from the team leader, because sometimes he wasn’t able to complete all the other administrative tasks as assigned. The dilemma this
employee reported was also reflected in the Manion survey results, which indicated that 14% of the employees strongly disagreed, and 64% only agreed sometimes that their managers wanted to know what was important to them. Yet, all the leaders responding to a similar question thought that they did ask staff what was important to them. The Manion results are a clear indication that there are some differences between what employees and leaders perceive as critical to keeping the patient at the forefront of their work together, and how doing so aligns with quality patient-care metrics.

**Workplace Conditions Contribute to High Engagement**

Workgroups and leaders discussed the importance of continuous learning, their mutual engagement in practices ranging from hiring through retaining staff, how communication occurs in their workplace, and aspects of the work environment that support or hinder their engagement. In some cases, leaders and workgroup members had similar points of view on these matters. In other cases, they differed. This section will describe those similarities and differences.

**Opportunities for Continuous Learning**

Overall, leaders spoke about how they helped facilitate learning in the workplace. They addressed the need for continuous learning from both philosophical and practical perspectives. On the philosophical side, the Clinical Education leader spoke about how Stephen Covey had influenced her leadership style; she had used his book and principles for staff development and proactive planning. The Clinical Education workgroup members gave examples of how they used some of the Covey principles in their meetings and general work environment. The Radiology leader also spoke about being drawn to
books that assisted him with his management style. He mentioned he wanted to bring what he read and learned into his interactions with people in his department, yet seemed to do this on a less formal basis.

The practical perspective leaders addressed pertained to having people stay current in best practices in their fields. This was especially the case for clinical staff who required ongoing credentialing and certification. Leaders described activities they sponsored to keep staff technically up-to-date, like bringing in guest lecturers as part of their regular meetings, and recording the presentations for staff who couldn’t be present. Similarly, workgroup members also spoke about the practical aspects of their learning in the workplace. These included technical training sessions on new equipment, being trained on new policies and procedures, and learning to use best practices at the bedside.

The Nuclear Medicine leader and her workgroup members were distinct in how they spoke about their passion for learning, and how this was translated into their training and succession planning for students who might eventually join their workgroup. The Nuclear Medicine leader commented that her goal was that her staff be cross-trained when they have to work within different areas of the Radiology department. She regretted that the high cost associated with such training is an obstacle to making it happen.

The Clinical Education leader explained how continuous learning was accomplished through clinical inquiry and best practices. She described how such learning improved the competency of her workgroup to provide continuous learning for clinical staff hospital-wide. One example the leader mentioned was how her workgroup trained clinical staff on the new EMR system. The leader was proud of the planning that took place, and what her workgroup had accomplished without complaint. When clinical
education members talked about the training they conducted, they too seemed proud of the way the whole team pulled together to get the training done under difficult time constraints. However, different from their leader, group members also spoke about their concerns of having insufficient time for employees to come up to speed or be able to translate the new EMR system for use at the bedside. Also, many of the workgroup members found themselves enmeshed in helping with the EMR system implementation, while trying to do their full time jobs.

There was a general sense among clinical education members that more had to be done so clinical staff could feel comfortable using the EMR before it could be fully implemented. This was also an opinion voiced by the Nursing Administration workgroup member. Yet, while the Clinical Education leader was pleased that her staff had done extra work without complaint, and that the CNE to whom she reported had congratulated them publically on their accomplishment, the leader did not seem to be aware of the distress that people experienced in implementing the EMR. The leader did not mention doing any kind of debriefing with her staff in the aftermath, to talk with them about what worked and what didn’t, and how this huge initiative had affected them.

It’s interesting to note that the workgroup members’ perceptions regarding what happened in this matter are in concert with data from the Manion survey. Employees taking the survey agreed sometimes (54%) that they are frequently asked what needs to be fixed; and 8% of employees strongly disagreed. Leaders, however, all agreed (75% strongly; 25% sometimes) that they frequently ask employees what needs to be fixed. This clearly did not seem to be the case regarding the EMR.
Leaders and their workgroups all seemed to have some involvement in the processes associated with interviewing, selecting, hiring, and orienting new staff into their teams. Several departments were particularly engaged in robust processes: Human Resources, Cardiac Rehab, Nuclear Medicine, and Nursing Administration. Moreover, many workgroup members spoke at length about the importance of a comprehensive process for orienting new staff into their departments, and the interpersonal skills they would require after being hired. Workgroup members described at length the tools and processes they used to orient and socialize the new employees. In addition, the new employees spoke of how helpful their colleagues had been in supporting the transition into their new jobs.

One point of differentiation for the leaders was their focus on core competencies in potential hires, and wanting people who could help them achieve their business objectives. Interestingly, clinical workgroups and leaders honed in on the advantages of hiring people with a combination of clinical, administrative, and interpersonal skills for a highly engaged team. On the other hand, the Manion survey results indicated that employees were less actively involved in the hiring and selection process of new employees than as appeared to be the case in the interviews and focus groups. For example, 14% strongly disagreed that they were actively involved in hiring and selection and 29% agreed that they were actively involved sometimes. Interestingly, leaders had a different perspective on how actively involved their employees were in these processes. Leader responses indicated that all agreed (75% strongly; 25% sometimes) that employees were involved actively in hiring and selection.
Also worth note, while several workgroups and their leaders spoke about employee retention or turnover and its effect on morale and engagement, there was little conversation on what was being done to retain staff. Exceptions were comments by the leaders of the Nuclear Medicine, Nursing Administration, and Clinical Education departments. The Nuclear Medicine leader was an exemplar in countermanding turnover through her unit’s: (a) hiring and selection practices, (b) training students for eventual positions in her department, (c) cross-training staff whenever possible, and (d) making her department a center of excellence professionally—particularly noticeable in its highly successful state-wide audits.

In addition, the Nursing Administration’s CNE offered that he attempts to reduce turnover by given his Nursing Administration group stretch assignments to keep them engaged, and helping them climb the career ladder at TCH to meet their professional goals. The Clinical Education leader felt she was able to retain staff by drawing on their specialty areas, aligning them with nurses in departments where they could teach best practices, and promoting ongoing learning and clinical inquiry within the Clinical Education department.

Work-based Communication Practices

Discussions pertaining to meetings, intra and inter-departmental communications, workspace, equipment, and other resources highlighted what leaders and workgroup members felt both supported and hindered their engagement. There were clear similarities in how leaders and workgroups spoke of the value of intra-departmental communications, but differences in how they perceived what was happening with inter-departmental and organization-wide communications.
Workgroup members and leaders commented on the constant need for good communication within their departments. People spoke about how media—like email or cell phones—were used effectively to keep in touch on both a personal and professional basis. In addition, they also described problems which arose when there was a lack of procedural consistency in working remotely, or when people failed to check in when doing evening or weekend coverage.

Further, leaders spoke about the value of using consistent processes like agenda-driven meetings and brief but regular staff huddles—where everyone on their team contributes. However, staff had mixed opinions about the value of meetings. They agreed that agenda-driven meetings seemed to provide some advantage for leaders and staff to do problem solving, keep communication lines open, and actually achieve outcomes. Yet, sometimes workgroup members cited meetings as a waste of time when information could have been handled in a memo or email. The larger concern among workgroup members seemed to be that meetings took time away from direct patient-caregiver interactions with their patients. Given the issues that workgroup members raised about meetings and communications, it is surprising that all leaders and employees (100%) responded positively to a Manion question specifying that they had regular department or staff meetings, which included active dialogue on current issues and concerns.

While some workgroup members bemoaned the problems with working with other departments, it was leaders who wanted more connectivity on an inter-departmental level to break down silos, and have their department’s voice heard more broadly organization-wide. Some leaders spoke about how they made an effort to share with their staff what they learned from higher levels in the organization. Yet, it’s noteworthy that
while leaders spoke of the necessity for wider communication across departments and organization-wide, there were limited examples of how these highly engaged leaders were taking systematic steps to make this happen.

Unlike their leaders, some workgroup members appeared troubled that the councils and additional committees their leaders had them on, required them to spend time at home completing the work demanded by their jobs. In such situations, the sense was that they were being asked to go above and beyond already demanding work. This added level of responsibility also seemed to create stress for people who were swamped working two jobs for financial reasons. Leaders did not mention being aware of such concerns.

Moreover, some workgroup members found it difficult to maintain a high level of engagement past 6 to 8 months on committees where they saw little action or change occurring. They bemoaned the numerous steps it takes to get something through the bureaucratic systems, and expressed feeling worn out as a result. Again, the leaders appeared to be mostly unaware of staff concerns. It was apparent in the Manion survey that 14% of workgroup respondents strongly disagreed and 29% agreed sometimes that their department committees, councils, and teams are robust and active. On the other hand, all leaders agreed (75% strongly; 25% sometimes) that their department committees, councils, and teams are robust and active. This discrepancy indicates a gap between what leaders were aware of and what their workgroups experienced.

Work Environment: Workspace, Equipment, and Attire

Workspace, equipment, and attire were common topics among leaders and their workgroups. All participants registered concerns on what was or was not conducive to a
good work environment. The leaders seemed to speak mainly about what was within their sphere of control in these matters. The workgroup members spoke mostly about the effect of space, equipment, and attire on their interactions with patients.

Several leaders spoke about initiatives being undertaken to improve their work environment. They tended to give credit to staff for engagement in such initiatives as “Adopt a Spot,” the “3Cs,” and EMR training implementation and clinical inquiry at the bedside. Leaders talked about such initiatives as having sprung from creative brainstorming with staff. Workgroup members spoke of them as decisions which were generated by their leaders, who then invited them into figuring how to make it happen.

On a different topic pertaining to workplace conditions that supported or hindered employee engagement, work space was a general concern discussed by workgroups and their leaders. For example, the Cardiac Rehab leader had moved her department to temporary workspace and was optimistic about the new unit, which was being constructed next to the Emergency Department. The leader said it took a long time coming, but that she was glad to be part of its design. On the other hand, the Radiology and Nuclear Medicine leaders and their staff had a difficult time with poor workspace that was not conducive for their interactions with patients, and poor office area for their staff.

Further, some workgroup members spoke about the advantages of working in a centralized area with each other, and the camaraderie and communication benefits that resulted. Yet other workgroup members spoke of the disadvantages of being allocated to a workspace separate from the hospital. A common concern among workgroups, which was not discussed by leaders, was having their work disrupted by moves
departments were required to make by upper levels in the organization without first gaining input from staff on how such moves would impact their work.

The Nuclear Medicine working supervisor was most vocal about the link between good workspace and employee satisfaction. She spoke of the need to have consistently functioning equipment, sufficient updated technology, and proper workspace for people to do their jobs well. The leader also wanted a user-friendly environment for the patients, which included things like maintaining a patient’s privacy while waiting for a test, or having handicap-accessible bathrooms. There was only one accessible bathroom for handicapped persons currently available to patients in her department.

The discussion regarding wearing uniform attire was a point of concern among those interviewed. On the one hand, directors reporting to the CNE made a decision that their staff would wear attire color-coded by department, so that patients or staff in other departments could recognize them by their job function. However, with the exception of the Cardiac Rehab staff, that decision seems to have been handed down to working supervisors and staff without first giving them a voice in the matter. While patients and their families seemed to have been the primary concern of the leaders, staff felt they should have been part of the discussion. For some group members there was a tradition of professionalism associated with their attire, which was disregarded in the uniform attire decisions made by their leaders.

Leaders Contribute to High Engagement

Both leader and workgroup members talked about leader characteristics that facilitated high engagement within workgroups. Leaders took it a step further to describe how their own leaders (bosses) helped foster their engagement. There were many
commonalities between what workgroup members and leaders said about the role that leadership played in keeping people engaged. There were also some differences. The similarities and differences will be elaborated on in the following section.

Leader Characteristics That Foster High Engagement

As cited in previously in this chapter, workgroups and their leaders echoed the importance of having consistent values to promote teamwork and high engagement. Group members seemed to see their leaders as very much part of their team, and were pleased when leaders identified individual strengths, reinforced the importance of each person, and acknowledged the value of teamwork in general.

Workgroup members appreciated when their leaders asked for their input and were genuine in their behavior with staff. This included being fully “present” in their conversations with staff, listening and providing honest feedback whether in a performance dialogue process or in dealing with a work-related problem.

