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CLINICAL NURSES' PERCEPTIONS TOWARD THEIR NURSE MANAGERS' DEGREES OF TRANSFORMATIONAL LEADERSHIP AND TRUST

BY

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Dedication

I dedicate this thesis to my wife and soulmate, Mirvat, who has been the rock that I lean on during difficult times. You have been a constant source of reassurance and support in my life. Thank you for all the delicious snacks, and the quiet time that you insisted on providing me with to finish this work. I thank God every day for having you in my life. I also dedicate this work to my parents. Thank you for your sacrifice and inspiration. I know it wasn't easy raising a family during war and crisis. You have always insisted that my siblings and I get an education no matter what the circumstances are. Thank you for teaching me the value of education and hard work. I will endeavor to pass it on to my kids.

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Abstract

Scholars have emphasized the importance of trust as a critical foundation of effective and successful leadership. However, empirical evidence on behaviors that promote trust in leadership remains scarce and lacking. It is postulated that transformational leadership behaviors are a strong predictor of trust in the leader. The American Nurses Credentialing Center's Magnet Recognition Program® highlights transformational leadership as a main component for delivering nursing excellence. Since leadership behaviors can be perceived through the leaders' interactions with superiors, peers, and followers, this study aimed at examining clinical nurses' perceptions toward their nurse managers' degrees of transformational leadership and trust within a Magnet® designated hospital. The study utilized a cross-sectional survey using the Multilevel Leadership Questionnaire 5X-Short Rater Form to examine perceptions of the degree of transformational leadership, and the Trust in Leader Scale, to examine the perceptions of the degree of trust in the nurse manager. Results indicated that clinical nurses perceived their nursing manager to demonstrate transformational leadership "sometimes" to "fairly often". The mean trust in the nurse manager score indicated a neutral position of neither agree or disagree, with a propensity towards perceiving the nurse manager as trustful. The study found a strong and positive correlation between trust scores and transformational and its dimensions.

Keywords: magnet, nursing, transformational leadership, trust

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Clinical Nurses Perceptions toward their Nurse Managers' Degrees of Transformational Leadership and Trust

Chapter I – Introduction

The field of leadership has been, and continues to be, an evolving phenomenon. This is evident in the plethora of literature on leadership and its impact on various measures and paradigms, such as organizational outcomes, trust, employees' performance and satisfaction, and turnover (Andrews, Richard, Robinson, Celano, & Hallaron, 2012; Braun, Peus, Weisweiler, & Frey, 2013; Casida, 2011; Cummings et al., 2010). Likewise, literature on nursing leadership has received similar emphasis, with focus on leaders' influence on quality of care outcomes, and approach to contemporary challenges related to emerging technology, access to care, and changes in disease demographics (Ingebrigtsen et al., 2014; Kleinman, 2003). Nevertheless, the attention remains on the quality of care as a benchmark measure for success in healthcare (Squires, Tourangeau, Spence Laschinger, & Doran, 2010).

Considering the impact of nursing leadership on the continuum of patient care, and the provision of nursing excellence, successful and effective leadership must be agile rather than static (Jasper & Jumaa, 2008). Effective nursing leaders are strategic thinkers and managers of change (Morgan-Smith, 2012). They empower nurses to be part of creating the care delivery model (Jasper & Jumaa, 2008). Among the myriad of literature on leadership, transformational leadership has been amplified as a modern model for leading healthcare organizations to excellence in the current era (Morgan-Smith, 2012). The Magnet Recognition Program®, a model for nursing excellence, provides a strong foundation for contemporary nursing leadership, as well as, serves as a road map to transform organizations to meet the future challenges (American Nurses Credentialing Center [ANCC], 2013). The Magnet® model (see Appendix A)

highlights transformational leadership as a main component of its designation standards (ANCC, 2013). To become Magnet® designated, healthcare organizations must demonstrate defined standards set by the ANCC, such as transformational leadership, quality of care, and nurse satisfaction (ANCC, 2013). A Magnet® hospital is one that yields excellent patient outcomes, attracts and retains top nursing talents, has high nurse satisfaction, and disseminates innovative and best practices in nursing services (Aiken, Buchan, Ball, & Rafferty, 2008). Nursing leadership, particularly the nurse manager, is thought to assume a vital role in the performance of hospitals' nursing units (Casida, 2011). Within a Magnet® designated organization, the nurse manager is considered key for creating and sustaining a culture of nursing excellence where outcomes such as patient satisfaction, nurse satisfaction, and nurse-sensitive clinical indicators can outperform the mean or median benchmark measure of other hospitals (ANCC, 2013). However, Daft (2011) argues that successful leadership within organizations is no longer dependent on the premise of the individual nurse leader as the main element of prosperity and success for the organization; rather, success is reliant on interdependence, coordination, and collaborative relationships (Hurley, 2012), all of which are argued to be mediated by trust in leadership (Boies, Fiset, & Gill, 2015; Braun et al., 2013; Burke, Sims, Lazzara, & Salas, 2007; Cho & Dansereau, 2010). Hence, trust is regarded as central to successful leadership (Bligh & Kohles, 2013; Daft, 2011; Dirks & Ferrin, 2002; Hurley, 2012; Lee, Gillespie, Mann, & Wearing, 2010), and to leading a successful organizational performance (Savolainen, 2009). The leader's role in fostering an environment of mutual trust with followers is paramount for successful nursing leadership (Daft, 2011).

It is proposed that leadership exists only within the context of a leader-follower relationship, and that it ceases to exist without trust (Manion, 2015). It is suggested that the

leader's ability to influence followers becomes impeded when trust is lost in the relationship (Manion, 2015). Despite this significance, research on trust in leadership remains defragmented and disorganized (Burke et al., 2007). This was evident through the abundance of trust definitions, and the lack of agreement on its antecedents among scholars (Adams & Webb, 2003; Burke et al., 2007; PytlikZillig & Kimbrough, 2016). It is the opinion of this author that the hampered lack of consensus on the definition of trust and its attributes may cause misperception to those seeking to understand the nature of trust development in leadership. Particularly, it presents a challenge to the nurse managers working in a Magnet® hospital, where they are expected to exhibit transformational leadership behavior (Batson & Yoder, 2009). Based on the literature search conducted for this study through multiple scientific databases, it was noted that there is dearth in literature that describes the direct relationship between trust and transformational leadership within Magnet® context. This author believes that the examination of such relationship is valuable for understanding the conditions in which trust can develop in the transformational leader.

Statement of the Problem

Research on trust and transformational leadership is mainly focused on the mediating role of trust in achieving organizational outcomes. Literature that aims to explore the attributes of trust and its correlation with specific leadership typologies although available, it remains defragmented and lacks consensus among scholars (Adams & Webb, 2003; Burke et al., 2007; Costa, Roe, & Taillieu, 2001). Within a Magnet® designated hospital, it is assumed that nurse managers possess transformational leadership characteristics (ANCC, 2013; Batson & Yoder, 2009). However, during the documents review and designation process, evidence of transformational leadership is scrutinized through nursing outcomes, rather than direct

examination of leaders' characteristics (ANCC, 2013). It is proposed that if the outcomes stipulated within the Magnet® application standards demonstrate nursing excellence, they indicate transformational leadership behavior (ANCC, 2013). Hence, this author suggests that evidence of transformational leadership is implied rather than confirmed.

It is evident that transformational leadership correlates with better organizational and performance outcomes (Andrews et al., 2012; Boies et al., 2015; Casida, 2011; Cho & Dansereau, 2010; Chou, Lin, Chang, & Chuang, 2013; Cummings et al., 2010; Jiayan, Oi-Ling, & Kan, 2010; Jung & Avolio, 2000; Kelloway, Turner, Barling, & Loughlin, 2012). Furthermore, literature highlights the positive mediating effect of trust on organizational outcomes, team performance and staff satisfaction (Boies et al., 2015; Braun et al., 2013; Burke et al., 2007; Cho & Dansereau, 2010; Chou et al., 2013; Costa et al., 2001; Dirks & Ferrin, 2002; Dong & Bruce, 2000; Hurley, 2012; Jiayan et al., 2010; Jung & Avolio, 2000; Kelloway et al., 2012; Lee et al., 2010). However, within a Magnet® designated hospital, do outcomes alone predict transformational leadership behavior? If literature suggests that trust in leader mediates the achievement of organizational outcomes, what are the trust behaviors that leaders need to demonstrate to be perceived transformational? If nurses do not perceive their nurse managers transformational or trustful, there is a risk that an organization may not be able to demonstrate the level of nursing excellence demanded by the Magnet Recognition Program®. Despite the plethora of literature on leadership and trust, this author believes that the precise relationship between attributes of trust and dimensions of transformational leadership remains intangible, and not very well established. It is also not known if clinical nurses' perceptions of trustful leadership behaviors positively correlate with their perceptions of transformational leadership.

Purpose of the Study

The purpose of this study is to investigate the clinical nurses' perceptions toward their nurse managers' degrees of transformational leadership and trust. As well as, this author seeks to determine whether the clinical nurses' perceptions of transformational leadership, as measured by the dimensions of idealized influence, inspirational motivation, individualized consideration, and intellectual stimulation are correlated with trust in the nurse manager, as measured by its attributes of competence, benevolence, integrity, and predictability. Hence, the study will (1) describe the clinical nurses' perceptions toward their nurse managers' degrees of transformational leadership and trust, and (2) identify the correlations relationship between perceptions of transformational leadership and trust in the nurse manager.

Research Questions and Hypothesis

The leadership style that will be examined in this study is transformational leadership. Perceptions of clinical nurses working at a Magnet® hospital toward their nurse managers' degrees of transformational leadership and its dimensions of idealized influence-attributed (IIA), idealized influence-behavioral (II-B), inspirational motivation (IM), individualized consideration (IC), and intellectual stimulation (IS) will be determined by the Multifactor Leadership Questionnaire 5X-Short Rater Form (MLQ 5X-Short Rater Form (Bass & Avolio, 2014). Likewise, trust and its attributes of competence, benevolence, integrity, and predictability will be determined by the Trust in Leader Scale (Adams, Waldherr, & Sartori, 2008). There are three research questions, three hypotheses, and three null hypotheses identified in this proposal.

Question 1. What are the perceptions of the clinical nurses working at a Magnet® hospital toward their nurse managers' degree of transformational leadership?

Question 2. What are the perceptions of the clinical nurses working at a Magnet® hospital toward their nurse managers' degree of trust?

Question 3. What is the relationship between the nurse managers' degree of transformational leadership, and degree of trust as perceived by the clinical nurses working at a Magnet® hospital?

The hypotheses and the null hypotheses that will be examined in the research proposal are listed below.

Hypothesis 1. Perceptions of clinical nurses working at a Magnet® hospital toward their nurse managers' degree of transformational leadership, as determined by the MLQ 5X-Short Rater Form, are above the norm.

Null hypothesis 1. Perceptions of clinical nurses working at a Magnet® hospital toward their nurse managers' degree of transformational leadership, as determined by the MLQ 5X-Short Rater Form, are below the norm.

Hypothesis 2. Clinical nurses working at a Magnet® hospital perceive their nurse managers as trustful, as determined by the Trust in Leader Scale.

Null hypothesis 2. Clinical nurses working at a Magnet® hospital perceive their nurse managers as distrustful, as determined by the Trust in Leader Scale.

Hypothesis 3. Perceptions of clinical nurses working at a Magnet® hospital toward their nurse managers' degree of transformational leadership, as determined by the MLQ 5X-Short Rater Form, are positively correlated with their perceptions toward their nurse managers' degree of trust, as determined by the Trust in Leader Scale.

Null hypothesis 3. There is no correlation between the perceptions of clinical nurses working in a Magnet® hospital toward their nurse managers' degree of transformational

leadership, as determined by the MLQ 5X-Short Rater Form, and degree of trust, as determined by the Trust in Leader Scale.

Significance of the Study

This study does not aim to establish new theoretical concepts, but rather add to the body of knowledge that is already known about trust and transformational leadership. However, the knowledge that will be generated from this study may be of an interest to nursing leadership of Magnet® designated hospitals, and those seeking Magnet® designation. It aims to describe the perceptions of clinical nurses toward their nurse managers' degrees of transformational leadership and trust, as well as explore the conditions that moderate this relationship. Yet, no comprehensive model has been presented to systematically correlate perceptions of transformational leadership to perceptions of trust in the nurse manager within Magnet® context. If transformational leadership is identified as a core component of the Magnet® model (ANCC, 2013), and if trust mediates the achievement of improved outcomes (Andrews et al., 2012; Braun et al., 2013; Burke et al., 2007; Cho & Dansereau, 2010; Chou et al., 2013; Costa et al., 2001; Cummings et al., 2010; Jiayan et al., 2010; Jung & Avolio, 2000; Kelloway et al., 2012; Lee et al., 2010), which is a compulsory metric in the decision to designate a healthcare organization by the ANCC (ANCC, 2013; Batson & Yoder, 2009), it is important then that nurse managers understand the relationship between trust and transformational leadership as perceived by their direct followers, the clinical nurses. This author proposes that the knowledge that will be generated from this study will be valuable to the nurse managers, as it will allow them to develop an understanding of the conditions of effective and trustful relationship with their clinical nurses. Executive leadership of Magnet® designated organizations may also benefit from this study, as they will profit from improvements in their nurse managers' leadership behavior, thus improving

nurse retention, and eliminating factors that may hinder the clinical nurses from delivering care at the level of nursing excellence demanded to achieve Magnet® designation.

Nursing associations and organizations may also benefit from the study, as it will provide a comprehensive description of the relationship between trust and transformational leadership, which may aid in the systematic revisions of the Magnet® model and designation standards.

Lastly, nurses in general may benefit from changes in nurse managers' behavior due to their awareness of the relationship between trust and transformational leadership. The more the nurse managers are transformational, the more the clinical nurses are satisfied (Kelloway et al., 2012).

Chapter II – Review of the Literature

A systematic literature search was conducted through ProQuest Nursing and Allied Health Sources, Wiley Blackwell, Science Direct, and PubMed Central for the period from years 2000 up until 2017, including keywords related to transformational leadership, trust, magnet, and nursing. The search was limited to publications written in English language. The search yielded a total of 84 results, of which only 45 have partially met the search criteria. The reason these studies were deemed to have partially met the search criteria is due to the dearth of publications that addressed transformational leadership and trust constructs within a Magnet® environment, at least within the proposed search method. Nevertheless, there were several publications on transformational leadership and Magnet®. This was not an astounding finding, since transformational leadership is known to be an integral component of the Magnet® model, and as such it is expected to be highlighted in literature. It was noted that literature on transformational leadership and trust was examined through scholars view of trust as an antecedent to many value performance outcomes, and as a process that results in collaborative interaction between the leader and subordinates (Braun et al., 2013; Chou et al., 2013; Dong & Bruce, 2000; Jiayan et al., 2010; Majella, Anita, & Fiona, 2011; Yang & Mossholder, 2010; Yue & Syed, 2014). To support concepts, views, and provide foundational background for the study, seminal literature on transformational leadership, trust and Magnet® were included in the literature review.

Transformational Leadership

The earliest depiction of transformational leadership was introduced by Burns (1978) in his seminal work on political leadership. In his study, Burns (1978) described the two concepts of transforming leadership and transactional leadership. He described transforming leadership within the paradigms of intellectual, reform, and revolutionary leadership, and viewed the

transforming leader as a moral change agent with a conscious purpose who is courageous enough to transform an entire social system. According to Burns (1978), "the transforming leader looks for potential motives in followers, seeks to satisfy higher needs, and engages the full person of the follower" (p. 4). Burns added that it is through transforming leadership behavior that followers can be transformed into leaders, and leaders into moral agents.

Building on Burns' work, Bass (1985) indicated that transformational leadership can be measured, and identified four dimensions that are considered essential attributes of the transformational leader. These dimensions were identified as (1) idealized influence, which was initially known as charisma, (2) inspirational motivation, (3) intellectual stimulation, and (3) individualized consideration (Bass, 1985). These dimensions are further expanded in the theoretical framework chapter.

The transformational leader has been described as a leader who "develop followers by creating a vision that provides meaning and motivation" (Hutchinson & Jackson, 2013, p. 12). Daft (2011) classified transformational leadership as one of the three influential leadership styles next to charismatic and coalitional leadership. Transformational leaders empower and motivate their followers by setting challenging expectations, and help them discover their leadership potentials (Bass & Riggio, 2006). They instill inspiration and commitment in their followers, and clearly communicate future vision and organizational goals (Bass & Riggio, 2006). When followers feel involved and valued by their leaders, they bring significant improvement in performance and outcomes, as well as positive change to the organization (Braun et al., 2013; Daft, 2011).

The Magnet® Model and Transformational Leadership

The Magnet Recognition Program® is developed and administered by the American Nurses Credentialing Center (ANCC), a subsidiary and the credentialing arm of the American Nurses Association (ANCC, n.d.). The Magnet Recognition Program® is viewed as a framework to achieve nursing excellence (Aiken et al., 2008; ANCC, 2013; Grant, Colello, Riehle, & Dende, 2010). According to the ANCC (2013). Magnet® designated organizations are the leaders of the health care reformation and the discipline of nursing.

The inception of the Magnet® hospital was introduced in the 1980s by the American Academy of Nursing in response to the nursing shortage crisis in the United States (Aiken et al., 2008; McClure, Poulin, Sovie, & Wandelt, 1983; Schwartz, Spencer, Wilson, & Wood, 2011; Sellars, 2012). The American Academy of Nursing appointed a group of nurse leaders in the Task Force on Nursing Practice in Hospitals, and commissioned it to study the characteristics of hospitals, and health care systems that were successful in attracting and retaining competent and experienced nurses (McClure et al., 1983). The term Magnet® hospital was adopted as an indication of these hospitals' ability to attract nurses (McClure et al., 1983).

McClure et al. (1983) identified 165 hospitals nationwide through a nomination process by the Fellows of the American Academy of Nursing, and conducted distinct group interviews with nursing leaders and staff nurses of these hospitals. As a result of the study, the task force conceived 14 characteristics that differentiated those hospitals by their ability to attract nurses (McClure et al., 1983; Wolf, Triolo, & Ponte, 2008). The characteristics were later known as the 14 Forces of Magnetism (Wolf et al., 2008). The quality of nursing leadership, and management style were emphasized as integral components of the 14 Forces (Shirey, 2005). In 1990, the Magnet Hospital Recognition Program® was established, with the 14 Forces of Magnetism

being recognized as the standards in the decision to designate hospitals as Magnet® (Shirey, 2005).

Several revisions were conducted following McClure et al.'s (1983) seminal work on Magnet® hospitals, specifically during the 1980s and 1990s (Aiken et al., 2008). However, in 2008, the ANCC introduced a revised model that replaced the 14 Forces of Magnetism with a five model components to reflect the focus on measuring outcomes (ANCC, 2008). The new Magnet® model signified five components for delivering nursing excellence identified as (1) transformational leadership, (2) structural empowerment, (3) exemplary professional practice, (4) new knowledge, innovations, and improvements, and (5) empirical outcomes (ANCC, 2013). Under the transformational leadership component, the nurse leader in a Magnet® hospital is described as visionary, visible, influential, with strong expertise in professional nursing practice (ANCC, 2008). Furthermore, the nurse leader is accessible, acts as advocate for nurses, and ensures that adequate staffing and resources are available for nurses within the organization (ANCC, 2013). To achieve a Magnet® status, healthcare organizations must demonstrate evidence of excellence in all five components (ANCC, 2013). According to the ANCC (2013), the components of structural empowerment, exemplary professional practice, new knowledge, innovation and improvements, and empirical outcomes will cease to exist if evidence of transformational nursing leadership is not present within an organization. For example, ANCC (2013) suggested that within this model, (a) transformational leaders build structures within the organization that empower frontline nurses, and promote shared decision making; hence, frontline nurses become partners rather than merely followers. Being part of the decision-making process, nurses take ownership of their practice, and ensure delivery of exemplary professional practice within their areas of practice. Consistent exemplary practice eventually leads to

innovation and improvements within an environment of research and evidence based practice. The fifth component of empirical outcomes is incorporated in all four components, and is used as an empirical data evidence of nursing excellence (ANCC, 2013).

Gonzalez, Wolf, Dudjak, and Jordan (2015) conducted a retrospective study on the impact of Magnet® designation on infection rates, and patient and staff satisfaction during a major downsizing within an organization. Despite the significant changes to staffing and closure of some units due to the transition, Gonzalez et al. (2015) noted a decline in urinary tract infections, central line-associated blood stream infections, and ventilator associated pneumonia infections. Moreover, the authors conveyed an improvement in the patient satisfaction related to the overall experience, and recommending the hospital to others. Gonzalez et al. (2015) have also conducted qualitative focus group sessions with the nurses, and articulated that the nurses felt guided by the Magnet® Model during the hospital transition, and that "leadership walked together with them on this journey, describing leadership as "credible and trustworthy" (p. 328). The authors provided evidence of leadership and management support to the staff through visibility, frequent communication, empowerment through shared governance, ensuring that patient care resources are available, and supporting continuing education of nurses. They finally concluded that a Magnet® environment provides support for organizations during periods of change and disruption and that the leadership style is a determinant factor in the likelihood of success.

Aiken et al. (2008) examined the impact of Magnet® designation on one hospital's experience within the National Health Services Trusts (NHS) system in England, and compared it to 30 other hospitals within the same system. Prior to embarking on the Magnet® journey, the selected hospital was identified as one with a working environment and staff satisfaction that are

less positive than the sample hospitals (Aiken et al., 2008). Following a two-year period that was concluded with Magnet® designation, the study investigated the clinical nurses work environment, and quality of care as direct outcomes of the designation. In comparing these variables to before and after the designation, and benchmarking them against the sample hospitals, it demonstrated marked improvements that were superior to the sample hospitals (Aiken et al., 2008). The authors finally implied that it was the leadership's commitment to Magnet® that has contributed to the designation and improved outcomes.

Grant et al. (2010) discussed the Magnet® Model and its influence on nursing practice environment and successful change management. Although their work was descriptive as opposed to empiric, they provided reflections on the improvements that were made by relating them to each of the Magnet® Model components. Grant et al. (2010) described how the demonstration of transformational leadership behavior on behalf of the nurse manager had empowered nurses to assume clinical leadership roles, and enhanced their sense of accountability. They suggested that both the nurse managers and clinical nurses exhibited qualities of transformational leadership, implying a role model behavior on behalf of the nurse managers. The authors concluded that transformational leadership was a vital component to the success of the initiatives linked to the remaining Magnet® Model components, and that the Magnet® model can be utilized as a framework for building organizational capacity and vitality.

Trust

Trust is a process that evolves overtime, and is earned through hard work and commitment (Daft, 2011; Dirks & Ferrin, 2002; Frazier, Johnson, Gavin, Gooty, & Snow, 2010). There is a broad range of research on trust as a general construct, and on its relation to leadership styles, employees performance and satisfaction, and organizational outcomes (Boies et al., 2015;

Braun et al., 2013; Brian & Crystal, 2008; Burke et al., 2007; Chou et al., 2013; Costa et al., 2001; Dirks & Ferrin, 2002; Frazier et al., 2010; Jiayan et al., 2010; Kelloway et al., 2012; Kramer & Tyler, 1995; Lee et al., 2010; Majella et al., 2011; Manion, 2015; Pillai, Schriesheim, & Williams, 1999; Savolainen, 2009). This plethora of literature has added significantly to the body of knowledge on trust, but has also created inconsistencies and defragmentation of the trust constructs among scholars (Adams & Webb, 2003; Burke et al., 2007; Costa et al., 2001). Hence, research aimed at studying trust requires a thorough understanding of the various contexts of trust being explored or described, ensuring that the selected context fits the purpose and the methodology of the research (Adams, Bruyn, & Chung-Yan, 2004; Lyon, Mšllering, & Saunders, 2015). For example, studying trust in organizations requires the selection of measurements that are different from those needed for measuring trust in dyads, or teams (Lyon et al., 2015).

In their effort to create a measure of trust in small military teams, Adams et al. (2004) conducted a comprehensive review of the trust measures in research literature. They utilized their findings to create the Trust in Teams and Trust in Leader scales. Adams et al. (2004) presented specific concerns that need to be taken into consideration before administering a scale to measure trust. Among these concerns, they argued that asking participants to reflect on trust in an individual can have ethical implications that are not addressed in literature, and that careful consideration must be taken to minimize the ethical demands during trust measurement.

Lewicki and Brinsfield (2015) argued that trust cannot be observed directly, and that it needs a scientific agreement on the internal dynamics that constitute its meaning. They proposed that a measurement approach to trust should consider cognitive assessment and readiness to accept vulnerability, intuitive judgment, trusting behaviors, recognizing the difference in measuring trust and distrust, the role of neurobiology, trajectory of trust development, and

context of trust. Lewicki and Brinsfield (2015) pointed out to the fact that there is overabundance of 129 measurement tools of trust that have emerged over the last 48 years, of which only 24 instruments have attempted to replicate their results, indicating the lack of construct-validity of the majority of the tools.

Transformational Leadership and Trust

Many scholars examined the association between transformational leadership and trust; in fact, trust was suggested as an attribute of transformational leadership (Bligh & Kohles, 2013; Chou et al., 2013; Daft, 2011; Dirks & Ferrin, 2002; Kelloway et al., 2012; Lee et al., 2010; Pillai et al., 1999). Dirks and Ferrin (2002) suggested that trust in leadership has a significant relation to attitudinal, behavioral, and performance outcomes. It is also proposed that transformational leadership behaviors correlate with increased followers' trust in their leaders (Chou et al., 2013; Dirks & Ferrin, 2002).

Trust in leadership is an important component for strengthening both affective commitment and organizational identification (Bligh & Kohles, 2013). In a study that examined the relationship among transformational leadership style and cognitive trust as well as their impact on team performance, it found that leveraging cognitive trust in the team leader was necessary, although not sufficient on its own, for facilitating team performance (Chou et al., 2013).

Kelloway et al. (2012) examined employees' perception of their leaders' leadership style and its impact on the employees' psychological well-being. The study found that trust in the leader mediated a positive relation between transformational leadership and psychological well-being. Conversely, management-by-exception and laissez-faire leadership styles had negatively

affected employees' psychological well-being by exhibiting a reduced trust in the leader (Kelloway et al., 2012).

In their literature review on trust between nurse managers and staff in critical care areas, Mullarkey, Duffy, and Timmins (2011) found that although trust was viewed as essential in the nurse-patient relationship, it received little attention among the nurse managers and staff. They concluded that considering the stressful nature of working in critical care areas, developing trust with the staff is an essential element for transformational leaders, and that the nurse managers need to focus efforts on exhibiting trustworthiness through competence in the job.

Braun et al. (2013) conducted a study on 39 teams at a large German research university that examined the relationship between individual's perceptions of the supervisor's transformational leadership, job satisfaction, team performance, and the mediating role of trust in the supervisor. The study concluded that transformational leadership had a positive influence on job satisfaction, team performance, and on developing mutual trust among team members. The authors ascertained the supervisors' roles in facilitating trust in teams, and that they should make efforts to establish trustful relationship with individual team members as well. Braun et al. (2013) recommended that transformational leadership be taken into consideration within organizational processes for hiring, promoting, and training of supervisors.

Wilson (2012) investigated the experience of 342 registered nurses working in Ontario emergency departments towards their perceived trust in the nurse managers. The author concluded that trust in the nurse managers was influenced by the manager's attributes of benevolence, integrity, justice, ability to facilitate team work, communication, and emotional support. Nevertheless, Wilson (2012) also found that attributes related to the registered nurses such as experience, propensity to trust, and span of control did not seem to influence their trust

perceptions toward the nurse managers. The author recommended the establishment of educational programs that support the managers' ability to attain the attributes necessary to enhance trust in the registered nurses.

Burke et al. (2007) presented an integrative model of trust in leadership by examining the literature conducted on trust, leadership, and trust in leadership. The authors adapted a bottom-up approach focused on the perceptions of individuals and teams to examine multiple propositions of trust attributes and moderators as well as outcomes of trust in leadership. The trust framework that was examined included attributes related to competence, benevolence, and integrity (Burke et al., 2007).They concluded that trust in leader may be indirectly influenced by the passive observation of leader's interaction with other team members, and that there may be other factors besides trust that may contribute to better leadership outcomes related to communication, turnover, and performance.

Chapter III – Theoretical Framework

The theoretical framework of this research builds on the premise of transformational leadership as an integral component of the Magnet® model (ANCC, 2013), and utilizes the transformational leadership framework as described in the Full Range Leadership (FRL) model by Avolio and Bass (1991), as well as the trust in leader as described by Adams et al. (2004), to explore the perceptions of clinical nurses working at a Magnet® hospital toward their nurse managers' degrees of transformational leadership and trust. The study also aims to describe the relationship between trust, and transformational leadership. The FRL model created by Avolio and Bass (1991) is signified by three typologies of leadership identified as transformational, transactional, and nontransactional laissez faire. This study is focused on the examination of the transformational leadership component of the FRL model, as opposed to its entirety. Hence, only the transformational leadership component will be explored in this section.

Transformational Leadership

Transformational leadership is represented by four distinct dimensions, symbolized as the 5 I's, and described as (1) idealized influence – attributed (IIA), (2) idealized influence-behavioral (IIB), (3) inspirational motivation (IM), (4) intellectual stimulation (IS), and (5) individualized consideration (IC) (Avolio & Bass, 2004). The five dimensions will be measured by the MLQ 5X-Short Rater Form.

Idealized influence. The two aspects of the idealized influence dimension, IIA and IIB, refer to the leader's behavior and the follower's attribution about the leader (Antonakis & House, 2013; Avolio & Bass, 2004; Bass & Riggio, 2006). Idealized influence refers to the leader's charismatic quality ability to act as a role model to the followers, by demonstrating high ethical and moral behavior (Antonakis & House, 2013; Avolio & Bass, 2004). This charismatic quality

inspires the followers to foresee beyond self-interests, and commit to the organizational vision and goals (Avolio & Bass, 2004; Libsekal, 2006). According to Antonakis and House (2013) the leader's characteristic of idealized influence allows followers to shift interest towards the greater good. However, Avolio and Bass (2004) warns against the personally charismatic leader who is focused on own goals accomplishment, and in the process falls short in fostering a culture of autonomy and empowerment. Leaders with this type of personal charisma are described as pseudo transformational, since they fail to exhibit the idealized influence attributes and behaviors (Avolio & Bass, 2004).

Inspirational motivation. Inspirational motivation refers to the leader's ability to empower and motivate followers to reach their utmost potential and achieve ambitious goals (Antonakis & House, 2013). The transformational leader instills enthusiasm and optimism by communicating expectations and visions for the future (Bass & Riggio, 2006). An inspirational leader is one who articulates a vision and provides guidance and directions to followers to attain this vision (Avolio & Bass, 2004). They instill optimism about the future and motivate followers to challenge the status quo within the organization (Avolio & Bass, 2004; Libsekal, 2006).

Intellectual stimulation. This dimension relates to the leader's ability to challenge the followers' creativity and arouse their curiosity (Avolio & Bass, 2004; Daft, 2011). The transformational leader empowers followers to approach problems with innovative solutions and new ideas that allow them to think and learn (Avolio & Bass, 2004; Bass & Riggio, 2006; Daft, 2011). Leaders who possess intellectual stimulation behavior can empower and capacitate the followers to resolve problems on their own effectively (Avolio & Bass, 2004). They also encourage followers to challenge their own assumptions as well as those of the leader, create awareness on the opportunities and threats, and explore creative solutions to routine problems

(Avolio & Bass, 2004). It is the intellectual stimulation behavior of the leader that allows the creation of a culture of autonomy among nurses (Libsekal, 2006), which is considered crucial in a Magnet® designated organization (ANCC, 2013).

Individualized consideration. The transformational leader treats followers with individualized consideration, listening to their individual needs and concerns (Antonakis & House, 2013; Bass & Riggio, 2006). Under this premise, the leader acts as a mentor and a coach, ensuring that each employee has equal opportunity for growth and development (Bass & Riggio, 2006). This dimension is important considering the diverse interests and capabilities of people (Bass & Riggio, 2006). However, leaders need to take into account that providing equal opportunities to the followers should be aligned with their interests and career development plans (Bass & Riggio, 2006). Careful attention of the leader should be directed towards ensuring that the followers transcend their interests for the benefit of the organization, and maintain balance between personal and organizational interests (Daft, 2011). The element of individualized consideration is extremely important for staff retention and satisfaction and in meeting the Magnet® standards.

Trust

It was previously noted in this paper that research on trust is defragmented and lacks consensus on its definition (Adams & Webb, 2003; Burke et al., 2007; Costa et al., 2001). Therefore, in following scholars' recommendation to conform the definition and context of trust to methodology (Adams et al., 2004; Lyon et al., 2015), and for the purpose of this paper, trust is defined as per the following.

> Trust is a psychological state involving positive confident expectations and willingness to act on the basis of these expectations. Issues of trust arise in contexts that involve risk,

> vulnerability, uncertainty and interdependence. Trust expectations are created primarily by the interaction of the perceived qualities of the trustee and contextual factors in play when trust decisions are made (Adams & Webb, 2003, p. 38).

When examining the literature retrieved for this study for attributes of trustful leadership behaviors, it was noted that there was no consensus among scholars. However, some scholars indicated that promoting trust in the leader can be gained through demonstration of behaviors such as competence, benevolence, integrity, credibility, and predictability (Adams et al., 2004; Bligh & Kohles, 2013; Cho & Dansereau, 2010; Chou et al., 2013). Daft (2011) posits that our encounters with leaders and how we perceive their behaviors and attitudes are the main components that lead us to a decision to trust them. The process of building trustful relationships is depicted through behaviors that are perceived as trustworthy by the followers.

The conceptual framework of trust adapted in this study is based on Adams et al.'s (2004) work on creating a measure of trust in small military teams. The Trust in Leader scale that was utilized to measure the clinical nurses' perceptions of the degree of trust among their nurse managers is comprised of the trust dimensions of competence, benevolence, integrity, and predictability (Adams et al., 2004).

Competence. Competence raises the question whether the leader has the right knowledge, skills and attitudes to get the job done. Scholars describe competence in terms of specific traits, such as intelligence, conscientiousness, openness to experience, and emotional stability (Derue, Nahrgang, Wellman, & Humphrey, 2011). According to Derue et al. (2011) intelligence reflects the cognitive ability of the leader and is positively related to the effectiveness of the leader, while conscientiousness reflects the extent to which a person is dependable. The authors continue by depicting that openness to experience is commonly

associated with being imaginative, and open minded to new and different ways of working. Finally, emotional stability refers to a person's ability to remain calm and not be easily upset when faced with challenging tasks (Daft, 2011).