Leaders too thought it was incumbent upon them to have respectful conversations with staff, and to work with them through difficult situations. Leaders thought it best to have direct and crucial conversations as issues arose. Leaders mentioned how staff morale was negatively affected when they did not immediately address personnel issues. In the Manion survey, both leaders and workgroup respondents confirmed the importance of the leader listening. When asked the question whether “my manager listens to me when I come with my concerns and issues,” 93% of employees strongly agreed, and all leaders (100%) thought employees believed their leaders listened to staff concerns and issues.
Workgroup members wanted leaders to keep focused on the work at hand, and valued those who kept promises they made to staff. Employees also liked to be recognized by their leader for accomplishing set goals. Similarly, leaders said it was essential to set goals and expectations with their workgroups, and to involve them in decision-making pertinent to their work unit.

Clinical workgroup members liked having leaders who had clinical expertise, who were on the floor with them and accessible. They applauded leaders who asked staff to do things they themselves would do to meet the job demands. Both clinical and non-clinical staff liked leaders who were flexible in scheduling and who provided backup coverage when someone needed it. The Human Resources leader was cited for taking time to be with staff who worked evenings or on holidays. In addition, the new Nuclear Medicine employee valued her leader for taking time to walk her through protocols and regulations she needed to know, not assuming that it was something the new employee could pick up elsewhere or on her own. The new employee felt her leader set the bar for being easy and approachable; someone she could call anytime day or night with work-related questions. On the other hand, her colleague in the same workgroup spoke of difficulties he had being in matrix relationships within the larger Radiology department. The employee mentioned he sometimes felt micromanaged and received mixed messages from leaders depending on whom he was working for on a given day.

How Leaders Role Model Behaviors Conducive to Fostering High Engagement

Leaders felt that to promote employee engagement they had to walk the talk of modeling the actions and behaviors they wanted to see in others. The Nursing
Administration workgroup member praised her leader’s philosophy, “What you accept is what you teach.” She spoke about how that mentality was firmly implanted inside the culture of their workgroup. For example, she cited how their leader set expectations and boundaries within the team, and had healthy discussions with staff about practicing behaviors consistent with good teamwork.

Leaders took an additional tack in their conversations about leadership. They described actions and practice of their own bosses; they often spoke of how they in turn tried to emulate their bosses. For example, leaders valued having an approachable boss with open-door policies. They liked being coached by their boss in how to deal with tough work or personnel situations. They also recalled the satisfaction they derived from peer-to-peer relationships where they could speak candidly with their boss or another colleague, receive honest feedback, and have their confidentiality respected. Leaders spoke of 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 them in and outside of work. Interestingly, leaders did not describe their interactions with staff in the same way. For example, more than one leader used the stage as a metaphor for how they felt they had to sometimes behave around staff. They thought they had to put on a happy face when that wasn’t necessarily how they were feeling inside.

Leaders often spoke about their broader responsibilities within the hospital, and often recalled inter-departmental or hospital-wide concerns. With the exception of Nuclear Medicine, Clinical Education, and Cardiac Rehab, other workgroups seldom did so. Leaders spoke a lot about what the organization needed (e.g., breaking down silos,
new initiatives, regulatory and financial directives), and how they wanted their teams to be perceived at higher levels in the organization. In addition, leaders talked about changes coming down the pike in healthcare, and said they wanted their workgroups to be aware of what was going on at the local, state, and national levels regarding healthcare policies and practices. Workgroups did not address the same concerns.

On the whole, a recurring issue for leaders was about how much to communicate with their workgroups about problems or issues arising out of their actual department. The push-pull dilemma for leaders centered around being clear about staff priorities, practicing shared decision-making, and determining when and how much to engage staff outside of the immediate department. Interestingly, the differences in how workgroups and leaders perceived what was going on showed up in their responses to a Manion question about how leaders handled employee involvement in decision-making. All leaders agreed (100%) that they put the employee first when making decisions. However, 8% of employee respondents strongly disagreed that managers put them first when making decisions and 46% only agreed sometimes.

For the most part, unlike their leaders, employees appeared focused more inside the department about what they expected of each other and their leader in achieving results. Workgroup members wanted leaders to demonstrate transparency, listen to concerns, ask staff questions concerning what’s going on, be available to staff for coaching, and set priorities with the team especially regarding providing excellent patient care. When workgroups and leaders talked about their teams, they appeared to harmonize on how they viewed their work together. However, dissonance occurred when group members perceived a leader’s time or attention shifting away from team objectives and
goals, towards inter-departmental or organization-wide initiatives—without first asking staff how it would affect them or their ability to provide quality patient care. A good example of this is what happened with the EMR project. The leader was focused on implementing the EMR training; her staff was trying to figure out how to get their jobs done and implement the training as well. This was also true for initiatives like the “Adopt a Spot” project and the “3Cs” initiative. In cases like these, leaders made commitments of staff time and resources without fully involving staff in the decision, clarifying the team’s priorities, or taking into consideration the full impact on the employees.

Summary

Chapter 6 addressed the research question: “How are the workgroup member and leader actions and practices similar or different?” Material was organized under the same themes as those used previously in the study. Similarities and differences in how workgroups and leaders perceived actions and practices integral to their engagement were described. The material presented in this chapter is elaborated upon further in the discussion of findings and recommendations presented in Chapter 7.
CHAPTER SEVEN

SUMMARY AND CONCLUSIONS

Introduction

In the United States we know that a large number of people are not engaged at work, and that the lack of engagement affects the service outcomes as well as financial bottom line of organizations. Therefore, this study was conducted to learn from the high-engagement workgroups about individual actions, practices, and workplace conditions that contribute to high engagement.

This chapter presents a summary of the study context, problem and purpose, and the three research questions that guided the research. It reviews the research design including the conceptual framework, why qualitative methods were used, and the data collections and analysis processes, and presents the study findings as well as a discussion of the findings and recommendations.

Context of the Study

TCH belongs to the Healthcare Corporation, which employs more than 7,200 people and cares for more than 450,000 men, women, and children in the community each year among its various entities and services. Since 2005, TCH has examined employee engagement using the Gallup organization’s Q12 survey to assess the levels at which its employees are committed to their jobs and workplaces. From 2005 to 2010, the
Healthcare Corporation employee engagement scores have monitored the ratio of “engaged” to “actively disengaged” employees organization-wide. In general, Gallup data indicated the Healthcare Corporation staff were above average relative to engagement compared with Gallup’s accumulated U.S. working population data. Since TCH is the largest acute care hospital with the Healthcare Corporation system, and responsible for contributing the largest amount of revenue to the system’s income, it was a good candidate for studying actions, practices, or workplace conditions that fostered its high-engagement teams. No previous examinations of what makes teams highly engaged had been done at TCH, or anywhere else in the Healthcare Corporation system.

**Conceptual Framework**

The importance of the workgroup and its leader in initiating and maintaining engagement has been cited in the Social Exchange Theory (SET) and employee engagement literature. Further, the literature cites the importance to organizations of examining their business units that have scored high on employee engagement in order to learn about the talents and practices that drive business outcomes.

Two research areas provided the conceptual framework for this study. The first area was Social Exchange Theory (SET) that examines benefits individuals and groups perceive themselves as deriving from interactions and relationships in their workplace. The second area was employee engagement literature, which builds from SET and describes practices and workplace conditions that facilitate engagement at the individual, workgroup, and organization-wide level.

Social Exchange Theory is called one of the “most influential conceptual paradigms for understanding workplace behavior” (Cropanzano & Mitchell, 2005,
Cropanzano and Mitchell described 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.

SET literature offers two distinct conceptualizations of what a social exchange is and how to interpret it. A relationship might be interpreted as a series of interdependent exchanges, or it might be regarded as the interpersonal attachments, which result from a series of interdependent exchanges. This study watched for exchange elements among workgroups and between the leader and workgroup members.

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 is, 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 organization 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 the individual in their work role, and in their role as a member 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.

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.

After Saks’s (2006) research, Mackoff and Triolo (2008a, 2008b) and Manion (2009) completed engagement studies in the healthcare sector. Mackoff and Triolo (2008b) claimed staff nurses leave managers, not organizations, and managers who feel supported by their organization reciprocate this support with their staff. In addition, they
found nurse executives who build cultures of nurse manager engagement “are also cultivating staff nurse longevity and vitality, which translates into high-quality care and patient satisfaction” (p. 170).

Manion (2009) reported five strategies that exemplary leaders pursue to create a culture of engagement. They include managers who made their employees the first priority as a way to ensure that the employee would put the patient first. Managers also focused on building strong healthy connections with their employees. Manion’s employee and leader surveys were adapted for use in this study, and cited extensively in previous chapters.

In essence, Mackoff and Triolo’s (2008a, 2008b) research and that of Manion (2009) were similar to Kahn and Saks in that they examined “rules” of exchange where the actions of one party led to a response or actions by the other party. Their studies provided the conceptual context for examining engagement at TCH.

**Research Design**

The dissertation study used a qualitative research design utilizing a single-case study with two groups, workgroups and their leaders, and focus groups and interviews to collect data. Qualitative methods were used to gain an encompassing, integrated overview of what is being studied (Miles & Huberman, 1994). A case study was used “to arrive at a comprehensive understanding of the groups under study” (Merriam, 1998, p. 29). The groups under study in this research were highly engaged workgroups and their leaders at TCH. The study used findings from the stories, examples, and interpretations provided by workgroup members and their leaders who participated in the study in the natural setting where they worked.
The dissertation study used a qualitative research design utilizing a single-case study with two groups, workgroups and their leaders, and focus groups and interviews to collect data. A case study was used because it allowed me to develop an encompassing view of high-engaged workgroup members and their leaders at TCH: what supported or hindered engagement from the stories, examples, and interpretations provided by workgroup members and their leaders who participated in the study in the natural setting where they worked.

The Sample

Patton (2007) attested to the power of purposive sampling, saying it “lies in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research” (p. 46). Therefore, workgroups at TCH who had scored in the 75th percentile (top quartile) of the Gallup 2010 for their high engagement were candidates for participating in the study. Additional criteria required that it was necessary that workgroups have the same 2010 leader in place as of October 7, 2011 (seven leaders were identified); the current workgroups have at least four of the original 2010 members. New employees who had joined one of the high-engagement workgroups since 2010 were also invited to participate in the study. They had to have worked with their workgroup for at least 3 months. Consequently, seven workgroups were identified for participation in the study. Eighteen members of the seven highly engaged workgroups participated in the study. All seven leaders plus three new employees participated.

Patton (2007) advises the researcher, “The key issue in selecting and making decisions about the appropriate unit of analysis is to decide what it is you want to be able
to say something about at the end of the study” (p. 229). This held true in the data collection and analysis as well. For data collection, focus group and interview sessions were selected with members from the seven workgroups, and their seven workgroup leaders. This method was chosen because focus groups permitted me to learn participant attitudes and opinions on the topics at hand (Morgan, 1997). Participants were asked to complete a non-mandatory online survey to triangulate those findings with those from the focus and interview sessions.

Data were analyzed based on codes that emerged in the transcripts of participant sessions. They were clustered by recurring patterns and themes in the data, and categorized under major themes and subheadings and analyzed by workgroups and workgroup leaders. A final analysis compared how workgroups and their leaders were similar or different in their perspectives regarding actions, practice, and workplace conditions.

**Findings**

The study findings are organized by the research questions being addressed. The findings are reported under the four major themes that emerged in the study. Further, for the most part they are presented under the subtopic headings in the study chapters with several slight modifications.

**Workgroup Findings**

The first question the study asked was: How do workgroup member actions, practices, and workplace conditions contribute to high engagement? It opens with a discussion of findings regarding how teams contribute to high engagement.
Teams Contribute to High Engagement

This segment describes workgroup actions and practices that contribute to high engagement. It is reported under six subtopics.