Benevolence. Benevolence is the personal concern for the wellbeing and interests of others (Cho & Dansereau, 2010). Leaders cannot build trust if they demonstrate careless attitude toward others' interests (C. Wilson, 2008). When followers perceive their leader as caring and considerate, they tend to develop trust taking into account that their leader will be protecting them when their interests are at stake (Daft, 2011). This also relates to the transformational leadership element of idealized influence that requires the leader to have high moral and ethical standards, and act as an ethical role model to influence a reciprocal benevolent behavior on the followers (Antonakis & House, 2013).

Integrity. When people compromise their integrity, trust falls apart. Leaders can demonstrate integrity by being honest and transparent with their followers, by taking responsibility for their actions, and support their employees in their successes and failures (Palanski, Kahai, & Yammarino, 2011). Leaders who role model high ethical convictions through their daily actions reap the loyalty, trust, and respect of their followers (Daft, 2011; Storr, 2004)

Predictability. Predictability is considered essential for trust development in the leader, and is generally extended through repeated interactions between the leader and the follower (Adams & Webb, 2003; Lewick & Bunker, 1996). Repeated behaviors allows individuals to forecast similar behavior in the future, thus reducing uncertainty and vulnerability to adverse effects from the relationship (Adams & Webb, 2003). This requires constant communication between the leader and the follower (Lewick & Bunker, 1996). The Magnet® sources of

evidence required to demonstrate that an organization's leader is transformational, highlights that the leader is visible and accessible to the frontline nurses (ANCC, 2013). Visibility and accessibility on the part of the leader ensures that communication opportunities with the frontline nurses are always present, allowing for predictability to develop.

Chapter IV – Methodology

Research Design

This research employed a cross-sectional descriptive approach that utilized a non-experimental quantitative correlational design to describe the perceptions of clinical nurses working at a Magnet® designated hospital toward their nurse managers' degrees of transformational leadership and trust. The descriptive research approach allowed this researcher to construct hypothesis, describe occurrence, and generate knowledge on what is already existing within the population of interest (Swatzell & Jennings, 2007). It did not aim to establish a theory or influence an outcome (Swatzell & Jennings, 2007), although results may be utilized to support a specific theoretical standpoint about transformational leadership and trust (Brink & Wood, 1997). This research design is also correlational as it attempts to describe a potential relationship between two or more variables, taking into consideration that correlation doses necessarily mean causation (Brink & Wood, 1997). The design for this study was appropriate as it allowed this researcher to investigate two or more variables of a specific population at cross sectional points in time, and collect relevant statistical scores (Trochim & Donnelly, 2008). This design also provided the ability to analyze and interpret the study results based on statistical scores significance, allowing this researcher to describe any potential relationship between perceived degrees of transformational leadership, and trust.

As stated previously, this research does not aim to establish novel theoretical concepts, but rather build on existing literature to add to the body of knowledge on transformational leadership and trust. This study utilized Bass and Avolio's (2014) transformational leadership framework, as well as Adams et al.'s (2008) Trust in Leader scale as its theoretical framework. It investigated three questions related to the perceptions of transformational leadership and trust, as

perceived by the clinical nurses working at a Magnet® hospital, and potential relationship between transformational leadership, as determined by the MLQ 5X-short Rater From, and trust, as determined by the Trust in Leader Scale.

Organization Profile and Magnet® Designation Process

The study was conducted at a large tertiary care and Magnet® designated facility located in Riyadh, Saudi Arabia. The nursing workforce is predominantly comprised of multinational nurses with Saudi nurses comprising less than 10% of the entire nursing workforce. The organization received its initial Magnet® designation in April 2014. The designation was obtained through a rigorous process that involved document submission demonstrating evidence of the Magnet® standards and examples of their existence within the organization, and was concluded with a site visit by three ANCC appraisers. The Commission on Magnet® reviewed the documents and appraisers' report and granted the organization its Magnet® status.

Data Collection

The data was collected through the use of an online survey tool (see Appendix B) that incorporated the transformational leadership components of the MLQ 5X-Short Rater Form (Bass & Avolio, 2014), the Trust in Leader scale (Adams & Sartori, 2006), and questions aimed at describing the demographic characteristics of the population of interest. The use of a survey tool allowed the standardization of the survey questions to all participants throughout the study. The question items adapted from the MLQ 5X-Short Rater Form, and Trust in Leader scale were randomly ordered within the questionnaire.

Multilevel leadership questionnaire. The MLQ 5X-Short is described as the benchmark measure for transformational leadership (Bass & Avolio, 2014). The MLQ 5X-Short is available in two questionnaire forms, known as the self-rating form, where leaders rate themselves, and the

rater form, where associates rate their leaders (Avolio & Bass, 2004). When using the rater form within an organization, Avolio and Bass (2004) define associates as individuals that are above the leader, same level as the leader, below the leader, or those who have other relationship with the leader, such as a customer. The MLQ 5X-Short Rater Form (see Appendix C) was utilized as an integral component of the survey tool in this study. The leaders who were rated in this study were the nurse managers, while the associates were the clinical nurses that are below the nurse managers and report directly to them.

The MLQ 5X-Short Rater Form consists of 45 descriptive rater statements items, of which 36 items assess perceptions of leadership behaviors, including transformational leadership, transactional leadership, and nontransactional laissez faire leadership (Avolio & Bass, 2004). The remaining 9 items assess three leadership outcomes described as extra effort, effectiveness, and satisfaction (Avolio & Bass, 2004). For this study, only the components of transformational leadership were utilized in the survey tool. Literature on the MLQ 5X-Short supports the selective choice of individual items from questionnaire (Antonakis, Avolio, & Sivasubramaniam, 2003). In fact, Antonakis et al. (2003) demonstrated that although the transformational leadership dimensions of idealized influence, intellectual stimulation, individualized consideration, and inspirational motivation are highly related, they also presented good fit when loaded separately, indicating that the dimensions of transformational leadership within the MLQ 5X-Short can be studied collectively and individually (Boies et al., 2015). Table 1 summarizes the MLQ 5X Short Rater Form items that measure the transformational leadership dimensions, which will be included in the proposed survey (Avolio & Bass, 2004).

The scientific basis for selecting the transformational leadership components measures from the MLQ 5X-Short Rater Form in this study is influenced by the purpose of the study. First,

the purpose of the study is to describe the degree of transformational leadership as perceived by the clinical nurses working at a Magnet® hospital. It does not aim to identify perceptions about the leadership style of the nurse managers. Although it would be beneficial to identify the nurse managers' leadership styles from a follower perspective overall, it does not fall within the scope of this study. Second, in keeping with the reliability of the survey, it has been noted that lengthy questionnaires may inflate the reliability coefficient of the survey (Avolio & Bass, 2004). Considering that the survey that will be utilized in this study employs two different tools, along with demographic questions, adapting the transformational leadership component separately from the MLQ 5X-Short contributes to a shorter survey. As noted previously, the MLQ 5X-Short allows for this procedure due to the ability of the dimensions to function separately (Antonakis et al., 2003; Boies et al., 2015).

Table 1

Transformational Leadership Constructs within The MLQ 5X-Short Rater Form

Construct	Items
Idealized influence (attributed)	10, 18, 21, 25
Idealized influence (behavioral)	6, 14, 23, 34
Inspirational motivation	9, 13, 26, 36
Intellectual stimulation	2, 8, 30, 32
Individualized consideration	15, 19, 23, 31

*Source: Bass, B., & Avolio, J. B. (2014). *Multifactor leadership questionnaire* Vol. 2014. Retrieved from http://www.mindgarden.com/products/mlq.html

The MLQ 5X-Short Rater Form was used to measure the nurse managers' degree of transformational leadership from the clinical nurses' perspective. As mentioned earlier in this chapter, only the items that measure transformational leadership in the MLQ 5X-Short Rater

Form were included in the survey. Hence, the degree of transformational leadership was measured through the attributes of idealized influence-attributed (IIA), idealized influence-behavioral (IIB), individualized consideration (IC), intellectual stimulation (IS), and inspirational motivation (IM). Each attribute was measured by a 4-item scale, with a total of 20 items constituting the overall transformational leadership score. Each item was scored on a Likert scale from zero to four, with zero being "not at all", one is "once in a while", two is "sometimes, three is "fairly often", and four is "frequently if not always". Degree of transformational leadership was determined by grouping the question items for each attribute, adding the scores for all responses to these items, and averaging them into a single index of transformational leadership.

The MLQ 5X-Short Rater Form does not aim to identify the leader being rated as transformational or not (Avolio & Bass, 2004). Rather, the authors recommend the use of the percentiles table provided with the MLQ 5X Administration Manual to interpret the results, and identify whether a leader is more or less transformational than the norm (Avolio & Bass, 2004). Appendix H shows the percentiles table based on a lower level rating for the United States (US) sample. A lower level rating means that the scoring of the MLQ 5X-Short Rater Form was completed by raters working at a lower organizational hierarchy level than the leader being assessed (Avolio & Bass, 2004). The US sample was chosen due the absence of a percentile sample for Saudi Arabia, and due to the fact that the Magnet® Model is developed by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA). For this study, the statistical norm is benchmarked at the 50^{th} percentile. Therefore, a manager's score below the 50^{th} percentile is considered below the norm, and a score above the 50^{th} percentile is considered above the norm.

The MLQ 5X-Short Rater Form was chosen due to its capacity to measure the four dimensions of transformational leadership identified in this paper and known as idealized influence, intellectual stimulation, inspirational motivation, and individualized consideration. The MLQ 5X-Short has been extensively validated in literature (Antonakis et al., 2003; Avolio & Bass, 2004; Bass & Avolio, 2014; Boies et al., 2015; Heinitz, Liepmann, & Felfe, 2005; Rowold & Heinitz, 2007; Tejeda, Scandura, & Pillai, 2001; Tepper & Percy, 1994) across cultures and types of organization (Bass & Avolio, 2014). Permission for using and replicating the MLQ 5X-Short instrument was obtained from Mind Garden Inc. for a fee.

Trust in leader scale. The Trust in Leader scale was utilized to measure the clinical nurses' perception toward their nurse managers' degree of trust and its attributes (see Appendix D). The Trust in Leader scale is a 20 descriptive rater statements that measure the degree of trust in leader across the four dimensions of competence, benevolence, integrity, and predictability (Adams & Sartori, 2006). The Trust in Leader scale was originally developed to investigate trust in Canadian Forces military teams and leaders. All statements are rated using a 7-point scale ranging from one to seven, where one indicates a response of "completely disagree", and seven indicates a response of "completely agree". The scale was mainly used in military setting, but has gone through validity and reliability testing in the general setting as well (Adams & Sartori, 2006).

Unlike the MLQ 5X-Short Rater Form, Adams et al. (2008) did not identify a percentile or norm scores for measuring the trust in leader. They implied that a neutral midpoint of "neither agree or disagree" can be used as a measure towards the propensity to trust the leader (Adams et al., 2008). For this study, the midpoint neutral mean score of 4.0 was utilized to determine the

clinical nurses' perceptions toward their nurse managers' degree of trust. Permission for using and replicating the Trust in Leader Scale was obtained from the authors (see Appendix E).

Instruments Reliability and Validity

Instrument reliability refers to the ability of an instrument in "estimating how well the items that reflect the same construct yield similar results" (Trochim & Donnelly, 2008, p. 89). It is assumed that the Cronbach's alpha measurement is a high estimate of reliability (Trochim & Donnelly, 2008). Furthermore, construct validity refers the extent to which inferences can support the constructs it was ideally built to measure (Trochim & Donnelly, 2008).

The MLQ 5X-Short has gone through several reviews for its psychometric properties since it was first introduced (Avolio & Bass, 2004; Bass & Avolio, 2014; Heinitz et al., 2005; Kanste, Meittunen, & Kyngas, 2007; Lievens, Geit, & Coetsier, 1997). Although some researchers criticized it for its failure to support structure (Tejeda et al., 2001), Avolio and Bass (2004) responded by calling for additional research for a more comprehensive examination of the questionnaire's structure. As outlined in Table 2, a sample of N = 12,118 was employed in the analysis of the MLQ 5X-Short's internal consistency, and its conformity to the construct validity of the transformational leadership score (Avolio & Bass, 2004). The questionnaire was supported by a Cronbach's alpha scores ranging between .70 and .80 for raters at a lower level than the focal leader (Avolio & Bass, 2004), meeting the .70 criteria (Nunnally, 1978).

The internal consistency of the Trust in Leader scale was measured in a sample of N = 220 by Adams et al. (2008) , and demonstrated a Cronbach's alpha scores ranging from .89 to .97, as shown in Table 3. However, the mean inter-item correlation score was .62, in which Adams et al. (2008) consider this level of internal consistency to be higher than desirable. Confirmatory factor analysis of the Trust in Leader scale was demonstrated by comparing the

four factor model against a unidimensional leadership construct (Adams & Sartori, 2006). Comparative results showed that the four factor model was superior to the one factor model, and provided a better fit of the data with $\Delta\chi 2 = 324.40$, $p < .001$. The Trust in Leader scale was also compared to other scales that measure the same construct, and it has shown to be significantly and positively correlated with these scales (Adams & Sartori, 2006).

Table 2

Reliability Scores of the Transformational Leadership Constructs within the MLQ 5X-Short Rater Form

Construct	Cronbach's Alpha*
Idealized influence (attributed)	.77
Idealized influence (behavioral)	.70
Inspirational motivation	.83
Intellectual stimulation	.75
Individualized consideration	.80

*Source: Avolio, J. B., & Bass, M. B. (2004). *Multifactor leadership questionnaire manual and sample set* Retrieved from www.mindgarden.com.

Sampling Design

Sampling is defined as "the process of selecting a portion of the population to represent the entire population" (Profetto-McGrath, Polit, & Beck, 2010, p. 208). Profetto-McGrath et al. (2010) posit that even though it is credible to obtain information from samples, there is no method for guaranteeing the representability of a sample. The authors note that although researchers cannot warrant their research to be completely flawless, they should always attempt to minimize and control the risk of error.

Table 3

Reliability scores of the Trust in Leader Scale

Construct	Cronbach's Alpha*
Competence	.95
Integrity	.89
Benevolence	.94
Predictability	.90
Overall	.97

*Source: Adams, B. D., Waldherr, S., & Sartori, J. (2008). Trust in teams scale, trust in leaders scale: Manual for administration and analyses. Defense Research and Development. Canada - Toronto.

The sample population that was employed for this study was clinical nurses working at a Magnet® designated hospital. A clinical nurse is defined as "the registered nurse who spends the majority of his or her time providing direct patient care" (ANCC, 2013, p. 64). A non-probability convenience sampling approach was employed for this study. In this study, convenience sampling implicates the use of most convenient sample of clinical nurses available to administer the survey (Profetto-McGrath et al., 2010). Although convenience sampling is an acceptable sampling method in quantitative research, one of its disadvantages is the potential of atypical study participants being included in the survey, which can lead to the risk of sampling bias (Profetto-McGrath et al., 2010). To minimize the potential for sampling bias, and ensure homogeneity of the sample, only clinical nurses who work full time, and provide beside direct-patient care were included in the study. A set of questions were included in the survey to ensure appropriate filtering of the sample during the results analysis phase.

The proposed sample size for this study is 160 clinical nurses. The calculated sample size was based on similar literature that utilized the MLQ 5X-Short to examine staff nurses

perceptions toward their nurse managers leadership style (Casida, 2011). The correlation coefficient r=0.71 taken from Casida (2011), which measured the correlation between inspirational motivation and satisfaction, was used to determine the sample size, with t-value=12.706, and degree of freedom (df)=1 at the 97.5^{th} percentile of the t distribution table.

There is no minimum and maximum sample size required to administer the MLQ 5X-Short Rater Form, although Avolio and Bass (2004) warns that in order to protect the anonymity of the raters, the questionnaire report should not be provided when there are fewer than three raters evaluating the same leader. This recommendation was not a concern in this study since the raters are anonymous, and the survey did not identify a nurse manager in particular.

To ensure that the study questionnaire reaches all potential participants and meets the required sample size, the participants were recruited through an online survey. An email that contained a link to the survey was sent to the clinical nurses. Permission to obtain and use the email addresses of the clinical nurses was obtained from the nursing department where the clinical nurses are working, and through approval from the Research Advisory Council of the organization where the study and data collection was conducted. A letter of information that explains the nature and purpose of the study, assurance of confidentiality and anonymity, as well as clear instructions on how to use the survey was included in the questionnaire (see Appendix F). The letter of information endeavored to provide the potential participants with accurate and relevant information that allows them to make an informed and voluntary decision to participate in the study. The participants were given four weeks to complete the questionnaire. Once completed, the participants were able to click on an electronic submission button at the end of the survey.

Sampling Criteria

For this study to achieve the purpose it was designed for, it was important to examine the sample's characteristics that made it feasible to describe the relationship between transformational leadership and trust from the clinical nurses' perspective. Inclusion and exclusion criteria provide a framework for determining the characteristics that the potential sample subjects must have to be included in or excluded from the study. The inclusion and exclusion criteria for the proposed study are summarized in Table 4.