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 problem solve together. 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 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 one’s self 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 the best part of their job as working with patients. They described a cyclical pattern of interactions with patients where 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 oneself 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 a patient 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 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 Conditions Contribute to High Engagement

This segment presents findings regarding conditions that facilitated high engagement and some that did not. The findings are presented under four subtopics.
Opportunities for Continuous Learning. Continuous learning options brought both practical and philosophical benefits to workgroups. They noted how from the practical perspective they were able to stay current in best practices including ongoing staff development, credentialing and certification requirements. On the philosophical side, they commented how their leaders proposed books to them, which allowed them to stay current on leadership practices and staff development principles that were then 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- vs. inter-departmental-level committees and meetings. They preferred structured meetings with action-based outcomes. Workgroup members used email, 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 at the inter-department level 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 conditions. 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—particularly the top-down decision that had been made regarding them to follow suit.

**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 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.
Leader Findings

The second question in the study was: How do leaders contribute to developing high-engagement workgroups?

Teams Contribute to High Engagement

This segment describes leader actions and practices that contributed to high engagement. 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. They 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 theirs. 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, “there is not I and the team.”

*Balancing Professionalism With Having Fun.* Like their workgroups, leaders mentioned occasions where fun occurred. However, unlike their workgroups they spoke of fun and humor less as day-to-day spontaneous actions, and more as planned events or initiatives where 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 where they had people publically 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 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 for what the patient 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 keep an eye on clinical and financial outcomes, along with 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 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 Conditions Contribute to High Engagement**

This segment presents what leaders said about workplace conditions: 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 for orientation, where they were very involved.

Work-based Communication: Meetings and Processes. Leaders spoke about procedures they followed for meetings be they intra- or 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 were similar traits 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 key in 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 Role 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 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

The third question in the research study was: How are the workgroup member and leader actions and practices similar or different? There were a series of currents that intersected through this comparison of leader and workgroup perceptions. Some currents highlighted the similarities between what the highly engaged workgroup members and leaders thought contributed to high engagement. Others differed.

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 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 were 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, for many leaders, patient care was 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 CNE leader of the Nursing Administration group, and the Radiology Department director whose attention was more broadly spent. Findings in the Manion 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 conditions 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 of
their departmental culture than their leaders—what it took to support each other whether 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 in sync in how they described actions and practices, people and priorities, and workplace conditions 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.

Indeed, what employees wanted was a safe haven for their meaningful work, where they could trust each other and their leader’s availability to get things done within the local environment where they worked. Leaders, however, didn’t seem to be aware that this is what employees wanted. Leaders were not in sync with their workgroups about what it takes to maintain a highly engaged team, did not draw staff into discussions about these matters, and did not always put the employee first.

**Discussion of Findings**

The people who participated in the study demonstrated candor, openness, and a willingness to tell their stories and describe what they thought contributed to their high
engagement. This segment presents some of the overall conclusions I drew from the findings.

1. I was surprised at how strongly the workgroups viewed themselves as teams. The teams did not characterize themselves by where they worked, who they worked for, or their work environment. Instead, all the workgroups identified themselves based on their interactions and relationships with each other at their department or work unit. They described how at the local level they valued, supported, and cared for each other.

   There were many commonalities across teams in how they spoke about what made them highly engaged. What stood out was how they were conscious and appreciative of their meaningful relationships. It was as if each department had its own unique culture—much of it influenced by the kind of work they did, including the actions and practices of their leaders, which fostered their engagement. As in Kahn’s (1990) research, the study findings revealed that all workgroup members “felt worthwhile, useful, and valuable, as though they made a difference and were not taken for granted. They felt able to give to others and to the work itself in their roles and also able to receive” (p. 704).

2. What surprised me was how unaware leaders were of the impact of their actions and practices on the people who directly reported to them. When leaders were attuned to their workgroups and provided the internal support that teams needed (be that through coaching; providing the tools, equipment, and space necessary to do the job; or being on the floor with staff), workgroups saw their leader as being in alignment with the team. This finding concurs with Saks’s (2006) observation that employee perceptions of
supervisory support (PSS) are essential to fostering and maintaining employee engagement.

However, when leader responsibilities took them outside the team’s work, team members saw leaders as less in sync with their concerns. In some cases, leaders had so many work units under their span of control, they didn’t know everyone’s name, and much less what engaged them. Interestingly, this did not occur when the workgroup was comprised of five to 10 employees, which Fleming and Asplund (2007) considered optimal in their research.

Another interesting twist was that some of the highly engaged workgroup leaders had other work units reporting to them, which scored low on the Gallup engagement index. These leaders never made the leap in awareness that having such a broad span of control lessened the likelihood of their spending time necessary for the interactions with employees that foster engagement. In fact, few of the workgroup leaders thought about how they could model what was happening on their highly engaged teams with those workgroups that were not engaged.

3. Respondents to a Manion (2009) survey indicated that employees did not think that leaders put them first, but leaders thought they did. It’s worthy of note that contemporary healthcare literature indicates that if leaders do not put the employee first, employees will not be able to focus on the patient as their first priority (Spiegelman & Berrett, 2013). Except for one person, leaders did not speak about their ongoing responsibility in maintaining employee engagement, or draw the connection between such engagement and the quality of direct patient care.
Furthermore, leaders spent as much or more time discussing other tasks and responsibilities they had, as they did on ways they contributed to employee engagement. When leaders spoke about patient care, many did so with an emphasis on business outcomes and local, state, and federal requirements they had to meet. Again, current healthcare literature notes, “Hospitals have missed the point that the best way to improve the patient experience is to build better engagement with their employees, who will provide better service and care to patients” (Spiegelman & Berrett, 2013, p. 15).

Workgroup leaders appear to have missed the point.

4. Clinical and non-clinical leaders did not talk about working in partnership with each other. There was a disconnect between direct-patient-care leaders, and those who provided support services that funneled resources and personnel to clinical workgroups. There was little awareness by clinical workgroups of what was going on in other patient-care departments, or what was going on in non-clinical ones. The lack of curiosity among these workgroups was initially disconcerting, but then I realized it may have been connected to the intense daily demands of their work, leaving little space for much else.

Furthermore, there was little mention about patient care as a driving priority among non-clinical workgroups. There were recurring complaints from clinical leaders about how little feedback they received on data they supplied, up through the chain of command in the larger organization. Yet, leaders did not suggest ways to break through those stalemates in the leadership chain. Moreover, leaders also raised concerns about inter-departmental silos, but did not offer suggestions on how to break them down.

5. Leaders sought counsel and support from their peers and bosses, not from members of their workgroups. This belies the thrust of leader claims that they practiced
transparency, trust, and candor in their workgroups. Kahn (1990) observed that people experienced psychological safety when they were able to show and employ themselves without fear of negative consequences to self-image, status, or career. This was not the case for workgroup leaders at TCH. This may have been because relationships with people representing lower hierarchical echelons “were potentially more stifling and threatening than relationships with peers” (p. 709).

6. I was surprised that workgroups that participated in the study did not know that they were ranked in the 75th percentile or better of highly engaged workgroups at TCH. Several leaders had some recollection of that data, possibly because their engagement scores directly affected their bonuses. However, there was little indication that the leaders had done anything to celebrate, reward, or acknowledge workgroup members for their engagement, nor did they build upon practices that brought those teams to high engagement. There was also no mention of leaders at the higher echelons who authorized the expense of the Gallup survey, acknowledging the contributions of the high-engagement workgroups, or building upon their success.

Because there was no apparent extrinsic reward or acknowledgment of their high engagement, it’s likely workgroup members, especially those working directly with patients, operated out of a passion for the work they do rather than dedication to the corporate entity. In Saks (2006) this finding would indicate that workgroups perceived low organizational support (POS) for their work.

Clearly, the workgroups had created a culture fueled by physical and emotional energy at work. Kahn (1990) found that strong personal engagement, like that found within these workgroups, demanded higher levels of physical energy, strength, and
readiness than that of less engaged employees (p. 714). However, the antithesis of such engagement, that is, emotional fatigue and burnout, occurred among the original high-engagement workgroups at TCH. This was apparent when, in determining who could participate in the study, I realized that many of the original members of these groups were gone in the less than 2 years between when the Gallup survey was conducted and my study began.

Maslach et al. (2001) indicated that burnout occurs when people feel overwhelmed with their workload, a lack of control over decisions affecting them, and few rewards and recognition for their efforts. Several workgroup members addressed what it felt like to lose staff to turnover, but there were few discussions among them or their leaders about why it happened or how it affected morale or productivity. Perhaps this is because in healthcare, high turnover is regarded as a fact of life, rather than as a problem to be solved. Yet it’s clear from SET research and the study findings that if leaders are not conscious of what impacts engagement, they will fail to build within their teams the scaffolding necessary to maintain engagement over time. There was no indication that the infrastructure required to maintain engagement among workgroups at TCH was on the radar screen for the majority of workgroup leaders in the study.

7. 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 show how beliefs get in the way of improving customer care and patient services. They describe repetitive cycles where employees believe that it’s the leader’s responsibility to provide quality patient care, when it’s the employees’ responsibility to connect with the
patient. In turn, the leader believes it’s his or her job to acquire resources, meet regulations, and maintain the financial solvency of the organization, when first and foremost it’s the leader’s responsibility to connect with the employee. So, no one has real clarity or accountability for who does what. This pattern was also apparent in the study findings.

It’s clear that in healthcare, in general, and at TCH, in particular, we have to bust these beliefs. Kahn (1990), Saks (2006), and Manion (2009) point the way. The challenge is that in hierarchical organizations like TCH, the change must start at the top and percolate down. Leaders must create the safe environment about which Kahn (1990) writes. They have to build trust through transparent recognition that we are all human beings and errors will happen. That safe environment must also be a place of learning, where if you learn from a mistake, you can fix it. The greatest weakness in healthcare is when people deny that problems exist, do not support learning from mistakes, and continue the cycle of fear and blame that leads to disengagement and poor outcomes.

**Recommendations**

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 who had been quantitatively rated and highly engaged. Following are recommendations based upon the findings in the study.

1. Each team in an organization has its own unique culture. Therefore, it’s imperative that leaders put employees first, and focus time and attention on building the relationships and reciprocity that fosters engagement between themselves and team members.
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.

4. Since hierarchical leadership exists in many organizations, it’s 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. People today work in fast-paced environments that allow little time and space for reflection. On the other hand, to be an engaged leader requires being open to such reflection and professional coaching to help see the blind spots.

6. Achieving and maintaining high engagement is a process that occurs over time. Leaders can use easily accessible and inexpensive surveys (like those Manion developed for healthcare) to take a quick pulse of 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.

7. This study used information gathered from highly engaged workgroups and leaders, then triangulated on those findings via a survey, which addressed many of the
same concerns raised in the study’s focus groups and interview sessions. Future studies could flip that process by starting with a survey to assess which workgroups are currently exemplary in fostering high engagement, then probe deeper into the culture of engagement within those exemplar groups. Such a study would add to the research about commonalities that exist among distinct work-unit cultures to foster engagement. Action research methods could also be useful for such a study.
APPENDIX A

GALLUP Q12 SURVEY
Research done by the Gallup organization across occupations, industries, and geographic locations characterized engagement as situations where employees are using their natural skills and talents, where more work is done in a more efficient manner, and where engagement directly affects an organization’s bottom line (Clifton & Harter, 2003). To further an understanding of employee engagement, the Gallup organization set out to identify and measure workplaces that would attract and retain the most productive employees. Its employee engagement model encompassed successive stages of engagement from both employee and customer perspectives. It charted an organization’s growth and financial outcomes from the baseline of meeting an employee’s basic needs. Gallup’s Work Audit (GWA) morphed into the immensely successful Q12 survey which was based upon a number of qualitative and quantitative studies Gallup had conducted over 30 years (Harter et al., 2002).

The Gallup Q12 survey assesses the levels at which employees are committed to their jobs and workplaces within and across business units in an organization. Employees assessed the following stems on a scale of 1 to 5 with 5 being the highest:

1. I know what is expected of me at work.
2. I have the materials and equipment I need to do my work right.
3. At work, I have the opportunity to do what I do best every day.
4. In the last seven days, I have received recognition or praise for doing good work.
5. My supervisor or someone at work seems to care about me as a person.