Table 4

Inclusion and Exclusion Criteria of the Clinical Nurses

Inclusion criteria	Exclusion criteria
Full time employed nurses with the following position titles within the organization where the study will be conducted: • Staff Nurse I • Staff Nurse II	• All newly hired Staff Nurse I and Staff Nurse II with less than three months employment within the organization. • Staff Nurse I and Staff Nurse II that have been working in the unit or clinic for less than 3 months. • Nurses that do not directly report to a nurse manager

The inclusion criteria were limited to the clinical nurses who provide full bedside direct-patient care. Within the organization where the study was conducted, the position titles that meet these criteria were investigated with the help of the nursing and human resource departments. Accordingly, the position titles were limited to Staff Nurse I and Staff Nurse II. The exclusion criteria took into consideration the clinical nurses' duration of employment at the organization, and at the unit or clinic where they are working. Newly hired nurses, and those that have been newly transferred from another area within the last three-month period prior to taking the survey, were excluded from the sample due to the short duration of interaction with their nurse

managers. The three-month period is also the official probationary period duration of the organization where the study was conducted. Since this study investigated the clinical nurses' perceptions towards their nurse managers, clinical nurses that do not report to a nurse manager were excluded from the sample. Questions were included in the survey tool to check against these parameters so that they can be filtered during the data entry process.

Variables

Since this study utilized a descriptive non-experimental design, the variables in each phase were not manipulated; rather, association among the following variables were studied:

1. Clinical nurses' perceptions toward their nurse managers' degree of transformational leadership.
2. Attributes of transformational leadership known as IIA, IIB, IC, IS, and IM.
3. Clinical nurses' perceptions toward their nurse managers' degree of trust.
4. Attributes of trust known as competence, benevolence, integrity, and predictability,

Internal and External Validity

Descriptive research designs are generally considered to have weak internal validity, because they do not establish a cause-effect relationship (Trochim & Donnelly, 2008). Therefore, scholars argued that internal validity is not relevant in most descriptive studies (Trochim & Donnelly, 2008). Since the study design is descriptive, and does not attempt to establish a causal relationship, threats to internal validity were not addressed. However, external validity refers to the degree of generalizability that this study will be able to accomplish (Trochim & Donnelly, 2008). To improve this study's external validity, selection of participants was incorporated by sending the survey link through email to all the clinical nurses working in the organization where the study was conducted. This eliminated the possibility of researcher having control or previous

knowledge over the attendance or scheduled shifts for the nurses working during the survey period. All clinical nurses that met the inclusion criteria had an equal chance of participation in the survey. Moreover, the study allows, to a certain degree, to ascertain the generalizability of the study to transformational leadership in a Magnet® hospital, considering that Magnet® organizations models the presence of transformational leadership as attested by the application and designation procedures by the ANCC. This researcher believes that this notion supports a proximal similarity model for sampling.

Data Preparation and Analysis

To conduct the analysis and achieve the aims from this study, the International Business Machines' (IBM) Statistical Package for the Social Sciences (SPSS) version 22 was utilized. The completed online questionnaires were screened for accuracy, completeness, and legibility (Trochim & Donnelly, 2008). Each participant was assigned a code starting at P1 to P203. To ensure high level of accuracy and reliability of the results, the double entry method was utilized to enter the data into the SPSS database. The double entry method involves entering the data first and second time into two independent data sheets, then comparing both datasets for discrepancy through SPSS (Trochim & Donnelly, 2008). In the final step of data preparation, the data was screened to ensure that it falls within the acceptable limits and boundaries set for the scales in the questionnaire. The likewise deletion method was employed for missing data on any variable.

The data analysis procedure included a series of descriptive statistics to calculate the means and standard deviations of all scales in the survey. Descriptive statistics was used to acquire the profile of the study participants through a series of anonymous demographic questions. Degrees of transformational leadership and trust were determined by grouping the question items for each attribute, adding the scores for all responses to these items, and

averaging them into a single index for transformational leadership, trust, and their attributes (Adams & Sartori, 2006; Avolio & Bass, 2004). Next, the relationship between degree of transformational leadership and degree of trust was computed using Pearson's correlation analysis *r*. The correlation was considered significant at $p \leq 0.05$, which indicated a strong evidence to reject the null hypothesis (Trochim & Donnelly, 2008), and accept the alternative hypothesis. Finally, Pearson's correlation analysis was conducted to determine if dimensions of transformational leadership perception scores correlate with overall trust score.

Confidentiality and Ethical Considerations

During the data collection period, this researcher used to work in the capacity of the Program Director for Magnet® within the nursing department at the organization where the study was conducted. However, the researcher was not directly linked to the clinical nurses, nor to the nurse managers within the reporting structure. Clinical nurses and nurse managers report to nursing operations, while this researcher reported directly to nursing administration. Hence, the researcher had no influence over the hiring or termination process of the clinical nurses and the nurse managers, and was linked only through affiliation to the same nursing department.

The study proposal was approved by Athabasca University's Research Ethics Board (Appendix G), and the Research Advisory Council at the organization where the study was conducted. This researcher has also completed the Tri-Council Policy Statement (TCPS) on Ethical Conduct for Research Involving Humans Course (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014).

Study participants received an online cover letter explaining the aims and purpose of the research, and indicating that their participation is voluntary. A consent waiver was granted from

Athabasca University's Research Ethics Board, and the organization's Research Advisory Council. The request for consent waiver was consistent with Article 3.7A of the TCPS 2 (Canadian Institutes of Health Research et al., 2014, p. 35). Firstly, the study involved minimal risk to the participants which may have presented in the form of discomfort in answering specific questions about their nurse managers. There were no experimental interventions administered to the participants. The cover letter also emphasized that refusal to participate will not lead to any adverse consequences on the participant. Secondly, participants were informed through the online cover letter that completing and submitting the completed questionnaire to the researcher is considered as their agreement and consent to participate in the study. Lastly, the survey is anonymous, with no means to identify the clinical nurse as the rater nor the nurse manager as the person being rated by the researcher or by any other individual involved in the process of conducting this study.

To ensure the anonymity of the respondents, there were no personal identifiers on the questionnaire. Participants were not asked about the name of the unit or clinic where they are working. At the same time, this allowed the anonymity of the nurse manager under appraisal to be preserved. Completed online questionnaires were routed directly to the researcher's electronic survey account.

To protect the privacy and confidentiality of the participants, once completed questionnaires were received by the researcher, they were coded and saved in an encrypted and password protected file located on the researcher's personal computer. Access to the completed questionnaires was limited to the researcher.

Chapter V: Results

This research aims to investigate the perceptions of clinical nurses, working at a Magnet® designated hospital, toward their nurse managers' degrees of transformational leadership and trust. The purpose of this chapter is to present the collected data, and provide an analysis based on the research objectives and hypotheses outlined in this paper.

Response Rate

Data was collected through an electronic survey method from clinical nurses working at a Magnet® designated hospital over a period of four weeks. The survey link was set by the researcher to close after the deadline period has ended, so that participants do not have access to the survey afterward. The survey link was sent to the clinical nurses' emails which were obtained with permission from the nursing department. The emails were provided to the author by the Information Technology department, A total of 2,342 participants' emails were included in the survey. Weekly email reminders containing the survey link were sent to the participants throughout the data collection period with the aim of reaching the required sample size. A total of 203 questionnaires were submitted by the participants marking a response rate of 8.66%, and fulfilling the sample size requirement of 160 participants. Out of the 203 submitted surveys, 185 met the inclusion criteria, and were included in the results analysis procedure.

Sample Demographics

A descriptive statistical analysis was conducted to determine the participants' profile. The demographic information was obtained through a series of questions related to the nurses' position within the organization, age, gender, nationality, education, years of experience in nursing, nursing specialty, employment duration, and items related to their nurse manager's profile. Results of these items are summarized in Table 5.

Table 5

Sample Demographics

Item	N	%
Position title		
Staff Nurse I	182	98.4
Staff Nurse II	3	1.6
Age [1]		
24 or under	1	0.5
25-34 years	89	48.1
35-44 years	45	24.3
45-54 years	32	17.3
55-64 years	14	7.6
Gender		
Female	168	90.8
Male	17	9.2
Nationality [2]		
American	10	5.4
Australian	7	3.8
British	8	4.3
Canadian	9	4.9
Egyptian	2	1.1
Indian	24	13
Irish	1	0.5
Jordanian	8	4.3
Lebanese	5	2.7
Malaysian	23	12.4
New Zealander	7	3.8
Pakistani	1	0.5
Philippino	54	29.2
Saudi	13	7
South African	8	4.3
Other	5	2.6

Item	N	%
Highest degree in nursing		
Associate	2	1.1
Bachelor's	140	75.7
Diploma	34	18.4
Master's	9	4.9
Years working in nursing		
< 2 years	26	14.1
2-5 years	69	37.3
6-10 years	25	13.5
11-14 years	61	33
≥ 15 years	4	2.2
Primary nursing specialty		
Ambulatory care	30	16.2
Cardiovascular	13	7
Critical care	37	20
Emergency	4	2.2
Liver and transplant	11	5.9
Maternal and infant	6	3.2
Medical surgical	25	13.5
Oncology	38	20.5
Pediatric	10	5.4
Peri-operative	10	5.4
Other	1	0.5
Current working area		
Ambulatory	83	44.9
Inpatient	102	55.1
Years working at current hospital [3]		
< 1 year	58	31.4
1-2 years	49	26.5
3-5 years	36	19.5
6-9 years	7	3.8
> 10 years	33	17.8

Item	N	%
Years working in current unit/clinic		
3-6 months	48	25.9
7-12 months	69	37.3
13-23 months	5	2.7
2-5 years	8	4.3
> 5 years	55	29.7
Nurse manager's position		
Acting assistant head nurse	3	1.6
Acting head nurse	15	8.1
Assistant head nurse	15	8.1
Head nurse	144	77.8
other	8	4.3
Years working under current nurse manager		
3-6 months	62	33.5
7-12 months	80	43.2
13-24 months	17	9.2
2-10 years	18	9.7
> 10 years	8	4.3
Nurse manager's gender		
Female	120	64.9
Male	65	35.1

1 Missing=4
2 Other= European, Danish, Czech, Portuguese
3 Missing=2

The study participants were dominantly females with an overall rate of 90.8% (*n* = 168), where males constituted 9.2% (*n* = 17) of the total respondents. Almost two thirds of the participants were aged between 25-34 years (48.1%, *n* = 89), and 35-44 years (24.3%, *n* = 45), indicating a young population. Since the organization where the study was conducted is comprised of multinational nursing workforce, there was a wide array of participation from various nationalities. However, the majority of the participants were from Philippines (29.2%, n = 54), India (13%, *n* = 24), and Malaysia (12.4, *n* = 23). This was not a surprising result considering that the nursing workforce within the organization is mainly comprised of nurses

from these countries. North American and European nationalities constituted 17.7% (*n* = 33), whereas Middle Eastern, and Australian and New Zealander nationalities constituted 14% (*n* = 26) and 7.6% (*n* = 14) respectively. The nationality was included in the survey to determine whether cultural backgrounds have an influence over the nurses' perception towards their nurse manager's degrees of transformational leadership and trust.

The educational background demonstrated a 75.7% (*n* = 140) of participants holding a bachelor degree in nursing. It was evident that 31.4% (*n* = 58) of respondents had been working in the organization for less than one year. Nevertheless, those that had been working in the organization for more than one year still constituted the majority at 67.6% (*n* = 125). It was important to determine the time that the participants had spent working under their current nurse managers to investigate whether it correlated with variation in perceptions. It was noted that 76.7% (*n* = 142) had been working under their nurse manager for less than or equal to 12 months. As demonstrated earlier, the majority of the study participants had been working in the organization for more than one year suggesting that either the nurse manager had been in the position for one year or less, or some of the participants have transferred from another unit. The gender of the nurse manager demonstrated 64.9% (*n* = 120) females compared to 35.1% males (*n* = 65).

Hypothesis 1: Degree of Transformational Leadership

The mean transformational leadership score was *M* = 2.27, *SD* = 0.88 (*N* = 185). According to Avolio and Bass's (2004) percentile table shown in Appendix H, this score indicates that the clinical nurses perceived their nurse managers to be transformational leaders sometimes. Further analysis of the attributes of transformational leadership were consistent with the overall mean score of transformational leadership. The mean scores of II-A, and II-B were *M*

= 2.33, *SD* = 0.88, and *M* = 2.32, *SD* = 0.87 respectively. Moreover, the mean scores of IS, IM, and IC were *M* = 2.23, *SD* = 1.16, *M* = 2.30, *SD* = 1.14, and *M* = 2.19, *SD* = 0.87 respectively. In comparing the transformational leadership dimensions scores to Avolio and Bass's (2004) percentiles table for lower level rating, the results indicate that IIA, IIB, IM, and IC scores are within the 30th percentile, while IS score is within the 20th percentile. These scores indicate that the overall nurse mangers degree of transformational leadership is below the US leaders' transformational leadership norm (see Table 6). Hence, the results lead to the acceptance of the null hypothesis that perceptions of clinical nurses working at a Magnet® hospital toward their nurse managers' degree of transformational leadership, as determined by the MLQ 5X-Short Rater Form, are below the norm, and rejection of the alternative hypothesis. Nevertheless, it is important to note that the results reflect the overall mean scores of all nurse managers being rated. Therefore, attention to individual nurse manager scores will need to be taken into consideration for organizations that uses the MLQ 5X-Short Rater Form to investigate individual nurse managers' leadership styles.

Table 6

Nurse Managers Overall Transformational Leadership Attributes Score

Construct	Mean Score	Norm Score at the 50th Percentile*
Idealized influence (attributed)	**2.33**	3.00
Idealized influence (behavioral)	**2.32**	2.75
Intellectual stimulation	**2.23**	2.75
Inspirational motivation	**2.30**	3.00
Individualized consideration	**2.19**	3.00

*Source: Avolio, J. B., & Bass, M. B. (2004). Multifactor leadership questionnaire manual and sample set Retrieved from www.mindgarden.com.
Note. Mean scores below the norm score are in boldface.

This author would like to note that this study did not utilize Avolio and Bass's (1991) Full Range Leadership Theory to investigate the clinical nurses perceptions toward their nurse managers' leadership style, and it investigated their perceptions toward the degree of transformational leadership exclusively.

Hypothesis 2: Degree of Trust

Clinical nurses' perceptions toward their nurse managers' degree of trust was measured by the Trust in Leader scale (Adams et al., 2008). The Trust in Leader scale is comprised of twenty descriptive rater statements that measure the degree of trust in leader across the four attributes of competence, benevolence, integrity, and predictability (Adams & Sartori, 2006), with each attribute encompassing a 5-item statements out of the total 20 items . All statements are rated using a 7-point scale ranging from one to seven, where one indicates a response of "completely disagree", and seven indicates a response of "completely agree". Unlike the MLQ 5X-Short Rater Form, Adams et al. (2008) did not identify a percentile or norm scores for measuring the trust in leader. They implied that a neutral midpoint of "neither agree or disagree" can be used as a measure towards the propensity to trust the leader (Adams et al., 2008). For this study, the midpoint neutral mean score of 4.0 was utilized to determine the clinical nurses' perceptions toward their nurse managers' degree of trust.

The mean Trust in Leader score was $M = 4.79$, $SD = 1.41$ (N =185) indicating a neutral position of neither agree or disagree, with a propensity towards perceiving the nurse manager as trustful. Similarly, the attributes of trust represented in the scale as benevolence, predictability, competence, and integrity were $M = 4.62$, $SD = 1.62$, $M = 4.80$, $SD = 1.29$, $M = 4.89$, $SD = 1.63$, and $M = 4.85$, $SD = 1.52$ respectively. The scores indicated a propensity towards a positive trustful perception. Therefore, the results lead to the acceptance of the hypothesis that clinical

nurses working at a Magnet® hospital perceive their nurse managers as trustful, as determined by the Trust in Leader Scale, and rejection of the null hypothesis.

Demographic Influences on Transformational Leadership and Trust Perceptions

To test whether factors such as age, gender, experience, nationality, qualifications, time working on the unit, time working under the nurse manager, and nurse manager's gender had an influence over the clinical nurses' perceptions towards their nurse manager's degrees of transformational leadership and trust, a series of independent sample t-test and one-way ANOVA were conducted. Prior to conducting these tests, and to the validate the assumption that the comparison groups had equal variances, Levene's test of the homogeneity of variance was performed across all variables being investigated (Morgan, Gliner, & Harmon, 2006). A Levene's test with $p < .05$ was considered a validation for the assumption of equality. When the assumption was violated, Welch's test was utilized. Welch's test is considered a robust test to reduce the risk of Type I error when the assumption of homogeneity of variance is not met for the one-way ANOVA (Declare, Lakens, & Leys, 2017; Ruxton, 2006). According to the results of Levene's test of the homogeneity of variance (see Table 7 and Table 8), all variables being tested met the assumption of homogeneity except education and nationality against the trust score; hence, Welch's test was utilized for these variables.

Influences on Transformational Leadership Perceptions

An independent sample t-test was conducted to compare whether respondents' gender, age, years of experience in nursing, and time working under the nurse manager had an influence over their perceptions toward their nurse managers' degree of transformational leadership. Participants' gender showed no statistically significant difference between females ($M = 2.30$, $SD = .88$) and males ($M = 2.02$, SD = .85); $t = 1.22$, $p = .22$. To conduct a more meaningful

analysis, age was recategorized and recoded in SPSS under two categories. Young population included respondents aged 34 years and under, and older population included those aged 35 years and above. Similarly, years of nursing experience, and time working under the nurse manager were also recategorized and recoded as 10 years or less and more than 10 years for the nursing experience variable, and one year or less and more than one year for the time working under the nurse manager variable.

Table 7

Test of Homogeneity of Variances Against Transformational Leadership

Variable	Levene Statistic	df1	df2	*p* value*
Age	3.404	1	179	.067
Gender	.231	1	183	.631
Experience	3.656	1	183	.057
Nationality	1.864	1	181	.137
Qualifications	.429	3	181	.732
Time working under the nurse manager	1.486	1	183	.224
Nurse Manager's Gender	.005	1	183	.941

**p value is significant at <.05*

There was no statistically significant difference between younger population (M = 2.18, SD = .84) and older population (M = 2.40, SD = .91); t = -1.62, p = .29, and those with 10 years or less nursing experience (M = 2.34, SD = .91) against those with more than 10 years nursing experience (M = 2.20, SD = .84); t = 1.04, p = .29. Likewise, there was no statistically significant difference between those that have worked one year or less (M = 2.30, SD= .84) and those that have worked more than one year (M = 2.18, SD = .99) under the nurse manager; t = .76, p = .44.

Furthermore, gender of the nurse manager was found to have no statistically significant difference between females ($M = 2.30$, $SD = .88$) and males ($M = 2.23$, $SD = .88$); $t = 1.22$, $p = .22$.

Table 8

Test of Homogeneity of Variances Against Trust

Variable	Levene Statistic	df1	df2	*p* value*
Age	.705	1	179	.402
Gender	.191	1	183	.662
Experience	2.129	1	183	.146
Nationality	6.150	1	181	.001
Qualifications	3.378	1	181	.020
Time working under the nurse manager	1.933	1	183	.166
Nurse Manager's Gender	.752	1	183	.387

**p value is significant at <.05*

These results suggest that gender, age, nursing experience, time working under the nurse manager, and nurse managers' gender had no influence over the clinical nurses' perceptions toward their nurse managers' degree of transformational leadership.

A one-way ANOVA between variables was conducted to test whether nursing education and nationality had an influence over the respondents' perceptions toward their nurse managers' degree of transformational leadership. There was a total of 19 nationalities represented in the sample. To streamline the analysis process, they were recategorized into four categories and recoded in SPSS as (1) Western, (2) African, (3) Asian, and (4) Middle Eastern. This selection

was chosen by this researcher to reflect the regional and cultural intersections among nationalities, where western included North American, European, Australian, and New Zealand nationalities. A one-way ANOVA showed no statistically significant difference at $p < 0.05$ among nursing education backgrounds [$F(3, 181) = .38$, $p = .76$] on transformational leadership scores. However, there was a statistically significant difference among nationality background [$F(3, 181) = 6.58$, $p = .00$] on transformational leadership scores. Post hoc comparison using Bonferroni test indicated that the mean transformational leadership score for Asian nationalities ($M = 2.48$, $SD = .74$) was significantly different statistically from Middle Eastern ($M = 1.86$, $SD = .90$, $p = .00$) and Western ($M = 1.98$, $SD = .97$, $p = .00$). Nevertheless, African nationality background ($M = 2.64$, $SD = 1.05$) was not significantly different statistically from Asian ($p = 1.00$.), Middle Eastern ($p = .08$), and Western ($p = .15$) nationality backgrounds. The results suggest that while nursing education had no influence on the transformational leadership scores, nationality background may have in some way.

A one-way ANOVA, and Bonferroni post-hoc tests were then employed to investigate which dimensions of transformational leadership contributed to the difference in the mean scores among nationalities. The results are summarized in Tables 9.1 to 9.5, and demonstrated that the dimension of IIA had a statistically significant difference in the mean score in Middle Eastern ($M = 1.87$, $SD = .93$,) against Asian ($M = 2.47$, $SD = .76$, $p = .00$). The dimension of IIB did not have any statistically significant difference in the mean score between nationalities. Furthermore, the dimension of IS had a statistically significant difference in the mean score between Asian ($M = 2.52$, $SD = .98$) and Western ($M = 1.73$, $SD = 1.27$, $p = .00$) as well as with Middle Eastern ($M = 1.85$, $SD = 1.12$, $p = .04$).

Table 9.1

Bonferroni Post Hoc Test for Cultural Influences of Dimensions of TL

TL Dimension	Nationality		Mean Difference	Std. Error	*p* value*
IIA	Western				
		African	-.49	.29	.58
		Asian	-.27	.15	.41
		Middle Eastern	.33	.20	.69
	African				
		Western	.49	.29	.58
		Asian	.22	.28	1.00
		Middle Eastern	.82	.31	.06
	Asian				
		Western	.27	.15	.41
		African	-.22	.28	1.00
		Middle Eastern	.60	.18	.00
	Middle Eastern				
		Western	-.33	.20	.69
		African	-.82	.31	.06
		Asian	-.60	.18	.00

**p value is significant at <.05*

Table 9.2

TL Dimension	Nationality		Mean Difference	Std. Error	*p* value*
IIB	Western				
		African	-.27	.29	1.00
		Asian	-.33	.15	.16
		Middle Eastern	.16	.20	1.00
	African				
		Western	.27	.29	1.00
		Asian	-.06	.28	1.00
		Middle Eastern	.43	.31	1.00
	Asian				
		Western	.33	.15	.16
		African	.06	.28	1.00
		Middle Eastern	.49	.18	.052
	Middle Eastern				
		Western	-.16	.20	1.00
		African	-.43	.31	1.00
		Asian	-.49	.18	.052

**p value is significant at <.05*

Table 9.3

TL Dimension	Nationality		Mean Difference	Std. Error	*p* value*
IS	Western				
		African	-.88	.38	.13
		Asian	-.78	.19	.00
		Middle Eastern	-.11	.27	1.00
	African				
		Western	.88	.38	.13
		Asian	.10	.36	1.00
		Middle Eastern	.76	.41	.38
	Asian				
		Western	.78	.19	.00
		African	-.10	.36	1.00
		Middle Eastern	.66	.24	.04
	Middle Eastern				
		Western	.11	.27	1.00
		African	-.76	.41	.38
		Asian	-.66	.24	.04

**p value is significant at <.05*

The dimension of IM demonstrated that Asians had a statistically significant difference in the mean score ($M = 2.58$, $SD = .95$) against Western ($M = 1.87$, $SD = 1.24$, $p = .00$) and Middle Eastern ($M = 1.75$, $SD = 1.17$, $p = .00$). Lastly, the dimension of IC had a statistically significant difference in the mean score between Asian ($M = 2.34$, $SD = .84$) and Middle Eastern ($M = 1.83$, $SD = .82$, $p = .04$). These results suggest that the Middle Eastern nationalities had a statistically significant lower mean score on the dimensions of IIA, IS, IM, and IC of transformational leadership perceptions against Asian nationalities, and the Western nationalities had a statistically significant lower mean score on IS, IM compared to Asian nationalities.

Table 9.4

TL Dimension	Nationality		Mean Difference	Std. Error	p value*
IM	Western				
		African	-.95	.37	.07
		Asian	-.71	.19	.00
		Middle Eastern	.12	.26	1.00
	African				
		Western	.95	.37	.07
		Asian	.23	.36	1.00
		Middle Eastern	1.07	.40	.053
	Asian				
		Western	.71	.19	.00
		African	-.23	.36	1.00
		Middle Eastern	.83	.23	.00
	Middle Eastern				
		Western	-.12	.26	1.00
		African	-1.07	.40	.053
		Asian	-.83	.23	.00

**p value is significant at <.05*

Table 9.5

TL Dimension	Nationality		Mean Difference	Std. Error	*p* value*
IC	Western				
		African	-.68	.29	.13
		Asian	-.37	.15	.07
		Middle Eastern	.12	.20	1.00
	African				
		Western	.68	.29	.13
		Asian	.30	.28	1.00
		Middle Eastern	.81	.31	.06
	Asian				
		Western	.37	.15	.07
		African	-.30	.28	1.00
		Middle Eastern	.50	.18	.04
	Middle Eastern				
		Western	-.12	.20	1.00
		African	-.81	.31	.06
		Asian	-.50	.18	.04

**p value is significant at <.05*

Influences on Trust Perceptions

A similar analytic approach to the demographic influences on transformational leadership was used to test variations in trust perceptions. Hence, an independent sample t-test was conducted to compare whether respondents' gender, age, years of experience in nursing, and time working under the nurse manager had an influence over their perceptions toward their nurse managers' degree of trust. There was no statistically significant difference between females (M = 4.84, SD = 1.39) and males (M = 4.27, SD = 1.50); t = 1.59, p = .11. Furthermore, there was no statistically significant difference between the young (M = 4.63, SD = 1.37) and the older (M = 5.0, SD = 1.42); t = -1.79, p = .07 populations, as well as those with 10 years or less nursing

experience (M = 4.87, SD = 1.46) and more than 10 years nursing experience (M = 4.70, SD = 1.35); t = .83, p = .40. Likewise, there was no statistically significant difference between those that have worked under the nurse manager for one year or less (M= 4.85, SD= 1.38), and more than one year (M = 4.57, SD = 1.50); t = 1.14, p = .25. The gender of the nurse manager was also found to have no statistically significant difference between female (M = 4.78, SD = 1.45) and male (M = 4.70, SD = 1.34) nurse managers; t = -.05, p = .95. These results suggest that gender, age, nursing experience, time working under the nurse manager, and nurse managers' gender had no influence over the clinical nurses' perceptions toward their nurse managers' degree of trust.

Since nursing education and nationality background did not meet the assumption of the homogeneity of variance, Welch's test was utilized. The results showed no statistically significant difference at $p < 0.05$ among nursing education backgrounds [$F(3, 5.03) = 4.89$, p = .059] on trust scores as determined by Welch's test. However, there was a statistically significant difference among nationality background [$F(3, 34.179) = 7.26$, p = .00] on trust scores. Post hoc comparison using Games-Howell test (see Table 10) revealed that the mean trust score for Asian nationalities (M = 5.16, SD = 1.13,) was significantly different statistically from Middle Eastern (M = 4.15, SD = 1.35, p = .007) and Western (M = 4.21, SD = 1.70, p = .005). Nevertheless, African nationality background (M = 5.36, SD = 1.20) was not significantly different statistically from Asian (p = .95), Middle Eastern (p = .07), and Western (p = .08) nationality backgrounds. The results suggest that while nursing education had no influence on the trust scores, nationality background may have in some way.

Table 10

Games-Howell Post Hoc Test for Cultural Influences on Trust Score

Nationality		Mean Difference	Std. Error	*p* value*
Western				
	African	-1.15	.45	.08
	Asian	-.95	.27	.00
	Middle Eastern	.05	.36	.99
African				
	Western	1.15	.45	.08
	Asian	.19	.39	.95
	Middle Eastern	1.21	.46	.07
Asian				
	Western	.95	.27	.00
	African	-.19	.39	.95
	Middle Eastern	1.01	.28	.00
Middle Eastern				
	Western	-.05	.36	.99
	African	-1.2	.46	.07
	Asian	-1.0	.28	.00

**p value is significant at <.05*

A one-way ANOVA, and Games-Howell post hoc tests were conducted to further investigate the diversity in the mean scores against the attributes of trust. The results are summarized in Tables 11.1 to 11.4, and demonstrated that the dimension of benevolence had a statistically significant difference in the mean score in Asian ($M = 5.05$, $SD = 1.26$) against Western ($M = 3.85$, $SD = 2.03$, $p = .00$) and Middle Eastern ($M = 4.07$, $SD = 1.49$, $p = .01$). The dimension of predictability also had a statistically significant difference in the mean score in Western ($M = 4.32$, $SD = 1.65$) against Asian ($M = 5.07$, $SD = 1.06$, $p = 0.03$) and African ($M = 5.42$, $SD = .50$, $p = .00$), as well as between African and Middle Eastern ($M = 4.38$, $SD = 1.20$, p

= .00). Furthermore, the attribute of competence had a statistically significant difference in the mean score between Asian (M = 5.36, SD = 1.28) and Western (M = 4.14, SD = 1.91, p = .00) as well as with Middle Eastern (M = 4.14, SD = 1.63, p = .00). Lastly, the dimension of integrity demonstrated a statistically significant difference in the mean score between Asian (M = 5.17, SD = 1.24) and Middle Eastern (M = 4.01, SD = 1.61, p = .00). These results suggest that Asian nationalities had a statistically significant higher mean score on three out four trust attributes against Middle Eastern and Western nationalities, while Africans demonstrated a statistically significant higher mean score on the attribute of predictability against Western and Middle Eastern.

Table 11.1

Games-Howell Post Hoc Test for Cultural Influences on Trust Attributes

Trust Attribute	Nationality		Mean Difference	Std. Error	*p* value*
Benevolence	Western				
		African	-1.44	.52	.05
		Asian	-1.20	.32	.00
		Middle Eastern	-.21	.41	.95
	African				
		Western	1.44	.52	.05
		Asian	.24	.45	.94
		Middle Eastern	1.22	.52	.12
	Asian				
		Western	1.20	.32	.00
		African	-.24	.45	.94
		Middle Eastern	.98	.31	.01
	Middle Eastern				
		Western	.21	.41	.95
		African	-1.22	.52	.12
		Asian	-.98	.31	.01

**p value is significant at <.05*

Table 11.2

Trust Attribute	Nationality		Mean Difference	Std. Error	*p* value*
Predictability	Western				
		African	.09	.28	.00
		Asian	-.75	.26	.03
		Middle Eastern	-.06	.33	.99
	African				
		Western	1.09	.28	.00
		Asian	.34	.19	.29
		Middle Eastern	1.03	.28	.00
	Asian				
		Western	.75	.26	.03
		African	-.34	.19	.29
		Middle Eastern	.68	.25	.05
	Middle Eastern				
		Western	.06	.33	.99
		African	-1.03	.28	.00
		Asian	-.68	.25	.05

**p value is significant at <.05*

Table 11.3

Trust Attribute	Nationality		Mean Difference	Std. Error	*p* value*
Competence	Western				
		African	-1.33	.57	.13
		Asian	-1.21	.30	.00
		Middle Eastern	.00	.42	1.00
	African				
		Western	1.33	.57	.13
		Asian	.11	.51	.99
		Middle Eastern	1.34	.59	.14
	Asian				
		Western	1.21	.30	.00
		African	-.11	.51	.99
		Middle Eastern	1.22	.34	.00
	Middle Eastern				
		Western	-.00	.42	1.00
		African	-1.34	.59	.14
		Asian	-1.22	.34	.00

**p value is significant at <.05*

Table 11.4

Trust Attribute	Nationality		Mean Difference	Std. Error	*p* value*
Integrity	Western				
		African	-.74	.61	.62
		Asian	-.65	.28	.10
		Middle Eastern	.49	.40	.61
	African				
		Western	.74	.61	.62
		Asian	.09	.56	.99
		Middle Eastern	1.24	.63	.24
	Asian				
		Western	.65	.28	.10
		African	-.09	.56	.99
		Middle Eastern	1.15	.33	.00
	Middle Eastern				
		Western	-.49	.40	.61
		African	-1.24	.63	.24
		Asian	-1.15	.33	.00

**p value is significant at <.05*

Hypothesis 3: Correlation of Transformational Leadership and Trust

A Pearson product-moment correlation coefficient was computed to assess the relationship between transformational leadership and trust scores. There was a positive strong correlation between transformational leadership and trust at $r = 0.82$, $N = 185$, $p = .00$. The correlation scatterplot in Figure 1 demonstrates a positive linear correlation between transformational leadership and trust scores. A higher transformational leadership score was correlated with a higher trust score in the nurse manager as perceived by clinical nurses working at a Magnet® designated hospital. The results lead to the acceptance of the hypothesis that perceptions of clinical nurses working at a Magnet® hospital toward their nurse managers' degree of transformational leadership, as determined by the MLQ 5X-Short Rater Form (Avolio

& Bass, 2004), are positively correlated with their perceptions toward their nurse managers' degree of trust, as determined by the Trust in Leader scale (Adams et al., 2008). Further correlation analysis was conducted by utilizing the Pearson product-moment correlation coefficient to investigate the relationship between dimensions of transformational leadership and trust scores. As demonstrated in Table 12, there was a positive strong correlation between trust scores and the dimensions of IIA, IIB, IS, IM, and positive moderate correlation with the dimension of IC. The scatter plot graphs shown in Figures 2 through 6 also validate the linear positive correlation between dimensions of transformational leadership and trust scores as determined by the clinical nurses' perceptions.