6. There is someone at work who encourages my development.

7. At work, my opinions seem to count.

8. The mission/purpose of my company makes me feel my job is important.

9. My associates (fellow employees) are committed to doing quality work.

10. I have a best friend at work.

11. In the last 6 months, someone at work has talked to me about my progress.

12. This last year, I have had opportunity at work to learn and grow.

Gallup reports back the survey data to its client organizations and the report monitors the ratio of “engaged” to “actively disengaged” per 100 employees. The engagement ratio indicates the number of “engaged” to the number of “actively disengaged” employees in a given organization. Gallup also provides accumulated U.S. working population data, which it collects for all industries, so an organization can compare its engagement scores to the workforce population surveyed. The survey can be used by corporations to address how to optimize quality by managing, measuring and maximizing the employee-customer experience. Harter et al. (2002) noted that Gallup’s position is engaged workers result in higher amounts of productivity, profitability, and reduced safety instances and absenteeism. “One interesting finding in the Gallup studies is that basic needs such as expectations, materials, and equipment have relationships to basic outcomes including: customer satisfaction-loyalty and employee turnover-retention, which ultimately influence larger business outcomes like profitability” (p. 215).
APPENDIX B

CREATING A CULTURE OF ENGAGEMENT
EMPLOYEE SURVEY
**CREATING A CULTURE OF ENGAGEMENT EMPLOYEE SURVEY** © (Manion, 2009, pp. 157-159)

**Directions:** When you complete this survey, think about your department(s) and the employees with whom you work. Answer by circling the letter which best describes how strongly you believe the following statement describes your situation.

- Y = Yes, Strongly Agree
- S = Agree Sometimes
- N = Strongly Disagree

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th>1. We feel free to challenge any management decision in a respectful way.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>2. Management believes that I am an honorable person, and if I tell my leader I need something, he or she believes me.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>3. My leader puts the employee first when making decisions and solving problems.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>4. My leader continually looks for ways to show his or her appreciation through special gestures and events.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>5. Employees in my department regularly recognize each other and participate enthusiastically in any department recognition events.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>6. Employees are frequently asked, “What’s important to you?”</td>
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<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>7. We work hard at keeping scheduling in our department as flexible as possible in order to meet both customers’ and employees’ needs.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>8. My leader listens to me when I come with my concerns and issues.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>9. Employees in this department know they have been heard when they see action taken on their issues and concerns.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>10. Employees feel supported by management.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>11. Each employee has some kind of persona, individual connection with the leader.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>12. I know something personal about my leader.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>13. My leader knows the names and something personal about each and every one of the employees who works here.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>14. There is a strong sense of connection, of community, among people in the department.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>15. When an employee is having problems, other people in the department rally around and help in constructive ways.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>16. When interviewing job applicants for this department, we consider the personality and “fit” of the applicant a priority for hiring.</td>
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</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>17. Technical skills are secondary to other characteristics and interpersonal skills when we seek new employees.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>18. Department employees are involved actively in the hiring and selection process of new employees.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>19. Employees in this department enjoy coming to work.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>20. We enjoy spontaneous fun as well as planned fun together on a regular basis.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>21. The standards for performance are very high in this department.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>22. The expectations and standards are clearly articulated and communicated to everyone.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>23. A strong, consistent network of coaching is available to employees in this department.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>24. Development of employees is a key goal in this department.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>25. Leaders frequently ask employees, “What are you interested in learning,” and “What opportunities are you interested in?”</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>26. Our leader models the behavior he or she expects to see in employees and colleagues.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>27. My leader is always on the lookout for great performance in order to recognize and reward it in a concrete and immediate manner.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>28. My leader holds people accountable for their actions, dealing with inconsistent or inadequate performance and problems immediately and consistently.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>29. My leader deals with problems immediately and does not let them fester.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>30. When employees bring the leader problems of an interpersonal conflict, the leader uses his or her judgment about whether he or she should resolve the problem or coach and encourage the employees to do so.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>31. Most of the improvements in our department over the past year have come from ideas and concerns shared by employees.</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>32. Employees are frequently asked, “What needs to be fixed?”</td>
</tr>
<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td>33. If a problem brought by an employee cannot be solved, the leader at least gets back to the employee in a timely manner to let him or her know what has been done.</td>
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<tr>
<td></td>
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<td></td>
<td>34. We have a specific structure for involving employees in decision making in this department (department council, governance structure, problem-solving teams, etc.).</td>
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<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
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<tr>
<td>35. Employees are instrumental in helping make decisions that affect the department.</td>
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<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
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<tr>
<td>36. Our department’s committees, councils, and teams are robust and active.</td>
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<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
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<tr>
<td>37. If employees are asked to participate in a committee or task force, the leader makes certain they have the time scheduled off to attend the meeting and actively coaches them so they are prepared for their participation.</td>
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<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
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<tr>
<td>38. The leader sees an important part of his or her job as making certain that employees have the necessary equipment have the necessary equipment and supplies to do their job.</td>
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<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
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<tr>
<td>39. Employees are authorized to obtain adequate supplies and equipment, even in the leader’s absence.</td>
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<tr>
<td>Y</td>
<td>S</td>
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<tr>
<td>40. The leader works to ensure that the physical environment of our department is clean, organized, and pleasing.</td>
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<tr>
<td>Y</td>
<td>S</td>
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<tr>
<td>41. The leader believes that one of his or her most important jobs as leader is to facilitate the work of our employees.</td>
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<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
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<tr>
<td>42. Our leader believes that he or she works for us employees, rather than the employees work for him or her.</td>
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<tr>
<td>Y</td>
<td>S</td>
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<tr>
<td>43. Our leader regularly sees employees on all shifts.</td>
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<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
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<tr>
<td>44. Our leader jumps in and helps out employees with their work on a regular basis.</td>
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<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
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<tr>
<td>45. Employees know when the leader is available or how to find him or her when they need something.</td>
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<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
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<tr>
<td>46. The leader is readily visible throughout the department throughout the day.</td>
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<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
<td></td>
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<tr>
<td>47. The leader doesn’t hide anything from employees that they need to know. The leader doesn’t believe in secrets.</td>
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<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
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<tr>
<td>48. We have multiple methods of communicating important information within the department.</td>
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<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
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<tr>
<td>49. We have regular department or staff meetings that include active dialogue on current issues and concerns.</td>
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<tr>
<td>Y</td>
<td>S</td>
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<tr>
<td>50. Employees are comfortable giving the leader direct feedback.</td>
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</tbody>
</table>
**Scoring Directions:** Count up the number of Ys, Ss, and Ns. Each Y is two points, each S is one point, and each N is zero. Total the number of points by clusters of 10 questions.

Total for Questions 1-10 ______ (Put staff first)
Total for Questions 11-20 ______ (Forge strong connections)
Total for Questions 21-30 ______ (Coach for and expect competence)
Total for Questions 31-40 ______ (Focus on results)
Total for Questions 41-50 ______ (Partner with employees)

**TOTAL** ______

**Interpretation:** If your total score is 90–100, your workplace is likely to have a culture of retention; if your score is 70–89, you have opportunities for strengthening the environment. If your score is 69 or below . . . get going! Either get going to try and change things, or just get going!
APPENDIX C

CREATING A CULTURE OF ENGAGEMENT
MANAGER SURVEY
**CREATING A CULTURE OF ENGAGEMENT MANAGER**
**SURVEY © (Manion, 2009, pp. 154-156)**

**Directions:** When you complete this survey, think about your department(s). Answer by circling the letter that best describes how strongly you believe the following statement describes you or the people with whom you work.

<table>
<thead>
<tr>
<th>Y</th>
<th>S</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I encourage the employees who report to me to challenge me in any decision I have made.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>I trust that the employees who work with me are honorable people, and if they tell me they need something, I believe it.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>I believe, as a leader in this organization that I need to put the employee first.</td>
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<tr>
<td>4.</td>
<td>I continually look for ways to show my appreciation through special gestures and events.</td>
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</tr>
<tr>
<td>5.</td>
<td>Employees in my department regularly recognize each other and participate enthusiastically in any department recognition events.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>I continually ask employees, “What’s important to you?”</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>We work hard at keeping scheduling in our department as flexible as possible in order to meet both customers’ and employees’ needs.</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>My employees believe I listen to them when they come with their concerns and issues.</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>The employees in this department know they have been heard when they see action taken on their issues and concerns.</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Employees feel supported by management.</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>I believe each employee needs to have some kind of personal, individual connection with his or her leader.</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>I believe that it is important to share something personal of myself with my employees.</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>I know the names and something personal about each and every one of my employees.</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>There is a strong sense of connection, of community, among people in the department.</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>When an employee is having problems, other people in the department rally around and help in constructive ways.</td>
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<tr>
<td>Y</td>
<td>S</td>
<td>N</td>
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<tr>
<td>Y</td>
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**Scoring Directions:** Count up the number of Ys, Ss, and Ns. Each Y is two points, each S is one point, and each N is zero. Total the number of points by clusters of 10 questions.

Total for Questions 1-10 ______ (Put staff first)

Total for Questions 11-20 ______ (Forge strong connections)
Total for Questions 21-30 _____ (Coach for and expect competence)
Total for Questions 21-40 _____ (Focus on results)
Total for Questions 41-50 _____ (Partner with employees)

TOTAL _____

**Interpretation:** If your total score is 90–100, your workplace is likely to have a culture of retention; if your score is 70–89, you have opportunities for strengthening the environment. If your score is 69 or below . . . get going! Either get going to try and change things, or just get going!
APPENDIX D

SAKS’S DATA SCALES
SAKS’S DATA SCALES

This Appendix lists items for all scales Saks (2006) used in the study.

Job engagement

• I really “throw” myself into my job.

• Sometimes I am so into my job that I lose track of time. This job is all consuming; I am totally into it.

• My mind often wanders and I think of other things when doing my job. I am highly engaged in this job.

Organization engagement

• Being a member of this organization is very captivating.

• One of the most exciting things for me is getting involved with things happening in this organization.

• I am really not into the "goings-on" in this organization. Being a member of this organization make me come "alive." Being a member of this organization is exhilarating for me.

• I am highly engaged in this organization.

Job characteristics

• How much autonomy is there in your job? That is, to what extent does your job permit you to decide on your own how to go about doing the work

• To what extent does your job involve doing a "whole" and identifiable piece of work? That is, is the job a complete piece of work that has an obvious beginning and end? Or is it only a small part of the overall piece of work, which is finished by other people or by automatic machines?

• How much variety is there in your job? That is, to what extent does the job require you to do many different things at work using a variety of your skills and talents?

• In general, how significant or important is your job? That is, are the results of your work likely to significantly affect the lives or well-being of other people?
• To what extent do managers or co-workers let you know how well you are doing on your job?

• To what extent does doing the job itself provide you with information about your work performance? That is, does the actual work itself provide clues about how well you are doing . . . aside from any “feedback” co-workers or supervisors may provide?

Rewards and Recognition

• A pay raise.

• Job security. A promotion.

• More freedom and opportunities.

• Respect from the people you work with. Praise from your supervisor.

• Training and development opportunities. More challenging work assignments.

• Some form of public recognition (e.g., employee of the month). A reward or token of appreciation (e.g., lunch)

Distributive justice

• Do the outcomes you receive reflect the effort you have put into your work?

• Are the outcomes you receive appropriate for the work you have completed? Do your outcomes reflect what you have contributed to the organization?

• Are your outcomes justified given your performance?

Procedural justice

• Have you been able to express your views and feelings during those procedures?

• Have you had influence over the outcomes arrived at by those procedures? Have those procedures been applied consistently?

• Have those procedures been free of bias?

• Have those procedures been based on accurate information?

• Have you been able to appeal the outcomes arrived at by those procedures? Have those procedures upheld ethical and moral standards?

Perceived organizational support
• My organization really cares about my well-being.

• My organization strongly considers my goals and values. My organization shows little concern for me.

• My organization cares about my opinions.

• My organization is willing to help me if I need a special favor. Help is available from my organization when I have a problem. My organization would forgive an honest mistake on my part.

• If given the opportunity, my organization would take advantage of me.

**Perceived supervisor support**

• My supervisor cares about my opinions.

• My work supervisor really cares about my well-being. My supervisor strongly considers my goals and values. My supervisor shows very little concern for me.

**Employee engagement**

• Job satisfaction

• All in all, I am satisfied with my job.

• In general, I do not like my job.

• In general, I like working here.

**Organizational commitment**

• I would be happy to work at my organization until I retire.

• Working at my organization has a great deal of personal meaning to me.