Figure 1

Correlation Scatterplot between Transformational Leadership and Trust Scores

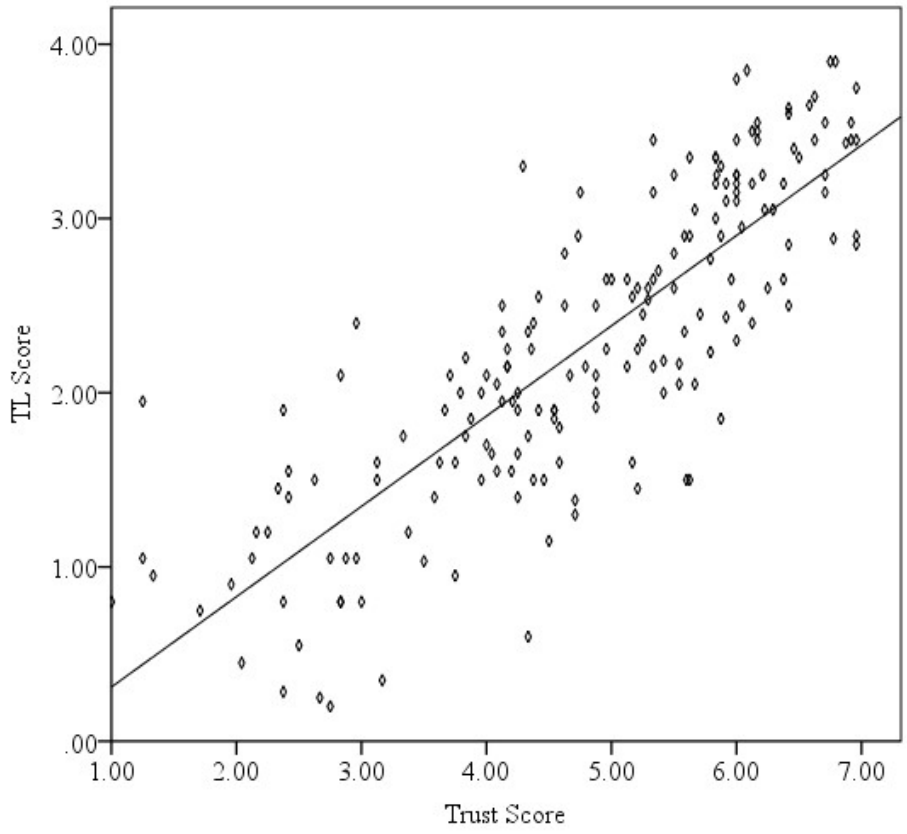


Table 12

Pearson Correlation Coefficients between Transformational Leadership Dimensions and Trust

		IIA	IIB	IS	IM	IC
Trust score	Pearson correlation	.74	.71	.81	.82	.56
	p value*	.00	.00	.00	.00	.00
	N	185	185	185	185	185

**p value is significant at <.05*

Figure 2

Correlation Scatterplot between Idealized Influence-Attributed and Trust Scores

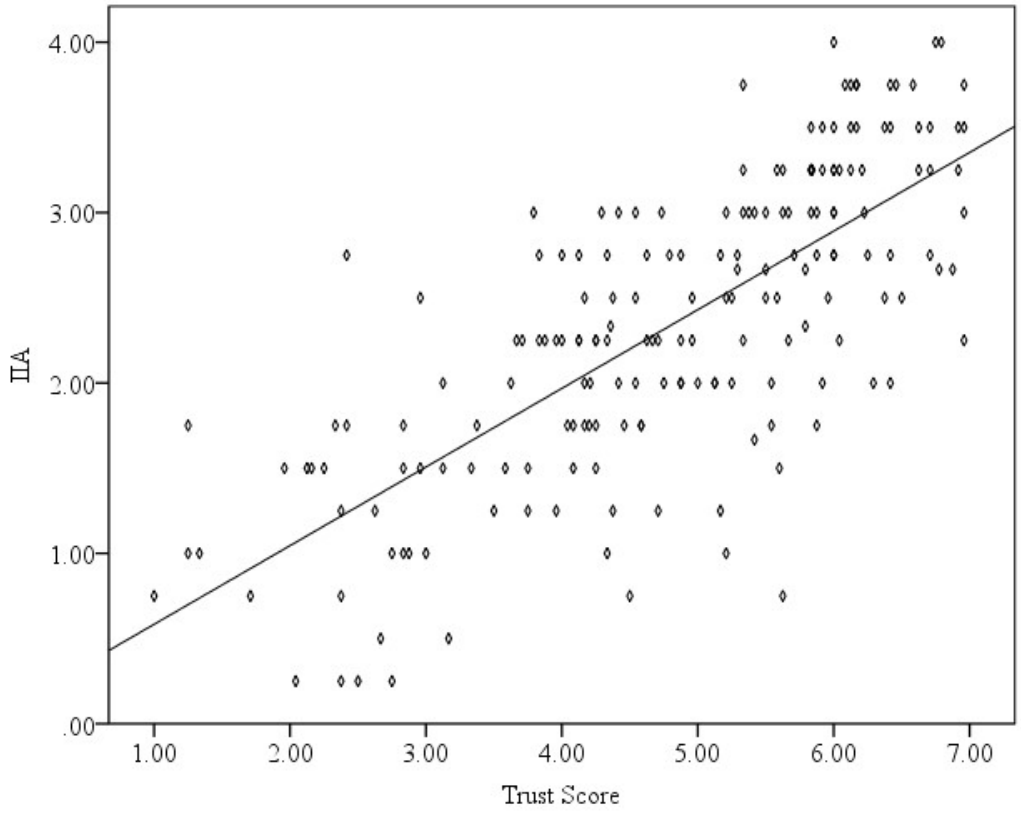


Figure 3

Correlation Scatterplot between Idealized Influence-Behavioral and Trust Scores

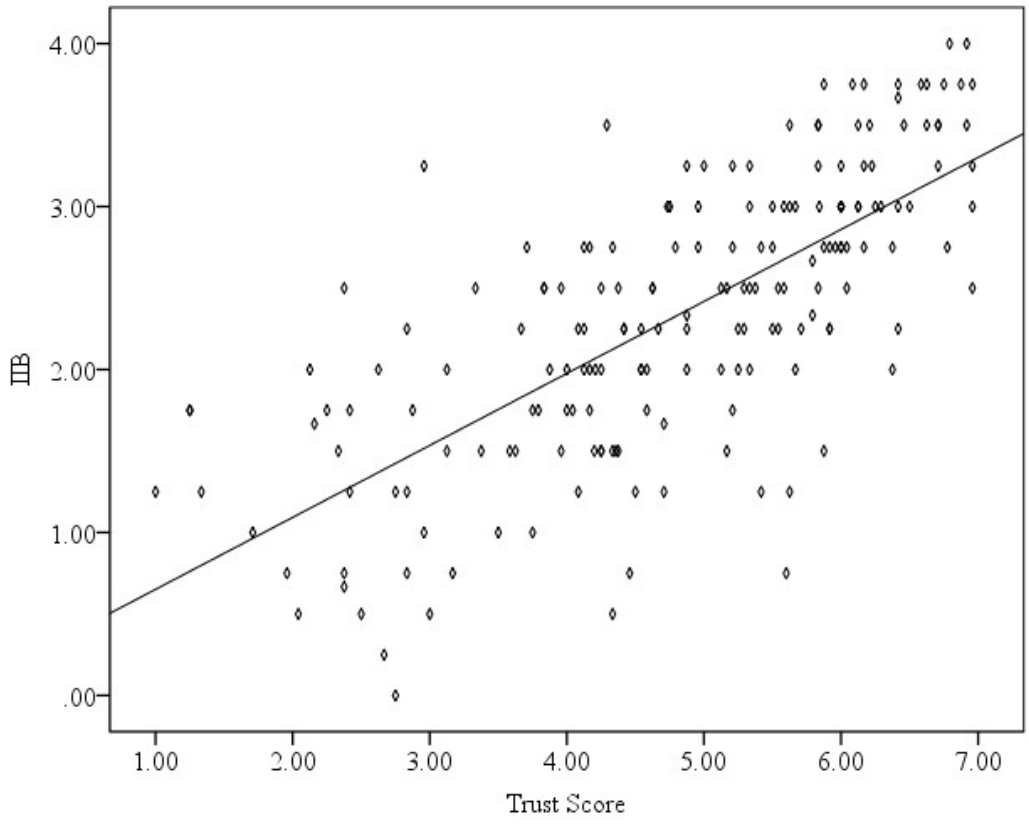


Figure 4

Correlation Scatterplot between Intellectual Stimulation and Trust Scores

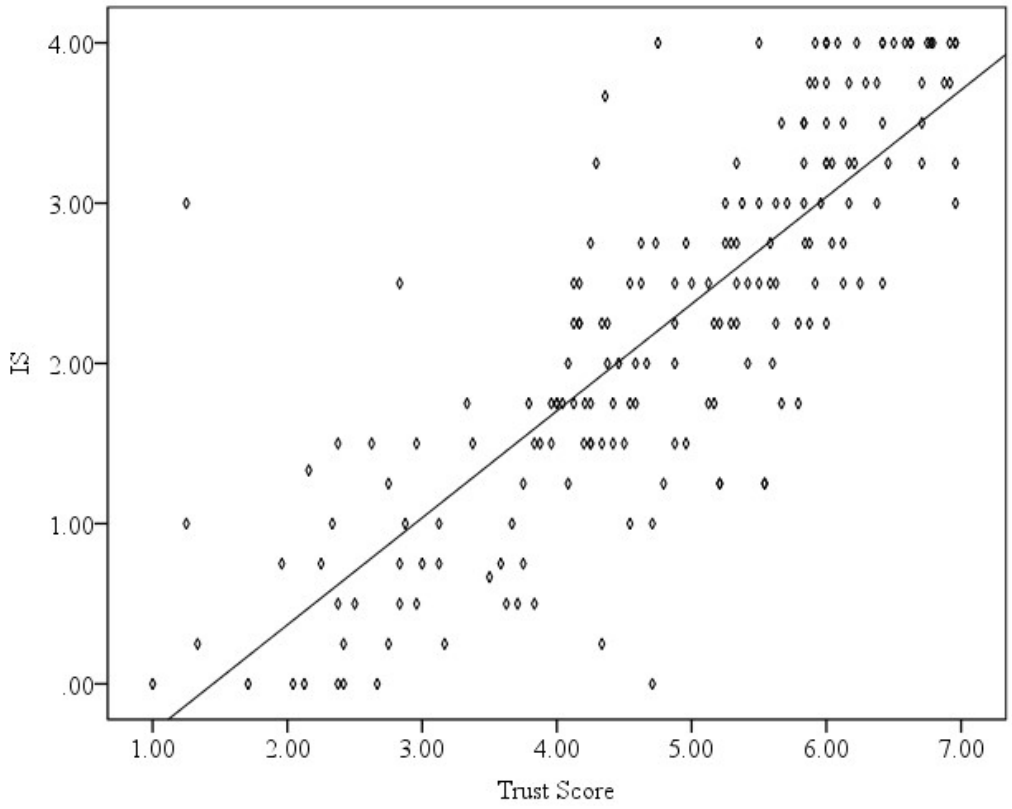


Figure 5

Correlation Scatterplot between Inspirational Motivation and Trust Scores

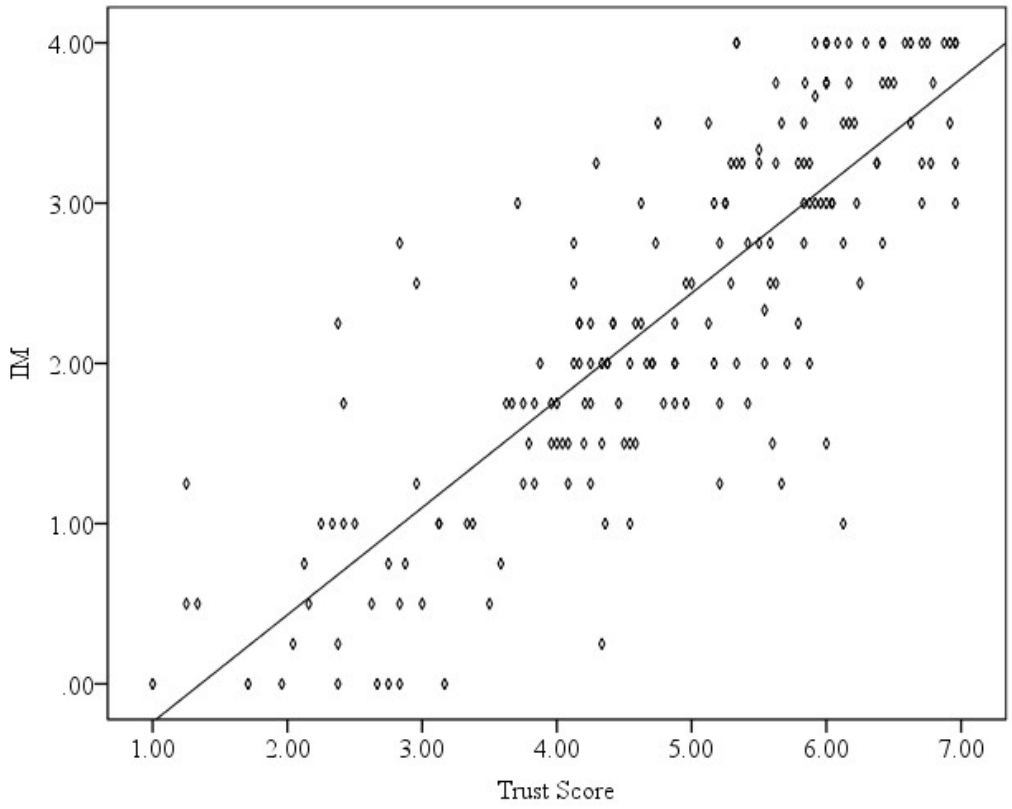
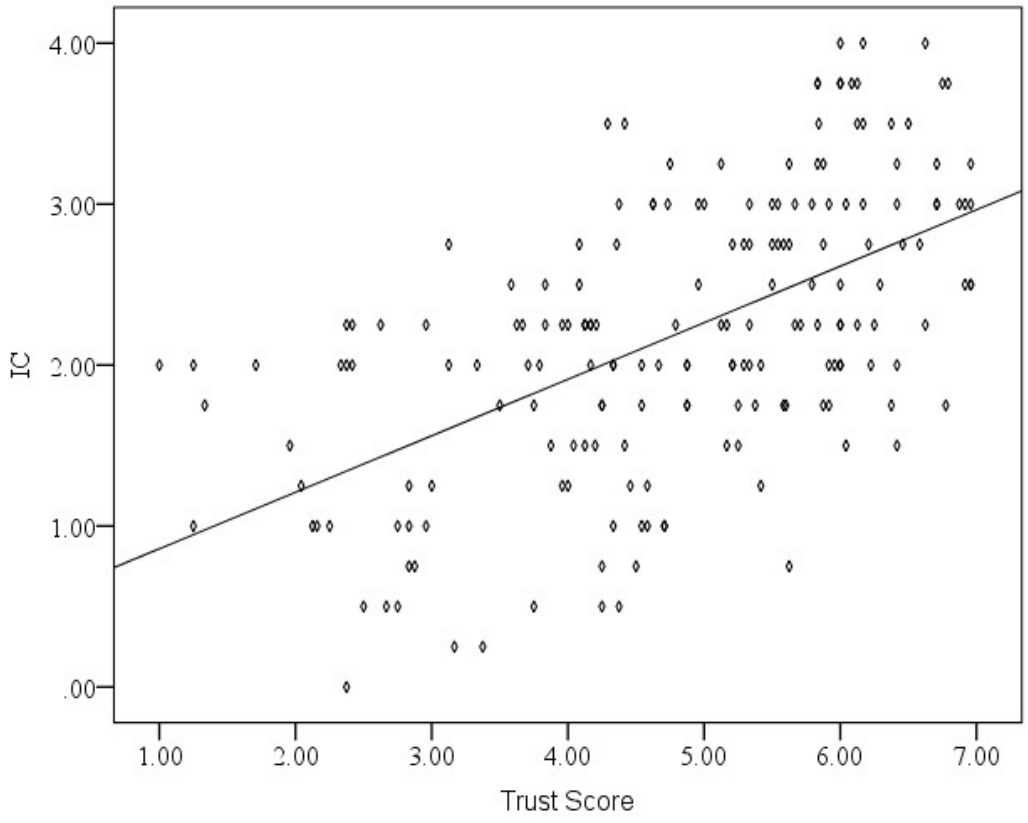


Figure 6

Correlation Scatterplot between Individualized Consideration and Trust Scores



Chapter VI: Discussion

The purpose of this research was to investigate the perceptions of clinical nurses working at a Magnet® designated hospital toward their nurse managers' degrees of transformational leadership and trust. It also aimed at exploring the relationship between transformational leadership and trust perceptions. This research posed the following questions that were identified in chapter I:

Question 1. What are the perceptions of the clinical nurses working at a Magnet® hospital toward their nurse managers' degree of transformational leadership?

Question 2. What are the perceptions of the clinical nurses working at a Magnet® hospital toward their nurse managers' degree of trust?

Question 3. What is the relationship between the nurse managers' degree of transformational leadership and degree of trust as perceived by the clinical nurses working at a Magnet® hospital?

As indicated in previous chapters, the results construed from this research are not aimed at generating a theoretical framework, but rather exploratory in nature. This chapter is focused on summarizing the study findings, and discussing their meaningfulness within the context of leadership and Magnet®. It also attempts to present the limitations of the study results.

Perceptions of Transformational Leadership

One of the observations that this author perceived during conducting this study is that leadership remains one of the widely argumentative concepts in literature. This is evident by the plethora of publications by scholars and renowned leaders from diverse leadership backgrounds in politics, business, and healthcare, just to name a few. The literature presents numerous theories and concepts on leadership styles, and several scholars posed arguments that idealized a

leadership style over others. This study does not attempt to prove the preeminence of transformational leadership style. It is merely investigating the clinical nurses' perceptions of the degree of transformational leadership in the nurse manager within the healthcare and Magnet® contexts. This identification is important for the generalizability of the results, and for carefully instigating the conclusions posed in this study. It is also important to note that a tendency toward a perceived transformational leadership score is not to be interpreted as a measure for leadership effectiveness within the Magnet® context. This study does not attempt to make such implication.

The perceptions of the degree of transformational leadership toward the nurse managers working at a Magnet® designated healthcare organization were investigated from the clinical nurses' perspective. A survey that included the items pertaining to transformational leadership measures in the MLQ 5X-Short Rater Form was utilized for this purpose. The results of the study indicated that the mean score of the nurse managers ($M = 2.27$, $SD = 0.88$, $N = 185$) was below the norm for US leaders according the percentile table proposed by (Avolio & Bass, 2004). The mean score also indicated that the nurse managers were perceived transformational at a degree between "sometimes" to "fairly often". Therefore, the nurse managers were perceived to display some level of transformational leadership.

Since the Magnet® model (see Appendix A) signifies transformational leadership as integral to award an organization the designation of Magnet®, healthcare facilities are required to provide evidence of transformational leadership to the American Nurses Credentialing Centre (ANCC). Hence, transformational leadership is expected to be demonstrated at various levels of nursing leadership including the nurse managers. Nevertheless, there are no conditions to the degree of transformational leadership that needs to be exhibited, as the ANCC does not require an organization to empirically measure their nursing leaders level of transformational leadership

(ANCC, 2013). Generally, the level of transformational leadership that is required to be demonstrated during the designation process must be exhibited at the level of excellence based on evidence from leaders' actions and outcomes (ANCC, 2013). The findings from this study poses an inquiry as to whether a Magnet® organization should be measuring their nursing leaders level of transformational leadership for enculturating excellence within the organization. It is important to note that this study examined one level of nursing leadership within an organization, i.e. the nurse managers, and that other levels of nursing leadership may have variations in the level of transformational leadership. Magnet® designated organizations have a culture of transformational leadership embedded within its mission, values and strategic intents (ANCC, 2013).

The findings from this study also provided insight over the demographic influences on the clinical nurses' perceptions toward their nurse managers' degree of transformational leadership. The findings suggest that the way clinical nurses perceived their leaders surpassed the test of age, gender, experience and education. However, cultural background seems to have some influence over interactions with the nurse managers, and the way they are perceived. The study results showed that Asian nationalities had rated their nursing managers at a higher mean score, which was statistically significant, than Western and Middle Eastern nationalities, while it had no statistically significant difference to those from African backgrounds. It is not known why this variation is demonstrated in the data. However, Ford and Airhihenbuwa (2010) argue that racial backgrounds may influence our experiences and social interactions and it may explicate our variations in perceptions. In a study that examined the cultural differences in endorsement of the aspects of servant leadership, Mittal and Dorfman (2012) found that culture clusters of people from different countries, but similar cultural backgrounds, had distinct affinities to certain

aspects of leadership. They recommended that leadership development programs should include a cross cultural component to help leaders become competent when working with multicultural groups (Mittal & Dorfman, 2012). Ospina and Foldy (2009) suggested that since societies and individuals are informed by race, then leadership must be influenced with this notion. As demonstrated in the data, the nursing workforce in the hospital where the study was conducted is multinational and multicultural. Therefore, cultural variations in perceptions towards the degree of transformational leadership in the nurse managers could have been informed by the cultural and ethnic differences in the endorsement of the dimensions of transformational leadership by the clinical nurses. The nationality of the nurse manager was not investigated in this study, and it would be beneficial in future research to investigate whether compatible cultural backgrounds between the leader and the follower may vary from those with different cultural backgrounds.

Perceptions of Trust

Trust has been examined in literature as a mediator to effective and outcome driven leadership (Costa et al., 2001; Lee et al., 2010; Liu, Siu, & Shi, 2010; Wong & Cummings, 2009). On the other hand, lack of trust has been viewed as a form of a dysfunction that may hinder growth and development of a healthcare system (Lexa, 2017). In this study, trust perceptions in the nurse manager were examined through the Trust in Leader scale, where trust attributes related to competence, benevolence, integrity, and predictability (Adams et al., 2004) constituted the metrics for this inquiry.

The findings from this study demonstrated an overall trust mean score of $M = 4.79$, $SD = 1.41$ ($N = 185$) indicating a neutral position of neither agree or disagree, with a propensity towards perceiving the nurse manager as trustful. The demographic analysis of the sample showed that the majority of the participants (77%) had been working under the nurse manager

for one year or less. At first, the predisposition to explain such an overall rating is to attribute it to the fact that developing trust between leader and follower is reinforced through the influence of time, since it presents more opportunities for social and professional interactions (Welter & Alex, 2015). Nevertheless, time working under the nurse manager did not contribute to a higher mean score, and there was no statistically significant difference between those that have been working for one year or less, and those that have been working for more than one year under the nurse manager. In fact, all demographic variables, except nationality, had no statistical significance on the variations in trust perceptions. Nationality had a statistically significant difference in mean scores between Asian nationalities in one hand, and those from Western and Middle Eastern nationalities on the other hand. African nationalities had no statically significant difference to the perceptions of trust compared to other three nationalities. Welter and Alex (2015) suggested that development of trust is influenced by cultural traditions, and that it is subjective and contextual. They argued that contexts can influence trust perceptions between individuals within the same cultural backgrounds, but different milieus, drawing on the example of trust contexts in rural settings where spatial proximity between individuals and groups promotes higher trust compared to metropolitan settings. Moreover, religion can be another contributing factor to consider when examining the nationality variance in the study.

The country where the study was conducted follows an Islamic and conservative doctrine that dictates the laws and regulations within the country, which is subsequently reflected in the work settings. Although this study did not seek to identify the religious affiliations of the participants and the nurse managers, it may be predicted through the nationality variable where religious attachments are known to be dominantly associated with a certain faith. A Malaysian study that examined the effect of ethnicity and religion on cooperation between student

participants found that having the same religion enhanced further cooperation (S.-H. Chuah, Hoffmann, Ramasamy, & Tan, 2014). S. Chuah, H., Gächter, Hoffmann, and Tan (2016) investigated the impact of similar religious affiliations on discrimination and perceptions of trustworthiness across three cultures, and concluded that having the same religion promoted more trust between the sender and receiver. They posited that religion may be a contributing factor to informing our perceptions of trustworthiness and interactions with each other. Nevertheless, these studies were conducted in simulated environments, and cannot be used to make an inference, without a reasonable doubt, about the results from this study, especially that data on the religious affiliations of the participants and nurse managers were not collected. In conclusion, perhaps religious influences on perceptions of trust between leaders and followers can be further investigated in future research, especially within multicultural settings.

Transformational Leadership and Trust Relationship

The third hypothesis that was investigated in this study was the relationship between perceptions of transformational leadership and trust in the nurse manager, as perceived by the clinical nurses working at a Magnet® designated hospital. Many studies examined the relationship between transformational leadership and trust from the mediating role of trust in enhancing organizational or team outcomes (Boies et al., 2015; Braun et al., 2013; Burke et al., 2007; Chou et al., 2013; Jiayan et al., 2010; Kelloway et al., 2012). However, fewer studies that investigated their relationship directly found that transformational leadership behaviors correlate with increased followers' trust in their leaders (Chou et al., 2013; Dirks & Ferrin, 2002). The results from this study concur with this conclusion, since there was a positive strong correlation between transformational leadership and trust scores as demonstrated by Pearson product-moment correlation coefficient at $r = 0.82$, $N = 185$, $p = 0.00$. Trust scores were also positively

correlated with all five dimensions of transformational leadership (see Table 12 and Figures 2 through 6).

Since the dimensions of transformational leadership were established as integral to the qualities that must exist in the transformational leader (Avolio & Bass, 2004), it seems logical to expect such a correlation. This notion becomes increasingly valid when examined against the trust definition that was provided in previous chapter which posits that trust evolves as we interact with the perceived qualities of the trustee (Adams & Webb, 2003). It is important, however, to distinguish the form and level of trust being examined in this situation. The form of trust being investigated in this study is at the leadership level, particularly the trust that is perceived in the leader by the team member, but other forms may also exist at the organizational level, and between team members as well (Burke et al., 2007). This distinction is important as it allows further elaborations to be contextual within this view. Some scholars argued that trust is multidimensional and can exist at the cognitive and affective levels (Dirks & Ferrin, 2002; Zhu, Newman, Miao, & Hooke, 2013). Cognitive trust refers to the perceived characteristics of reliability and dependability in the leader, while affective trust is grounded by the reciprocal demonstration of care and concern (Dirks & Ferrin, 2002; McAllister, 1995; Zhu et al., 2013). To understand the relationship between transformational leadership and trust, an examination of the congruence between dimensions of transformational leadership and attributes of trust will be employed.

The dimension of idealized influence, which refers to the leaders ability to act as a role model (Antonakis & House, 2013; Avolio & Bass, 2004), can support the leader-follower interactions and development of affective trust through the leader's demonstration of high ethical behavior and willingness to sacrifice own interests for the greater good (Zhu et al., 2013).

Eventually, this enhances reliability and predictability of the leader, leading to the development of cognitive trust (Zhu et al., 2013).

The dimension of inspirational motivation, which refers to the leaders ability to empower and motivate followers (Antonakis & House, 2013) towards a shared vision (Avolio & Bass, 2004), allows followers to develop a high sense of contribution and willingness to social interactions with the leader which triggers affective trust (Zhu et al., 2013). Likewise, cognitive trust develops when the leader is seen as competent individual who is capable of accomplishing goals and objectives (Zhu et al., 2013).

The dimension of intellectual stimulation corresponds to the leader's capacity to instill creativity and empower the followers to resolve problems on their own effectively (Avolio & Bass, 2004). The affective and cognitive trust can develop as followers feel more involved and respected, and enhance their perception of competence and integrity in the leader (Avolio & Bass, 2004; Yue & Syed, 2014; Zhu et al., 2013).

Finally, the leader with individualized consideration is one who pays attention to his followers needs and concerns (Antonakis & House, 2013; Bass & Riggio, 2006). This allows for more social interactions between the leader and the follower, and strengthen the affective domain of trust. The cognitive trust develops through the follower's attribution that the leader has integrity who acts with high sense of reliability and predictability (Zhu et al., 2013).

The strong correlation between transformational leadership and trust proven in this study, leads this author to believe that trust should be viewed as an attribute of transformational leadership, and beyond the notion of being a mediator or moderator for leadership outcomes. The rationale for this premise is driven by the logical deductions imposed from this study that

demonstrated how trust is deeply embedded, beyond separation, within the dimensions of transformational leadership.

Limitations

This study is descriptive, and a known limitation of descriptive research is that it describes norms rather than generating standards or proving causation (Houser, 2012)

The second limitation in this study is that the organization has a nursing workforce from over 35 different nationalities, and since the study utilized a convenience sampling, and self-reported perceptions, it may have risked the potential for participants' bias and varied cultural perceptions around transformational leadership and trust perceptions.

The third limitation is related to the use of Trust in Leader scale (Adams et al., 2008). There were no nursing studies found in literature that utilized this tool. Although this does not necessarily take away from the validity of the tool, but it would have added to its robustness in this study. However, this author considers this limitation to be common among similar studies due to defragmentation and lack of consensus on trust definition and construct in literature (Adams & Webb, 2003; Burke et al., 2007; Costa et al., 2001), which makes it difficult to replicate results regardless of the scale used.

The final limitation in this study was grasped during the analysis period, and is concerned with the cultural background of the nurse manager. Since nationality had a statistically significant difference to the clinical nurse's perceptions toward their nurse managers degrees of transformational leadership and trust, it would have been useful to investigate whether compatible nationalities between the clinical nurses and nurse managers would have yielded statistically significant results as well.

Chapter VII: Conclusion and Recommendations

Findings from this study demonstrated that the nurse managers working at a Magnet® designated hospital are perceived by the clinical nurses to possess transformational leadership characteristics "sometimes", but were below the percentile's norm for US leaders (Bass & Avolio, 2014). At the same time, they lean to the propensity to perceive their nurse managers as trustful. The findings from this study also agree with other studies that a positive relation exists between transformational leadership and trust (Chou et al., 2013; Dirks & Ferrin, 2002; Zhu et al., 2013).

This study contributes to the existing literature on leadership and trust in general, and within the context of Magnet® in specific. Recommendations from this study can be of an interest to Magnet® hospitals, the American Nurses Credentialing Centre (ANCC), leaders and health care organizations in general, and scholars interested in exploring concepts related to transformational leadership and trust. This chapter addresses the recommendations and implications for nursing practice that were concluded from this study.

The Magnet® Recognition Program is a model that represents an international recognition for nursing excellence (ANCC, 2013). Within the Magnet® model, transformational leadership is considered a pillar for organizations seeking to become or sustain the Magnet® status (ANCC, 2013). The premise that transformational leadership exists within an organization is dependent on the perceived leadership behaviors of nursing leaders, including the nurse managers. These behaviors are often measured within a framework of empirical outcomes that exhibits excellence in patient services and staff satisfaction. The nurse managers are in a pivotal position to achieve and sustain nursing excellence due to their level of engagement with the front line clinical nurses (Sellars, 2012). Results from this study found that the nurse managers are

perceived to demonstrate transformational leadership behaviors “sometimes”, but also below the norm of US leaders’ percentile table (Avolio & Bass, 2004). The implications from this result may indicate that the nurse managers are at risk of not being able to attain the level or excellence in nursing leadership required to sustain excellence in nursing services, patient outcomes, and nurse satisfaction. However, the nurse managers are often challenged with demanding financial constraints facing most healthcare systems in this era, and charged with the burden of reducing costs at the point of care (Batson & Yoder, 2009), improve patient outcomes and satisfaction, and decrease clinical nurse turnover rates. Nevertheless, transformational leadership within the Magnet® context is meant to be embedded within an organizational culture, and since nurse managers are expected to attain a certain degree of transformational leadership, they require support from transformational nurse executives. This notion is critical to consider for the recommendations elicited from this study to be practical and meaningful.

It is in this authors opinion that the support required for a culture of transformational leadership within an organization transcends through the hierarchical organizational chart starting at the level of the chief executive officer, down to the chief nurse executive, then to the middle nursing leadership, until it reaches the nurse managers and other nurses working in a leadership capacity at any level, including the clinical nurses. This study recommends that executive leadership within Magnet® hospitals invest in leadership development programs aimed at supporting the transformational leadership capacities of the nurse managers. Even though the ANCC does not require organizations seeking Magnet® designation to provide a direct measurement of the degree of transformational leadership of their nursing leadership, it is recommended that organizations maintain a baseline of the degree of transformational leadership of their nursing leaders through validated tools such as the MLQ 5x-Short (Avolio & Bass,

2004). This allows the organization to tailor the support needed for individual nurse leader, while maintaining pulse check on the transformational leadership culture within nursing and the organization. Avolio and Bass's (2004) Full Range Leadership model can serve as a framework to assess, implement, and evaluate the level of nursing leadership within an organization. A four-method assessment approach is usually ideal as it allows the measurement of leadership style from the perspectives of a rater that is at a higher level, same level, and lower level than the individual being rated, with the fourth method being self-rating. Moreover, nurse managers need to develop self-awareness about their own leadership limitations, and be more open to embrace the changes necessary to attain the perceived level of transformational leadership needed to maintain excellence. Data obtained from the leadership styles assessment can be utilized to focus efforts on the transformational leadership dimension that they are most vulnerable at. Nurse managers should also be aware of the impact of cultural diversity on their leadership insights and how it may inform the perceived interactions with staff from different cultural backgrounds. Being culturally competent, although can be overwhelming, is a key to being a successful and competent manager.

Trust has been measured in this study through the attributes of competence, benevolence, integrity and predictability (Adams et al., 2008). The results showed that clinical nurses had a neutral stance of neither agree or disagree, with a propensity towards perceiving the nurse manager as trustful. The results also showed that culture has some influence over the perceptions of trust. Based on these findings, it is recommended that nurse managers become mindful about the mechanisms of trust development in the leader. It is also important to recognize trust as a process that evolves through social interactions between the trustor and the trustee, and understand the emerging factors that may bolster or weaken trust in leader (Burke et al., 2007).

This recognition corresponds with nurse manager's self-awareness of their own level of competence, which is an attribute of trust (Adams et al., 2008). Moreover, the results also showed that cultural backgrounds may contribute to a variation in trust perceptions. Being culturally aware and informed is key to address this issue. In their application manual (ANCC, 2013), the ANCC highlighted that organizations must have structures and processes to address cultural diversity. This is an important factor to consider since Magnet® designated hospitals are known to have high nurse satisfaction and retention rates (Sellars, 2012). A culturally informed nurse manager is better positioned to demonstrate the characteristics of idealized influence and benevolence, both of which are central components of transformational leadership and trust. The factor of reciprocity in trust has been established to be pivotal to its development (Burke et al., 2007; McAllister, 1995). Nurse managers need to demonstrate role model behavior, and take actions that establish their competence, integrity, and benevolence. The factor of reliability is achieved through repeated social exchanges with the clinical nurses. A nurse manager that provides a nurturing and supportive environment, and acts as a coach and mentor, can instill feelings of value and importance in the clinical nurses (Batson & Yoder, 2009). This allows the nurse manager to have more interaction opportunities with the clinical nurses, and enhance their perceived sense of predictability in the nurse manager.

Trust has been also found to have strong positive correlation with transformational leadership and its dimensions. This relationship does not seem to be transient or incidental. Rather, it seems to be deeply rooted in the core of transformational leadership. Nurse managers cannot expect to be perceived transformational if they do not instill trust in their followers. Organizations that offer leadership development opportunities for their nurse managers need to address trust development at the forefront.

Within the context of Magnet®, perhaps the trust paradigm can be introduced into the Magnet® designation process, and be exhibited through the empirical outcomes of transformational leadership pillar. This can emphasize the significance of trust as integral to leadership and to nursing excellence.

Clearly, the above recommendations present more implications for future research on leadership and trust. The complexities and challenges future generations are, and will be, facing due to exponential advances in technology, global financial crisis, demographic shifts, and environmental changes will continue to influence the human condition both socially and physically. Therefore, scholars hold the responsibility of continuing to explore the phenomena of leadership within different contexts, as leadership should continue to remain agile in order evolve and meet the challenges ahead.