• I really feel that problems faced by my organization are also my problems. I feel personally attached to my work organization.

• I am proud to tell others I work at my organization.

• I feel a strong sense of belonging to my organization.

**Intent to quit**

• I frequently think of quitting my job.
• I am planning to search for a new job during the next 12 months.

• If I have my own way, I will be working for this organization one year from now.

**OCBI (organizational citizenship behavior directed to the individual)**

• Willingly give your time to help others who have work-related problems.

• Adjust your work schedule to accommodate other employees’ requests for time off. Give up time to help others who have work or non-work problems.

• Assist others with their duties.

**OCBO (organizational citizenship behavior directed to the organization)**

• Attend functions that are not required but that help the organizational image.

• Offer ideas to improve the functioning of the organization.

Take action to protect the organization from potential problems. Defend the organization when other employees criticize it.
APPENDIX E

MACKOFF AND TRIOLO SIGNATURE BEHAVIORAL FACTORS FINDINGS FROM THEIR RESEARCH WITH EXEMPLAR NURSE MANAGERS
MACKOFF AND TRIOLO SIGNATURE BEHAVIORAL FACTORS FINDINGS FROM THEIR RESEARCH WITH EXEMPLAR NURSE MANAGERS

1. Mission-Driven
   Defined: Characterized as motivated and driven to action by a sense of meaningful mission and context. Mission-driven managers in the study operated in a context that takes into account how the bigger picture relates to a specific issue. They maintained a clear line of sight between management and the values of care at the bedside.

2. Generativity
   Defined: A term that refers to the capacity to find pleasure and satisfaction in caring for and contributing to the next generation. Those facets included: gratification and joy in development of others, creating a legacy in one’s own image, maintaining continuity and linking generations, and offering and granting opportunities for autonomy and freedom.

3. Ardor
   Defined: The depth and breadth of passion that nurse managers expressed. The growing literature on work engagement links ardor to passion about the job and a heightened emotional connection to work and organization that goes beyond job satisfaction.

4. Identification
   Defined: Identifying with the work of others. Keeping a clear line of sight to the care at the bedside via their staff enables managers to stay in contact with the care-taking focus.

5. Boundary Clarity
   Defined: The capacity to build strong connections with others without losing the sense of self. A marked preference for creating and restoring clear boundaries between self and others. The nurse managers spoke of the ways that boundaries allowed them to maintain their focus and equilibrium in the face of the strong feelings of others.
6. Reflection
Defined: Refers to the ability to examine experience. Reflection is central to the development of leadership because it uncovers important data and the opportunity for course correction or continuation. Learning from experience is a central tenet of nursing education and has been a focus of the literature of reflective practice. It’s important to be able to scan for relevant cues about self and others in workplace situations and then reflect and make sense of these cues.

7. Self-regulation
Defined: Self-regulation combined several elements including using restraint to keep emotions in check, suspending judgment, and conserving energy. Nurse managers repeatedly used the word “patience” to describe the capacity to manage their internal emotional states.

8. Attunement
Defined: Learning about a reality quite different from my own. Three related aspects of attunement appeared in the data: regard of the individual and the appreciation of each person’s contribution to the organization, the capacity for understanding diverse perspectives and “standing in another person’s shoes,” and setting aside assumptions to hear the whole story. Attunement, in the form of the recognition of the unique strengths of staff, is critical to employee engagement.

9. Change Agility
Defined: Behaviors and attitudes that drive and seek model change. Three aspects of this signature element in nurse managers included challenging the process, welcoming and initiating change, and seeking change through new learning. In addition, the capacity to challenge the process was seen as a key leadership practice; this includes questioning the status quo with innovation, growth, and improvement. The data offer examples of personal and professional development through education, projects, and new positions that involve risk taking and innovation. These nurse managers are the unit fixers, the risk takers, and the lifelong learners.

10. Affirmative Framework
Defined: Resilient behaviors to prevent nursing burn out and longevity is well established (Mackoff & Triolo, 2008a, pp. 121-123).
APPENDIX F

MACKOFF AND TRIOLO SIGNATURE ORGANIZATIONAL FACTORS FINDINGS FROM THEIR RESEARCH WITH EXEMPLAR NURSE MANAGERS
1. Learning Culture. Organizational support of learning and growth as well as providing information and resources necessary to accomplish work. Three inter-related aspects of learning cultures: (a) creating opportunities for educational mobility and continuous learning; (b) encouraging learning through risk taking and increased visibility, and providing transparency and accessibility of information and resources; and (c) providing access and sponsorship for continuing education, as a means of “getting the tools that I need,” a consistent theme in the data.

   a. For a number of nurse managers, a learning culture is defined by the opportunities to grow outside of their own unit. This could be a challenging assignment, the development of new competencies, and appointment to task forces or the like.

   b. Accessibility is a key in sustaining a learning culture, the importance of “go-to people,” transparent organizational structure, and being initiated into a management role with an in-depth formal orientation.

2. Culture of Regard

   c. Defined: An organization’s ability to convey the value of being valued as a prime driver in their engagement.

   d. Three consistent elements in cultures of regard were: offering esteem and recognition of the significance of nursing, empowering nursing practice, and facilitating goal attainment.

   Others were:

   e. Demonstrates employees’ beliefs about how much organizations value their contribution and well-being are linked to their positive emotional commitment to the organization and high levels of performance.
f. Empowerment of nursing practice, which has been linked to satisfaction, goal accomplishment, and retention, was a dominant theme for nurse managers.

g. Leaders who were responsive to nurse manager’s viewpoints, evidence gathering, and decision making were another dimension of cultures of regard.

3. Culture of Meaning

h. Defined: The ability to create “meaningfulness” on the job is strongly linked to personal engagement.

i. Creating mission clarity and perception of the organization’s values and fostering alignment between organization and individual values and contributions.

j. The importance of clarity and perception of mission in nursing environments has been well documented, and the management of meaning was seen as a key element of leadership.

k. Mindfulness about the institutional values and goals.

l. Notably, engagement was also linked to the alignment and fit between organizational and individual values. Nurse managers expressed what Kahn (1990) called “a return on investments of self.”

4. Generative Culture

m. Defined: The signature elements of generative nursing cultures, like those of generative individuals, are defined by a commitment to caring for, and contributing to, the next generation.

n. Mentorship of nurse managers, providing exemplars to serve as role models, and offering available and approachable senior leadership.

o. The importance of a mentor or preceptor as a dominant theme in their preferred future wishes for new nurse managers.

p. The data underline research that links availability of a boss to listen and guide, along with access to administrative support, as key factors associated with nurse retention.

5. Culture of Excellence
q. Defined: The idea of organizations driven by excellence was defined in nursing practice through studies of Magnet hospitals and nursing quality management.

r. Nurse Managers defined cultural excellence and its link to their engagement in two distinct ways: communicating expectations of excellence in care and practice and cultivating brand pride and personal investment in organization’s reputation, results, research, and continued growth.

Nurse managers expressed pride about organization accomplishments and their institutional reputation (Mackoff & Triolo, 2008b, pp. 167)
MACKOFF AND TRIOLO EXAMPLE NURSE MANAGER ENGAGEMENT QUESTIONNAIRE (NMEQ)

1. Let's talk about your beginnings as a middle manager at _____ medical center. What were your first positive impressions or promising or satisfying experiences in the first few weeks or months?

2. What did you learn during that early time that has helped you succeed over the years in the role?

3. You have been in your role at _____ for at least 5 years? How do you explain the positive factors that have influenced your decision to stay in your job?

4. What gifts, values, attitudes, and capabilities do you bring to the challenges of being a nurse middle manager? How have these allowed you to be successful, and to work long-term in this role?

5. What do you bring to the middle manager role that allows you to connect with so many different people-patients, nurses, organizations, administrators?

6. What is satisfying and gratifying about your experience of middle management in this setting? What do you contribute day to day that gives you a feeling of pride?

7. Describe a standout or highpoint experience in this setting-a time when you felt most engaged and alive. What made it such a memorable experience? Who was involved? What part did you play?

8. Your collaborative relationship with staff nurses contributes to high-quality patient care. Describe a time when your partnership with a nurse made difference in the care of a patient. What factors were present? What did you contribute?

9. Your interface with administrators and senior leadership is essential you're your own leadership. Give an example of a time when administrator or senior manager helped you succeed? What was happening? Who was involved? What was the outcome?

10. How has this particular organization been a good fit in enhancing your success and longevity as a middle manager?
11. Recall a time when you felt supported by your organization. What happened? Who was involved? What conditions were present?

12. If you could be granted three wishes for new middle manager coming into the field, what would you wish them?

13. Imagine this: As you drive home from work today, you slip through a wrinkle in time. It is the year 2015. All of the vacancies for nurse managers across the country are filled, the average tenure of a nurse manager is 10 years and nurse manager satisfaction is among the highest in the nursing field. What has happened to create this change?
APPENDIX H

PROCEDURE MAP FOR INTERVIEWS & FOCUS GROUPS
PROCEDURE MAP FOR INTERVIEWS & FOCUS GROUPS

A spreadsheet has been created which documents and tracks the following tasks and activities.

1. Delimit

   a) Identify TCH workgroups with scores greater than 75th percentile in the Gallup Q12 employee engagement and patient experience index.

   b) Make a list of the high-engagement workgroups and identify each group as clinical or non-clinical.

   c) Identify the leader of each workgroup at the time of the January 2010 employee survey and determine which groups have the same leader as of October 7, 2011.

   d) Determine size of workgroup at time of January 2010 survey; identify current employees who as of October 7, 2010 still remain in those workgroups.

   e) Determine turnover in workgroups.

   f) Retain 2011 leader and workgroup members which have 4 or more employees remaining since the Gallup Q12 2010 survey.

2. Choose Workgroups

   a) Select workgroups whose leader is still in place as of October 7, 2011 (7 leaders were identified).

   b) Compare the number of people in the original January 2010 Gallup Q12 workgroups at TCH to those who remain as of October 7, 2011.

   c) Determine percentage of turnover (ranged from 25% to 63%).

   d) Remove workgroups with fewer than 4 people remaining in the workgroup.

   e) Rank orders the 7 workgroups that remain. The 7 workgroups that remained were rank ordered according to percentage of turnover. Two groups tied for first place with a 25% turn over. Group 3 had a 31% turnover, group 4 had a 36% turnover, group 5 had a 50% turnover, group 6 had 55%, and group 7 had 63% turnover.
i. Group 1a = Nuclear medicine (clinical) workgroup; 6 people to invite to the focus group & 1 clinical leader to invite to the interview.

ii. Group 1b = Human Resources (non-clinical) department 6 people focus group 1 leader to go to an interview

iii. Group 3 = Clinical education (clinical) department, 11 people, and 1 leader for an interview

iv. Group 4 = Executive nursing (clinical), 7 people, and one executive

v. Group 5 = Administration (non-clinical), 6 people, 1 lead executive

vi. Group 6 = Radiology (clinical), 10 people to invite and 1 leader

vii. Group 7 = Cardiac rehabilitation (clinical), 7 people to invite to the focus group and 1 leader for the interview

viii. New Hires: Identify new people in each workgroup to be interviewed. New people have to have been hired since October 2010, worked for at least 3 months in their workgroup, and are still employed in their same workgroup as of October 7th, 2011.

3. Procedure for Recruitment

   a) Invite people in the selected workgroups to participate in the study.

   i. Collect email addresses for participants and make into an email groups for materials distribution.

   ii. Write a letter to workgroup members and their leader to recruit participants. Explain in the letter what the study is about, that it will be audiotaped and transcribed, how confidentiality will be maintained and explain the informed consent process. See Step #4 below for an elaboration on this process. Explain that there are 2 parts to the research study. The first part consists of one of the following: a 90-minute interview with a workgroup leader, a two hour focus group with a specific workgroup, or a 90-minute interview with a new workgroup member. The second part is a request to complete either a leader or employee survey on “Creating a Culture of Engagement”© developed by Dr. Jo Manion. An online link to the electronic survey will be provided. Participants will be informed that it is not mandatory to complete the survey to be part of the study, but that completing it would be appreciated. Request return in one week.
iii. Send the letter to the email groups created in Step #1 to ascertain if they are willing to participate. Include a consent form in the email. Requests return response turnaround time of one week.

iv. Send reminder email requesting return response to those who do not reply within one week.

v. Confirm receipt of respondents’ willingness to participate and signed consent form. File signed consent forms, scan and send copy back to participants.

vi. Develop a schedule plan for the interviews and focus groups. Coordinate rooms with TCH formative committee.

vii. Schedule specific dates/times/locations for leader interviews and workgroup focus group meetings.

viii. Email participating respondents to confirm date, time and location of their interview or focus group.

ix. Order refreshments for sessions.

4. Collect Data: Collect Data: Part 1 (Leader Interview, New Employee Interview, and Workgroup Focus Group)

a) Confirm each participant signed consent form prior to start of session.

i. Remind participant that interview or focus group is being recorded and will be transcribed and that all personal identifying information will be removed in the final write up.

ii. The purpose of audio taping the interviews and focus groups sessions is so that the researcher can accurately record, transcribe and analyze the data.

iii. Research subjects will be recorded in order to maintain the integrity of the data by being true to what people actually say in their session. If the researcher does not have the tapes to refer back to, there is no way to go back and check the facts; this increases the possibility that the interpretation will be flawed. It would negatively impact the research.

iv. Using an alternative approach of having an additional person in the room to take notes and document the discussions would be disruptive and provide less accuracy to the process. This is because adding another human being to the process is disruptive to the flow of the interview or focus group conversation.
v. All data, hard or soft, will be managed by a project assistant who will store the data on a secured drive to ensure confidentiality is maintained throughout the data collection and analysis process.

vi. The following people will have access to the primary data:

Julie Colson, Executive Assistant to Barbette Weimer-Elder, Education Institute, The Healthcare Corporation, Valley Town, USA: assist in logistics and schedule coordination with TCH

Shirley Freed PhD, Andrews University: Dissertation Chair for Barbette Weimer-Elder

Jan Meredith, Project Assistant, Education Institute, The Healthcare Corporation, Valley Town, USA: assist in the management and tracking of project-related electronic data on a secured The Healthcare Corporation drive.

Mary Riley Sanders EdD, Internal Consultant and Analyst, Education Institute, The Healthcare Corporation, Valley Town, USA: assist in the set up, coordination, and review of project-related activities, files and material.

vii. All identifying information will be removed from the write up of the findings and all original data sources, be they audio tapes or transcriptions, will be destroyed after the dissertation study is reported and defended to the Andrews University dissertation committee.

b) Use dissertation committee approved interview and focus group questions.

c) Conduct leader interviews, and focus groups sessions with workgroup members. These will alternate based on people’s schedules and availability of rooms.

d) After the leader interviews and focus group sessions are completed, conduct the interviews with the new employees who have been recruited to the study.

e) Researcher will keep a journal that reflects upon the process, her observations, thoughts and feelings about what she is hearing and learning.

f) Remind participants that Part 2 of the process is completing a non-mandatory electronic leader or employee survey.

Part 2 (Dr. Jo Manion: Cultural Engagement Manager Survey™ or Employee Cultural Engagement Survey™)
a) Thank people for their participation in Part 1 of the study. At the end of their interview or focus group, give participants instructions on how to complete the electronic survey. Request they complete the survey online within a week after exiting their interview or focus group.

b) Review data received from the survey.

5. Analyze Data

a) All personal identifiers will be removed from the results during the coding the process.

b) The interview and focus group data will be analyzed and coded in light of the literature and research pertaining to employee engagement and social exchange theory.

c) The researcher will look for patterns and themes within a given workgroup and across workgroups pertaining to actions, behaviors and workplace conditions that facilitate high engagement at TCH.

6. Report Findings

The findings from the study will be reported and discussed in Chapters 4 and 5 of the dissertation.
APPENDIX I

FOCUS GROUP GUIDE FOR WORKGROUP MEMBERS
FOCUS GROUP GUIDE FOR WORKGROUP MEMBERS

Confirm participants have signed the Consent Form (IRB) before start of focus groups.

The moderator will introduce herself, and the purpose of the study.

Welcome the workgroup members.

- Thank you for taking time to participate in this focus group and share your experience.
- I look forward to learning from you.
- Congratulations for achieving a 75 percentile rating for high employee engagement and patient experience index on the 2010 TCH Q12 survey. You may recall from the invitation you received for this focus group that I’m talking with you because your workgroup had been identified as high performing. In addition, your workgroup scored in the top 25 percentile of U.S. healthcare workgroups for high employee engagement and the patient experience index.
- Our agenda is to talk about that accomplishment and how you work together.

__________________________________________

FOCUS GROUP QUESTIONS

Opening Question

1. Let’s go around the table and each person tells us your name, and what excites you about your work at TCH. (Note: Moderator will mention that after the opening question people are invited to participate at will without a prescribed order).

Introductory Question

2. How do you feel about being identified as part of a high-engagement workgroup at TCH?

Transition Questions

3. What do you think makes a high-engagement workgroup?
4. How do you keep your workgroup at high engagement, especially since some people have left and new people have been added? How are new people incorporated into the group?

5. Talk to me about some actions, behaviors and workplace conditions that facilitated your high engagement.

Key Questions

Note: The moderator will refer to the specific Focus Group by its unit or department name when conducting the session. She may also use probing questions to drill down for more detail in areas of specific interest to the study (e.g., pertaining to autonomy, communication, decision making, problem solving, employee-leader relationships, management support, recognition, incentives, trust, well-being, commitment, encouragement).

6. Walk me through a time that was memorable for your workgroup. What were you thinking, doing, feeling that fostered your engagement?

7. What has happened in your workgroup that has affected your engagement?

8. What is important to you in order to maintain high engagement in your workgroup and the workplace?

9. What workplace conditions foster or hinder your engagement?

10. What would you do to improve the level of engagement of ALL workgroups?

11. If you could change one thing about your workgroup—the hospital, leadership, or employees—what would you change?

Ending Question

12. What else do you think I should know about your workgroup?

Closing Comments:

Thank you for engaging in this research and focus group session. If you like, I can send you a summary of the findings from the study once it’s complete. You can let me know now if you’d like a copy of the findings, or you can always email me later.
APPENDIX J

LEADER INTERVIEW GUIDE FOR WORKGROUP LEADERS
LEADER INTERVIEW GUIDE FOR WORKGROUP LEADERS

Confirm participants have signed the consent form (IRB) before start of interview.

The interview moderator will introduce herself, and the purpose of the study.

Welcome the leader.

- Thank you for taking time to participate in this interview and share your experience.
- I look forward to learning from you.
- Congratulations for achieving a 75 percentile rating for high employee engagement and patient experience index on the 2010 TCH Q12 survey. You may recall from the invitation you received for this interview, that I’m interviewing you because your workgroup had been identified as high performing. In addition, your workgroup scored in the top 25 percentile of U.S. healthcare workgroups for high employee engagement and the patient experience index.
- Our agenda is to talk about that accomplishment and how you work together.

INTERVIEW QUESTIONS

Opening Question

1. Please tell me your name. What excites you about your work at TCH?

Introductory Question

2. How do you feel about being identified as part of a high-engagement workgroup at TCH?

Transition Questions

3. What do you think makes a high-engagement workgroup?

4. How do you keep your workgroup at high engagement, especially since some people have left and new people have been added to your workgroup? How have you incorporated the new people into the group?
5. Talk to me about some actions, behaviors and workplace conditions that have facilitated your high engagement.

**Key Questions**

Note: *The moderator will refer to the specific unit or department when conducting the interviews. She may also use probing questions to drill down for more detail in areas of specific interest to the study (e.g., pertaining to autonomy, communication, decision making, problem solving, employee-leader relationships, management support, recognition, incentives, trust, well-being, commitment, encouragement).*

6. Walk me through a time that was memorable for your workgroup. What were you thinking, doing, feeling that fostered your engagement?
7. What has happened in your workgroup that has affected your engagement?
8. What is important to you in order to maintain high engagement in your workgroup and the workplace?
9. What workplace conditions foster or hinder your engagement?
10. As you may know, we have some low performing workgroups at TCH. If you were in charge, what changes would you make in the first 100 days to facilitate their engagement?
11. If you could change one thing about your workgroup—the hospital, leadership, or employees—what would you change?

**Ending Question**

13. What else do you think I should know about your workgroup?

**Closing Comments:**

Thank you for engaging in this research and interview. If you like, I can send you a summary of the findings from the study once it’s complete. You can let me know now if you’d like a copy of the findings, or you can always email me later.
APPENDIX K

NEW EMPLOYEE INTERVIEW GUIDE: FOR NEW EMPLOYEES IN THE WORKGROUPS
NEW EMPLOYEE INTERVIEW GUIDE: FOR NEW EMPLOYEES IN THE WORKGROUPS

Confirm participants have signed the consent form (IRB) before start of interview.

The interview moderator will introduce herself, and the purpose of the study.

Welcome the participant.

- Thank you for taking time to participate in this interview and share your experience.
- I look forward to learning from you.
- TCH has an ongoing interest in looking at employee engagement in the hospital, and this dissertation study will help us understand actions, behaviors and workplace conditions that characterize engagement in workgroups.
- Our agenda is to talk about employee engagement and how you work together.

____________________________________

INTERVIEW QUESTIONS

Opening Question

1. Please tell me your name. What excites you about your work at TCH?

Introductory Question

2. How do you feel about being part of an engaged workgroup at TCH?

Transition Questions

3. What do you think makes an engaged workgroup?

4. How do you think workgroups can remain engaged especially since some people leave and new people are added? How have you been incorporated into your workgroup? (Note: for example, via orientation? Mentoring? Coaching? Training? Progress reporting?)
5. Talk to me about some actions, behaviors and workplace conditions that facilitate your engagement.

**Key Questions**

Note: *The moderator will refer to the specific unit or department when conducting the interviews. She may also use probing questions to drill down for more detail in areas of specific interest to the study (e.g., pertaining to autonomy, communication, decision making, problem solving, employee-leader relationships, management support, recognition, incentives, trust, well-being, commitment, encouragement).*

1. Walk me through a time that was memorable for your workgroup. What were you thinking, doing, feeling that fostered your engagement?
2. What has happened in your workgroup that has affected your engagement?
3. What is important to you in order to maintain engagement in your work?
4. What workplace conditions foster or hinder your engagement?
5. What would you do to improve the level of engagement of ALL workgroups?
6. If you could change one thing about your workgroup—the hospital, leadership, or employees—what would you change?

**Ending Question**

7. What else do you think I should know about you or your workgroup?

**Closing Comments:**

Thank you for engaging in this research and interview. If you like, I can send you a summary of the findings from the study once it’s complete. You can let me know now if you’d like a copy of the findings, or you can always email me later.
INVITATION TO PARTICIPATE IN THE STUDY

Date

Dear Colleague,

I am writing to seek your input on my dissertation study to examine actions, behaviors and workplace conditions in a hospital environment that contribute to engagement among workgroups and their leaders. You are invited to participate in this study because you were identified as a leader or member of a workgroup at The Community Hospital (TCH) that was reported as being in the 75th percentile for high employee engagement and the patient experience in the Gallup Q12 2010 survey. This study has been approved by the Andrews University Doctoral Review Committee and is being conducted to support my dissertation. The study will benefit those working at TCH by giving them an opportunity to share perspectives about actions and behaviors that support their engagement in their workplace. It will also benefit the Healthcare Corporation, and other healthcare organizations by providing insight about supports employee engagement in the workplace.

Although the composition of the original 2010 high-engagement workgroups has changed, I am choosing as participants to this study the 7 leaders of the 2010 high-engagement workgroups who still lead those groups in 2011, and workgroup members who still work in the same workgroup and with the same leader they did in 2010.

My request is that each workgroup leader participates in a 90-minute one-on-one interview with me. Workgroup members are asked to participate in a 2 hour focus group session which I will conduct with each separate workgroup. Every effort will be made to adapt the interview and focus group sessions to your work schedules. After those sessions are completed, I will conduct interviews with some new members of your workgroups.

Once you have completed an interview or focus group session, you are asked to take a 15-minute online survey. The survey is not mandatory for being selected to participate in
this study. However, it will give you an opportunity to reflect further on the culture of engagement at TCH.

There is a potential risk of the loss of confidentiality of data in a qualitative dissertation study. Interviews and focus group sessions will be recorded and transcribed, but your identity will not be disclosed in any published documents, or verbal and written material. Identifying information will remain confidential and not shared within the organization or elsewhere outside of the context of the dissertation study. All tapes and transcriptions and data files will be kept on a secure drive and be password protected, then destroyed after the study is completed. If you have a concern about confidentiality even given these safeguards, you should not volunteer to participate in this study. If you do participate, you will be offered a summary of the findings once the study is done.

If you agree to participate in the study you will be asked to sign an Informed Consent agreement prior to your interview or focus group session indicating that you are aware of the purpose of the study, risks and involvement, and that you can choose to discontinue participation at any time in the study.

I understand that you have a busy work life and other responsibilities outside of TCH, but want you to know that your input is valuable in assessing how we can build upon and improve and maintain employee engagement both at TCH and elsewhere. If you would like to participate in this study please notify Janet Meredith at xxx-xxx-xxxx or by email at jmeredit@xxx.xxx on or before date.

Thank you in advance for taking the time to participate in this research project.

Sincerely,

Barbette Weimer-Elder
Executive Director, Education Institute, The Community Hospital
APPENDIX M

CONSENT TO TAKE PART IN A DISSERTATION RESEARCH STUDY
CONSENT TO TAKE PART IN A DISSERTATION RESEARCH STUDY

Principal Investigator: Barbette Weimer- Elder  Office Number: xxx-xxx-xxxx

Study Name/ IRB Protocol No.: Actions, Practices and Workplace Conditions that Characterize High-Engagement Workgroups in a Hospital Environment.

Name of Sponsor: Andrews University

CONSENT TO TAKE PART IN A DISSERTATION RESEARCH STUDY

I have been told that Barbette Weimer-Elder will be conducting research with members of the staff of The Community Hospital (TCH) in Valley Town, USA, who were part of highly engaged workgroups which took the Gallup Q12 survey in 2010, for the purpose of completing her doctoral degree in Leadership and Administration from the School of Education at Andrews University.

I have been told that the purpose of the research is to explore actions, behaviors and workplace conditions that facilitate high engagement.

I have been told that my participation in the study will benefit those working at TCH by giving me an opportunity to share perspectives about actions and behaviors that support my engagement in their workplace. It will also benefit TCH by recognizing what facilitates and maintaining high engagement and to encourage engagement.
A total of 68 subjects will be invited to participate in the study at TCH.

The study will be conducted between January 9, 2012 and April 30, 2012. Each person’s actual engagement in the study will range from 2 to 2.5 hours based on the type of session they are invited to attend (as described below).

I have been told that the focus group session or interview I participate in will be conducted at TCH in Valley Town, USA and that the session will be 2 hours for focus group session and 90 minutes for the interview, plus 15 minutes to complete a survey after their interview or focus group. All in person sessions will be conducted by the researcher.

I agree to participate in a focus group or interview as part of this study. In addition, I am asked to complete a survey after my interview or focus group session which will allow me to reflect further on employee engagement and provide additional input to the researcher on what fosters a culture of engagement. I understand that completing the survey is not mandatory to my participation in this study.

I have been told that by my participation in this study there will be no implied liability whether oral or written of my legal rights.

I have been told that my participation in this study will result in no physical, sociological, psychological risks, stress, discomfort or invasion of my privacy. However, there is a potential risk of the loss of confidentiality of data in a qualitative study like the dissertation study to be conducted. All tapes and transcriptions and data files will be kept on a secure drive and be password protected, then destroyed after the study is completed. If you have a concern about confidentiality even given these safeguards, you should not volunteer to participate in this study.

I acknowledge that my participation in this study is fully voluntary. The other choice I have is not to participate in this study.

I have been told that refusal to participate in the study or withdrawing from this study at any time will involve no penalties or loss of benefits to which I am entitled.

I have been told that I will be audio-taped during the interview or focus session in which I participate; however, my identity in this study will not be disclosed in any published documents, and that the focus group sessions, verbal and written material, and identifying information will remain confidential and not shared within the organization or elsewhere outside of the context of this dissertation study. In addition, all tapes and transcriptions will be destroyed when the study is completed.

I have been told that there will be no cost to me for participating in this study.

I have been told that I will not receive any monetary compensation or other type of inducement for participating in this study.
I have been told that I may contact Barbette Weimer-Elder or Dr. Shirley Freed regarding any questions I may have about the study. I may contact Dr. Freed at Andrews University, School of Education, Bell Hall, Suite #173, Berrien Springs, MI 49104 or call (1-888-717-6247) for information about the research study and assistance. I am fully aware that if I have any additional questions or concerns that I may contact Barbette Weimer-Elder in writing at her home address of xxx, Valley Town, USA or by email at belder@xxx.xxx; or by phone at xxx-xxx-xxxx (home and cell), xxx-xxx-xxxx (work).

I may contact Barbette Weimer-Elder or Dr. Shirley Freed if I feel that confidentiality has been breached after the session ends.

For questions about your rights as a research subject, please contact The Community Hospital IRB Administrative Office at xxx-xxx-xxxx during regular business hours.

I have read the contents of this consent form and received from the researcher verbal explanations to any questions I had. My questions concerning this study have been answered to my satisfaction. I hereby give voluntary consent to participate in this study.

If you wish to withdraw from the study please contact Barbette Weimer-Elder at belder@xxx.xxx; or by phone at xxx-xxx-xxxx (home and cell), xxx-xxx-xxxx. You should call and write to the investigator if you want to withdraw from the study. Any identifiable research data already taken may still be used and disclosed by the investigators for the purposes described above.

I have been given a copy of this signed consent.

My participation in this study will occur in between late 2011 or early 2012.

I have reviewed the contents of this form with the person signing above. I have explained potential risks and benefits of the study.

Signature of Moderator  Telephone  Date
I have read (or someone has read to me) the information provided in this document. I have been given time to consider taking part in the study. I have had a chance to ask questions, and my questions have been answered to my satisfaction. I have received a copy of the Research Subjects Bill of Rights, and I understand I will receive my own signed and dated copy of this consent form.

By signing this form, I agree to take part in the research it describes.

<table>
<thead>
<tr>
<th>Name of Subject (or Legal Representative)</th>
<th>Legal Representative’s Relationship to Subject (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Subject (or Legal Representative)</th>
<th>Date and Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have explained the research to the subject or his/her legal representative and have answered all of his/her questions. I believe that he/she understands the information described in this document and freely consents to take part in the research study.

<table>
<thead>
<tr>
<th>Name of Investigator or Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Investigator or Representative</th>
<th>Date and Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>
APPENDIX N

CONFLICT OF INTEREST DISCLOSURE FORM
CONFLICT OF INTEREST DISCLOSURE FORM

THE COMMUNITY HOSPITAL, VALLEY TOWN, USA

RESEARCH CONFLICTS OF INTEREST DISCLOSURE STATEMENT

Name of Covered Party
Completing this Form:

Contact Number of Covered Party
(for Inquires from COIC):

Email of Covered Party (for
Inquires from COIC):

Category of Covered Party:
☐ Investigator (as defined in this policy) ☐ IRB Member ☐ Administrator
☐ HRPP Staff Member ☐ Consultant
☐ Other, Specify: ______________________

Name of Organizational Entity:
The Community Hospital (TCH) IRB
Protocol # (if assigned):

Complete Protocol Title:

Study Sponsor (if applicable):

Do you or your Immediate Family have any of the following? Circle one
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The economic value of compensation, consulting fees, commercial writing fees, honoraria, intellectual property rights, non-TCH-related royalties, or services and/or gifts-in-kind exceed $10,000 per year from a single for-profit entity? If yes, please specify:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Equity Interest (stock, stock options, warrants, and ownership rights) in a non publicly traded corporation that is a sponsor of this or any study or owner of the drug, device, or biologic being used in this or any study whose value cannot be readily determined through reference to public prices? If yes, please specify:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Equity Interest (stock, stock options, warrants, and ownership rights) in a publicly traded entity, that is a sponsor of this or any study or owner of the drug, device, or biologic being used in this or any study that exceeds $10,000 per year and/or 5 percent ownership? If yes, please specify:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>A financial agreement with this or any Sponsor whereby the value of compensation could be influenced by the outcome of the above mentioned study? This includes compensation that could be greater for favorable clinical results, compensation in the form of an equity interest or in the form of compensation tied to sales of product, such as the royalty interest. If yes, please specify:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Proprietary or other intellectual property rights (patents, license fees, copyrights, royalties) that exceeds $10,000 per year? If yes, please specify:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Nonfinancial value gained from benefits of publications, grants and commercial writing? If yes, please specify:</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

I certify that I have reviewed The Community Hospital Conflict of interest and Disclosure Policy and the information provided above is accurate. I understand that I am obliged to amend this statement if there is a change in this information.

Signature: ________________________________ Date: ____________________
APPENDIX O

CODES, CLUSTERS, THEMES
# Research Questions

1. How do workgroup member actions and practices contribute to workplace conditions that facilitate high engagement?
2. How do leaders contribute to developing high-engagement workgroups?

## Chapter 4

*Workgroup member perceptions of actions and practices that facilitate high engagement.*

## Chapter 5

*Leader perceptions of what contributes to developing high-engagement workgroups.*

### Theme

**Team Talk: Teams Contribute to High Engagement**

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>Initial Count</th>
</tr>
</thead>
</table>
| Cluster

**Team work**

Collaboration of the team results in positive outcome (e.g., patient).**

48

**Support from Team Members**

People never said “it’s not my job.” Team member asked “What do you need” and the person was able to state it—in turn, and the team member was able to respond to it, or to find somebody who could.

22

**Pride in Work**

People take responsibility and accountability for things like a clean and organized work environment, clear communication, and responsibility for the team outcomes. People don’t blame other people rather learn from outcomes whether something positive or negative happened.

22

**Employee Performance Standards**

The standards for performance are very high in this department. The expectations and standards are clearly articulated and communicated to everyone.

13

**Responsiveness from Team Members**

When asked for something by a colleague—respond in a timely, thoughtful and civil manner.

4

**Flexibility**

Being able to adjust when schedules change, number of patients and/or their needs change, there is an emergency Must have a sense of situational awareness of what’s going on in the moment.

5

**Total**

109
### Valuing Patients Contributes to High Engagement

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>Initial Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connection with Patient</td>
<td>Empathy with the patient. Individual connects with the patient and family and “puts himself into the other person’s shoes.” This connection can also serve as catalyst to discerning the clinician’s approach to the assessment of the patient’s needs.</td>
<td>14</td>
</tr>
<tr>
<td>Passion for the work &amp; the Patient Experience (rf. Mackoff)</td>
<td>A passion about the job and a heightened emotional connection to work with patients, team and the organization that goes beyond job satisfaction.</td>
<td>16</td>
</tr>
<tr>
<td>Patient as First Priority</td>
<td>Sense of knowing that the patient is always the priority (e.g., even to the extent that a performance review was negatively affected by spending time with a patient.)</td>
<td>8</td>
</tr>
<tr>
<td>Values for Patient Care</td>
<td>There is a high value for patient-focused care. The decisions made are always made based on what is best for the patient in a holistic way.</td>
<td>18</td>
</tr>
<tr>
<td>Mission Driven (rf. Mackoff)</td>
<td>Characterized as motivated and driven to action by a sense of meaningful mission and context. Mission-driven takes into account how the bigger picture relates to a specific issue. They maintained a clear line of sight between management and the values of care at the bedside.</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>74</strong></td>
</tr>
</tbody>
</table>

### Workplace Conditions Contribute to High Engagement

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Conditions</th>
<th>Initial Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conditions</td>
<td>An existing circumstance in the current work environment that supports engagement. A condition may include resources, physical environment, organizational structure, training, and resources—human, financial, physical.</td>
<td>106</td>
</tr>
<tr>
<td>Organizational Culture</td>
<td>The values and behaviors that contribute to the unique social and psychological environment of an organization.</td>
<td>18</td>
</tr>
<tr>
<td>Trust</td>
<td>Dependable, kept their word or agreements; believe somebody when they say they’re going to do something and they do it.</td>
<td>14</td>
</tr>
<tr>
<td>Recognition</td>
<td>What people think and/or feel should be acknowledged in their work, their work environment, and their interactions with their patients, their team members, other colleagues, physician and executive leaders.</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>151</strong></td>
</tr>
<tr>
<td>Theme</td>
<td>Leaders Contribute to High Engagement</td>
<td>Code</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Cluster</td>
<td>Leader Characteristics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Leader Models Behavior</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reflection (rf. Mackoff)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX P

SURVEY RESULTS
# Employee Survey Results Organized in the Three Major Themes

<table>
<thead>
<tr>
<th><strong>Team Focus</strong></th>
<th><strong>Strongly Agree</strong></th>
<th><strong>Agree</strong></th>
<th><strong>Sometimes</strong></th>
<th><strong>Strongly Disagree</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees in my department regularly recognize each other and participate enthusiastically in any department recognition events.</td>
<td>71%</td>
<td>29%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a strong sense of connection, of community, among people in the department.</td>
<td>64%</td>
<td>36%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When an employee is having problems, other people in the department rally around and help in constructive ways.</td>
<td>64%</td>
<td>36%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees in this department enjoy coming to work.</td>
<td>62%</td>
<td>38%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We enjoy spontaneous fun as well as planned fun together on a regular basis.</td>
<td>71%</td>
<td>29%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The standards for performance are very high in this department.</td>
<td>93%</td>
<td>7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most of the improvements in our department over the past year have come from ideas and concerns shared by employees.</td>
<td>57%</td>
<td>36%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Employees are instrumental in helping make decisions that affect the department.</td>
<td>57%</td>
<td>43%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees are comfortable giving the manager direct feedback.</td>
<td>71%</td>
<td>29%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Workplace Focus</strong></th>
<th><strong>Strongly Agree</strong></th>
<th><strong>Agree</strong></th>
<th><strong>Sometimes</strong></th>
<th><strong>Strongly Disagree</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>My manager continually looks for ways to show his or her appreciation through special gestures and events.</td>
<td>71%</td>
<td>29%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees are frequently asked, “What's important to you?”</td>
<td>21%</td>
<td>64%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>We work hard at keeping scheduling in our department as flexible as possible in order to meet both customers' and employees' needs.</td>
<td>79%</td>
<td>21%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When interviewing job applicants for this department, we consider the personality and &quot;fit&quot; of the applicant a priority for hiring.</td>
<td>79%</td>
<td>21%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical skills are secondary to other characteristics and interpersonal skills when we seek new employees.</td>
<td>43%</td>
<td>50%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Statement</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Sometimes</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-------</td>
<td>-----------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Department employees are involved actively in the hiring and selection</td>
<td>57%</td>
<td>29%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>process of new employees.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The expectations and standards are clearly articulated and communicated</td>
<td>93%</td>
<td>7%</td>
<td></td>
<td></td>
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<tr>
<td>to everyone.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of employees is a key goal in this department.</td>
<td>50%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managers frequently ask employees, &quot;What are you interested in learning,&quot;</td>
<td>43%</td>
<td>43%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>and &quot;What opportunities are you interested in?&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees are frequently asked, &quot;What needs to be fixed?&quot;</td>
<td>38%</td>
<td>54%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>We have a specific structure for involving employees in decision making</td>
<td>57%</td>
<td>36%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>in this department (department council, governance structure, problem-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>solving teams, etc.).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our department's committees, councils, and teams are robust and active.</td>
<td>57%</td>
<td>29%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>If employees are asked to participate in a committee or task force, the</td>
<td>50%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>manager makes certain they have the time scheduled off to attend the</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>meeting and actively coaches them so they are prepared for their</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>participation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The manager sees an important part of his or her job is making certain</td>
<td>79%</td>
<td>21%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>that employees have the necessary equipment and supplies to do their</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>job.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees are authorized to obtain adequate supplies and equipment, even</td>
<td>86%</td>
<td>14%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>in the manager's absence.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The manager works to ensure that the physical environment of our</td>
<td>77%</td>
<td>23%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>department is clean, organized, and pleasing.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>We have multiple methods of communicating important information</td>
<td>79%</td>
<td>21%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>within the department.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>We have regular department or staff meetings that include active</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>dialogue on current issues and concerns.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LEADER FOCUS</strong></td>
<td><strong>Strongly</strong></td>
<td><strong>Agree</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Strongly</strong></td>
</tr>
<tr>
<td>We feel free to challenge any management decision in a respectful way.</td>
<td>71%</td>
<td>29%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management believes that I am an honorable person, and if I tell my</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>manager I need something, he or she believes me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statement</td>
<td>Agree (%)</td>
<td>Neutral (%)</td>
<td>Disagree (%)</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>My manager puts the employee first when making decisions and solving problems.</td>
<td>46%</td>
<td>46%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>My manager listens to me when I come with my concerns and issues.</td>
<td>93%</td>
<td>7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees in this department know they have been heard when they see action taken on their issues and concerns.</td>
<td>72%</td>
<td>21%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Employees feel supported by management.</td>
<td>71%</td>
<td>29%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Each employee has some kind of personal, individual connection with the manager.</td>
<td>64%</td>
<td>29%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>I know something personal about my manager.</td>
<td>93%</td>
<td>7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My manager knows the names and something personal about each and every one of the employees who works here.</td>
<td>79%</td>
<td>14%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>A strong, consistent network of coaching is available to employees in this department.</td>
<td>64%</td>
<td>36%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our manager models the behavior he or she expects to see in employees and colleagues.</td>
<td>93%</td>
<td>7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My manager is always on the lookout for great performance in order to recognize and reward it in a concrete and immediate manner.</td>
<td>71%</td>
<td>21%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>My manager holds people accountable for their actions, dealing with inconsistent or inadequate performance and problems immediately and consistently.</td>
<td>71%</td>
<td>21%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>My manager deals with problems immediately and does not let them fester.</td>
<td>50%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When employees bring the manager problems of an interpersonal conflict, the manager uses his or her judgment about whether he or she should resolve the problem or coach and encourage the employees to do so.</td>
<td>64%</td>
<td>36%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If a problem brought by an employee cannot be solved, the manager at least get back to the employee in a timely manner to let him or her know what has been done.</td>
<td>86%</td>
<td>7%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>The manager believes that one of his or her most important jobs as a leader is to facilitate the work of our employees.</td>
<td>71%</td>
<td>29%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our manager believes that he or she works for us employees, rather than the employees work for him or her.</td>
<td>64%</td>
<td>21%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>Statement</td>
<td>Strongly Agree</td>
<td>Agree Sometimes</td>
<td>Strongly Disagree</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>Our manager regularly sees employees on all shifts.</td>
<td>43%</td>
<td>43%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>Our manager jumps in and helps out employees with their work on a regular basis.</td>
<td>43%</td>
<td>43%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>Employees know when the manager is available or how to find him or her when they need something.</td>
<td>71%</td>
<td>29%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The manager is readily visible throughout the department throughout the day.</td>
<td>69%</td>
<td>23%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>The manager doesn't hide anything from employees that they need to know. The manager doesn't believe in secrets.</td>
<td>79%</td>
<td>21%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MANAGER SURVEY RESULTS ORGANIZED IN THE THREE MAJOR THEMES**

**TEAM FOCUS**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree Sometimes</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees in my department regularly recognize each other and participate enthusiastically in any department recognition events.</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a strong sense of connection, of community, among people in the department.</td>
<td>75%</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>When an employee is having problems, other people in the department rally around and help in constructive ways.</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees in this department enjoy coming to work.</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We enjoy spontaneous fun as well as planned fun together on a regular basis.</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The standards for performance are very high in this department.</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most of the improvements in our department over the past year have come from ideas and concerns shared by employees.</td>
<td>75%</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Employees are instrumental in helping make decisions that affect the department.</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My employees are comfortable giving me direct feedback.</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**WORKPLACE FOCUS**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree Sometimes</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I continually look for ways to show my appreciation through special gestures and events.</td>
<td>75%</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>I continually ask employees, &quot;What's important to you?&quot;</td>
<td>75%</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>We work hard at keeping scheduling in our department as flexible as possible in order to meet both customers' and employees' needs.</td>
<td>75%</td>
<td>25%</td>
<td></td>
</tr>
</tbody>
</table>
When interviewing job applicants, I consider the personality and “fit” of the applicant a priority for hiring. 100%

When seeking potential employees, I believe that technical skills are secondary to other characteristics and interpersonal skills. 75% 25%

Department employees are involved actively in the hiring and selection process of new employees. 75% 25%

The expectations and standards are clearly articulated and communicated to everyone. 75% 25%

Development of employees is a key goal in this department. 100%

I am continually asking employees, “What are you interested in learning,” and “What opportunities are you interested in?” 50% 50%

I continually ask the employees, “What needs to be fixed?” 75% 25%

We have a specific structure for involving employees in decision making in this department (department council, governance structure, problem-solving teams, etc.). 75% 25%

Our department's committees, councils, and teams are robust and active. 75% 25%

If I ask employees to participate in a committee or task force, I make certain they have the time scheduled off to attend the meeting and I actively coach them so they are prepared for their participation. 75% 25%

I consider an important part of my job is making certain that employees have the necessary equipment and supplies to do their job. 100%

Employees are authorized to obtain adequate supplies and equipment, even in my absence. 100%

I work to ensure that the physical environment of our department is clean, organized, and pleasing. 75% 25%

We have multiple methods of communicating important information within the department. 75% 25%

We have regular department or staff meetings that include active dialogue on current issues and concerns. 100%

**LEADER FOCUS**

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree Sometimes</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I encourage the employees who report to me to challenge me in any decision I have made.</td>
<td>75% 25%</td>
<td></td>
</tr>
<tr>
<td>I trust that the employees who work with me are honorable people, and if they tell me they need something, I believe it.</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>I believe, as a leader in this organization that I need to put the employee first.</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>My employees believe I listen to them when they come with their concerns and issues.</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Statement</td>
<td>% Agree</td>
<td>% Disagree</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>The employees in this department know they have been heard when they see action taken on their issues and concerns.</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Employees feel supported by management.</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>I believe each employee needs to have some kind of personal, individual connection with his or her manager.</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>I believe that it is important to share something personal of myself with my employees.</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>I know the names and something personal about each and every one of my employees.</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>A strong, consistent network of coaching is available to employees in this department.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>I am continually aware that I must model the behavior I expect to see in my employees and colleagues.</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>I am always on the lookout for great performance so I can recognize and reward it in a concrete and immediate manner.</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>I hold people accountable for their actions, dealing with inconsistent or inadequate performance and problems immediately and consistently.</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>I deal with problems immediately and do not let them fester.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>When employees bring me problems of an interpersonal conflict, I use my judgment about whether they should resolve the problem or whether I should intervene.</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>If a problem brought by an employee cannot be solved, I at least get back to the employee in a timely manner to let him or her know what I have done.</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>I believe that my most important job as a leader is to facilitate the work of the employees.</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>I believe that I work for the employee, rather than the employee works for me, regardless of my status or positional authority.</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>I regularly see employees on all shifts.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>I jump in and help out employees with their work on a regular basis.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Employees know when I am available or how to find me when they need something.</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>I am readily visible throughout the department throughout the day.</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>I don't hide anything from my employees that they need to know. I don't believe in secrets.</td>
<td>75%</td>
<td>25%</td>
</tr>
</tbody>
</table>
REFERENCE LIST


VITA

Barbette R. Weimer-Elder

EDUCATION

2013 PhD in Leadership Andrews University, Berrien Springs, MI

1988 Master of Health Education, University of Utah, Salt Lake City, UT

1976 Bachelor of Science in Nursing, The College of New Jersey (formerly Trenton State College), Trenton, NJ

EXPERIENCE

2002-2012 Executive Director, Education Institute, Adventist Healthcare, Rockville, MD

1995-2002 Director, Organization Development, Easton Hospital, Easton, PA

1996-2002 Health Care Quality Consultant /Partner, The Hellwig Group, Lebanon, NJ

1979-2004 USAF Nurse Officer, United States Air Force

PROFESSIONAL AFFILIATIONS

American College of Healthcare Executive

The American Organization of Nurse Executives

American Society for Training and Development

Chesapeake Bay Organization Development Network