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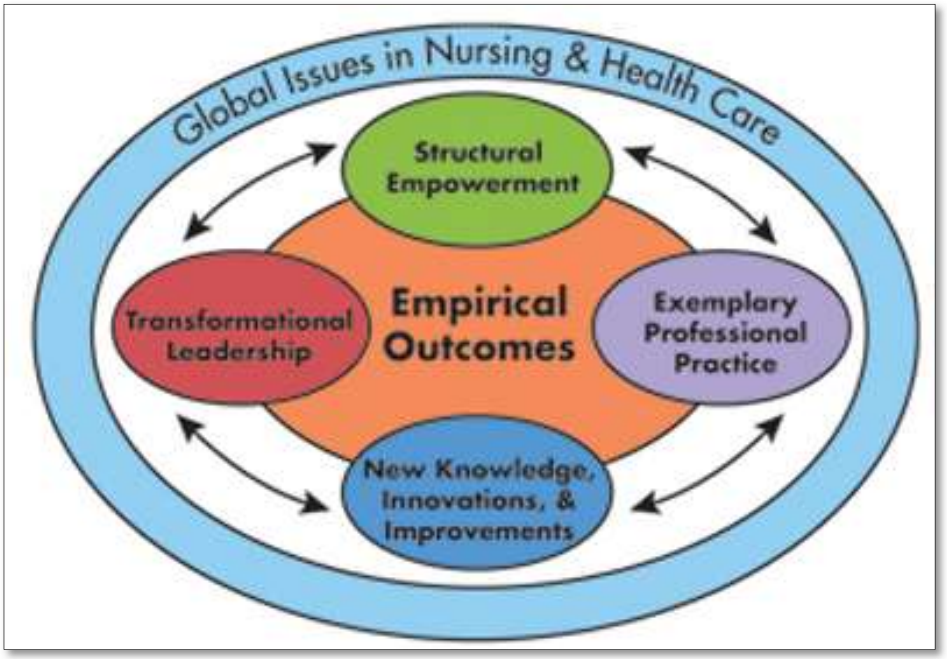
Appendix A

Magnet Model



Note: Used with permission from ANCC. Retrieved from www.nursecredentialing.com, 22 March 2016

Appendix B

Research Survey Tool

Clinical Nurses Perceptions toward their Nurse Managers' Degrees of Transformational Leadership and Trust within a Magnet® Hospital
Research Questionnaire

Demographic Information:

1. **What is your current position title?**
   a. ☐ Staff Nurse I b. ☐ Staff Nurse II c. Other (please specify): _____

2. **What is your age?**
   a. ☐24 or under b. ☐25-34 years old c. ☐35-44 years old
   d. ☐45-54 years old e. ☐55-64 years old f. ☐ 65 and above

3. **What is your gender?**
   a. ☐Female b. ☐Male

4. **What is your nationality?**
   a. American (United States) b. ☐Australian c. ☐British d. ☐Canadian
   e. ☐Egyptian f. ☐Indian g. ☐Irish h. ☐Jordanian
   i. ☐Lebanese j. ☐Malaysian k. ☐New Zealander l. ☐Pakistani
   m. ☐Philippino n. ☐Saudi o. ☐South African p. Sudanese
   q. ☐Other, please specify_____

5. **What is the highest degree that you completed in Nursing?**
   a. ☐Diploma b. ☐ Associate degree c. ☐ Bachelor's degree
   d. ☐ Master's degree e. ☐ Doctorate degree f. ☐ Other, please specify _____

6. **How long have you been working in nursing?**
   a. ☐2 years or less b. ☐3-5 years c. ☐6-10 years
   d. ☐11 – 14 years e. ☐15 years or more

7. Which of the following best describe your primarily area of nursing specialty?

a. ☐Oncology b. ☐Medical Surgical c. ☐ Pediatric
d. ☐Maternal and infant e. ☐Critical care f. ☐ Cardiovascular
g. ☐Ambulatory care h. ☐Peri-operative i. Liver and transplant
j. ☐Other, please specify_____

8. Which best describes your current working area?

a. ☐Ambulatory b. ☐Inpatient c. ☐Other, please specify_____

9. How long have you been working at your current hospital?

a. ☐ Less than 1 year b. ☐1-2 years c. ☐3-5 years
d. ☐6-9 years e. ☐ More than 10 years

10. How long have you been working in your current unit/clinic?

a. ☐ Less than 90 days b. ☐3 – 6 months c. ☐7 – 12 months
d. ☐13 – 24 months e. ☐2 -10 years f. ☐ More than 10 years

11. Which item best describes your current nurse manager's position?

a. ☐ Head Nurse b. ☐ Acting Head Nurse c. ☐ Assistant Head Nurse
d. ☐ Acting Assistant Head Nurse e. ☐ Other, please specify_____

12. How long have you been working under your current nurse manager?

a. ☐ Less than 90 days b. ☐3 – 6 months c. ☐7 – 12 months
d. ☐13 – 24 months e. ☐2 -10 years f. ☐ More than 10 years

13. What is the gender of your current nurse manager?

a. ☐Female b. ☐Male

The below questions are used to describe the leadership style of your current nurse manager as you perceive it. Answer all items on this answer sheet. If an item is irrelevant, or if you are unsure or do not know the answer, leave the answer blank.

Twenty descriptive statements are listed for this section. Judge how frequently each statement fits your current nurse manager that you are describing.

The person I am rating:	Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
1. Instills pride in me for being associated with him/her	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
2. Talks about his/her most important values and beliefs	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
3. Re-examines critical assumptions to question whether they are appropriate	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
4. Talks optimistically about the future	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
5. Spends time teaching and coaching	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
6. Acts in ways that builds my respect	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
7. Considers the moral and ethical consequences of decisions	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
8. Considers me as having different needs, abilities, and aspirations from others	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
9. Gets me to look at problems from many different angles	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
10. Articulates a compelling vision of the future	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
11. Helps me to develop my strengths	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
12. Seeks differing perspectives when solving problems	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
13. Talks enthusiastically about what needs to be accomplished	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
14. Goes beyond self-interest for the good of the group	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
15. Suggests new ways of looking at how to complete assignments	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
16. Specifies the importance of having a strong sense of purpose	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
17. Expresses confidence that goals will be achieved	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
18. Treats me as an individual rather than just as a member of a group	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
19. Emphasizes the importance of having a collective sense of mission	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
20. Displays a sense of power and confidence	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

Using the rating scale provided below, indicate the extent to which you agree with the following statements with respect to your current nurse manager:

	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree or Disagree	Somewhat Agree	Agree	Strongly Agree
1. My leader watches my back	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
2. I can anticipate what my leader will do	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
3. I know exactly what my leader will do in difficult situations	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
4. My team leader is highly skilled	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
5. My leader is fair	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
6. My team leader knows what he's doing	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
7. In risky situations, my leader tells the truth	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
8. I have confidence in the abilities of my team leader	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
9. My leader behaves in a very consistent manner	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
10. I usually know how my leader is going to react	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
11. I can depend on the fairness of my leader	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
12. I can anticipate my leader's actions before he does them	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
13. My team leader is capable at his job	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
14. My leader is honest	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
15. My team leader is likely to protect me	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
16. My team leader performs his job well	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
17. My leader is genuinely concerned about my well being	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
18. I can rely on my leader to behave predictably	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
19. My leader will keep his word	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
20. My team leader performs well even in stressful situations	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐

21. My leader has poor ethics	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐

End of Survey

Thank you for your participation

Appendix C

MLQ 5X-Short Rater Form

Multifactor Leadership Questionnaire
Rater Form

Name of Leader: _____ Date: _____

Organization ID #: _____ Leader ID #: _____

This questionnaire is used to describe the leadership style of the above-mentioned individual as you perceive it. Answer all items on this answer sheet. **If an item is irrelevant, or if you are unsure or do not know the answer, leave the answer blank.** Please answer this questionnaire anonymously.

Important (necessary for processing): Which best describes you?

___ I am at a higher organizational level than the person I am rating.
___ The person I am rating is at my organizational level.
___ I am at a lower organizational level than the person I am rating.
___ Other than the above.

Forty-five descriptive statements are listed on the following pages. Judge how frequently each statement fits the person you are describing. Use the following rating scale:

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
0	1	2	3	4

The Person I Am Rating. . .

1.	Provides me with assistance in exchange for my efforts	0	1	2	3	4
2.	*Re-examines critical assumptions to question whether they are appropriate	0	1	2	3	4
3.	Fails to interfere until problems become serious	0	1	2	3	4
4.	Focuses attention on irregularities, mistakes, exceptions, and deviations from standards	0	1	2	3	4
5.	Avoids getting involved when important issues arise	0	1	2	3	4
6.	*Talks about his/her most important values and beliefs	0	1	2	3	4
7.	Is absent when needed	0	1	2	3	4
8.	*Seeks differing perspectives when solving problems	0	1	2	3	4
9.	*Talks optimistically about the future	0	1	2	3	4
10.	*Instills pride in me for being associated with him/her	0	1	2	3	4
11.	Discusses in specific terms who is responsible for achieving performance targets	0	1	2	3	4
12.	Waits for things to go wrong before taking action	0	1	2	3	4
13.	*Talks enthusiastically about what needs to be accomplished	0	1	2	3	4
14.	*Specifies the importance of having a strong sense of purpose	0	1	2	3	4
15.	*Spends time teaching and coaching	0	1	2	3	4

Continued ➔

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
0	1	2	3	4

16. Makes clear what one can expect to receive when performance goals are achieved ... 0 1 2 3 4
17. Shows that he/she is a firm believer in "If it ain't broke, don't fix it." ... 0 1 2 3 4
18. *Goes beyond self-interest for the good of the group ... 0 1 2 3 4
19. *Treats me as an individual rather than just as a member of a group ... 0 1 2 3 4
20. Demonstrates that problems must become chronic before taking action ... 0 1 2 3 4
21. *Acts in ways that builds my respect ... 0 1 2 3 4
22. Concentrates his/her full attention on dealing with mistakes, complaints, and failures ... 0 1 2 3 4
23. *Considers the moral and ethical consequences of decisions ... 0 1 2 3 4
24. Keeps track of all mistakes ... 0 1 2 3 4
25. *Displays a sense of power and confidence ... 0 1 2 3 4
26. *Articulates a compelling vision of the future ... 0 1 2 3 4
27. Directs my attention toward failures to meet standards ... 0 1 2 3 4
28. Avoids making decisions ... 0 1 2 3 4
29. *Considers me as having different needs, abilities, and aspirations from others ... 0 1 2 3 4
30. *Gets me to look at problems from many different angles ... 0 1 2 3 4
31. *Helps me to develop my strengths ... 0 1 2 3 4
32. *Suggests new ways of looking at how to complete assignments ... 0 1 2 3 4
33. Delays responding to urgent questions ... 0 1 2 3 4
34. *Emphasizes the importance of having a collective sense of mission ... 0 1 2 3 4
35. Expresses satisfaction when I meet expectations ... 0 1 2 3 4
36. *Expresses confidence that goals will be achieved ... 0 1 2 3 4
37. Is effective in meeting my job-related needs ... 0 1 2 3 4
38. Uses methods of leadership that are satisfying ... 0 1 2 3 4
39. Gets me to do more than I expected to do ... 0 1 2 3 4
40. Is effective in representing me to higher authority ... 0 1 2 3 4
41. Works with me in a satisfactory way ... 0 1 2 3 4
42. Heightens my desire to succeed ... 0 1 2 3 4
43. Is effective in meeting organizational requirements ... 0 1 2 3 4
44. Increases my willingness to try harder ... 0 1 2 3 4
45. Leads a group that is effective ... 0 1 2 3 4

Appendix D

Trust in Leader Scale

A.2 Appendix B

Trust in Leaders

Using the rating scale provided below, indicate the extent to which you agree with the following statements with respect to your current section or team:

1 = Strongly disagree

2 = Disagree

3 = Somewhat disagree

4 = Neither agree nor disagree

5 = Somewhat agree

6 = Agree

Continue on next page

7 = Strongly agree

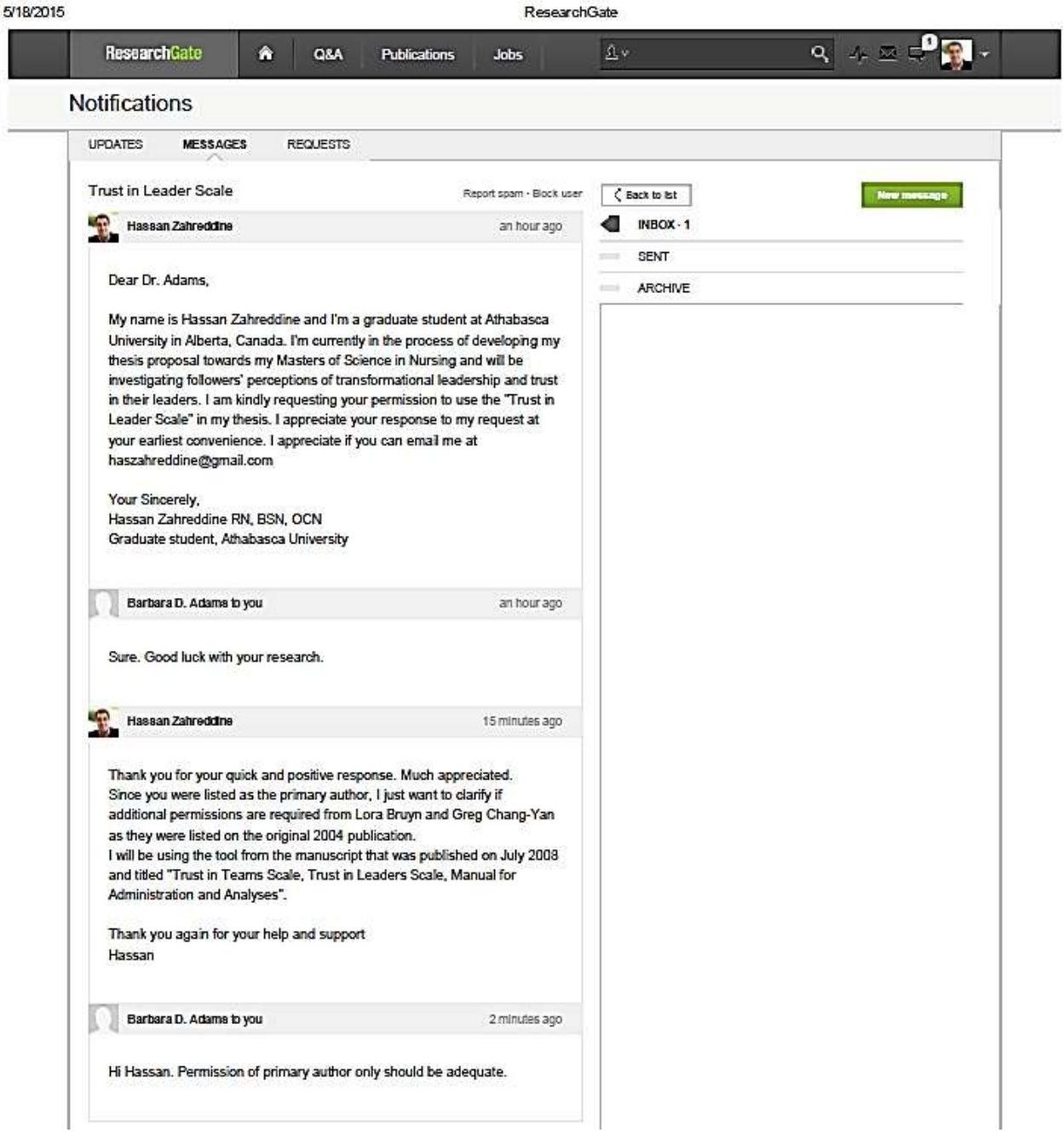
1. My leader watches my back. (B)
2. I can anticipate what my leader will do. (P)
3. I know exactly what my leader will do in difficult situations. (P)
4. My team leader is highly skilled. (C)
5. My leader is fair. (I)
6. My team leader knows what he's doing. (C)
7. In risky situations, my leader tells the truth. (I)
8. I have confidence in the abilities of my team leader. (C)
9. My leader behaves in a very consistent manner. (P)
10. I usually know how my leader is going to react. (P)
11. I can depend on the fairness of my leader. (I)
12. I can anticipate my leader's actions before he does them. (P)
13. My team leader is capable at his job. (C)
14. My leader is honest. (I)
15. My team leader is likely to protect me. (B)
16. My team leader performs his job well. (C)
17. My leader is genuinely concerned about my well being. (B)
18. I can rely on my leader to behave predictably. (P)
19. My leader will keep his word. (I)
20. My team leader performs well even in stressful situations. (C)
21. **My leader has poor ethics. (I – reversed item)**

B = Benevolence (i.e., to score, add all of the B items together and divide by 3, for a minimum and maximum of 1 and 7, respectively – We still need to work on this subscale)

C = Competence (i.e., to score, add all of the C items together and divide by 6, for a minimum and maximum of 1 and 7, respectively)

Appendix E

Permission to Use the Trust in Leader Scale from the Author



Appendix F

Participants Information Letter

Letter of Information

Principal Researcher:
Hassan Zahreddine
Email: hzahreddine@kfshrc.edu.sa
Internal Mail Box Address: MBC 73
Tel: 00966 11 5577270

Supervisor:
Dr. Kimberly Lamarche
Athabasca University

Purpose of the Study
You are invited to participate in a research study that investigates perceptions of clinical nurses toward their nurse managers' degrees of transformational leadership and trust. I am conducting this study in fulfillment of my Master of Nursing at Athabasca University.

As a participant, you are asked to take part in answering a survey. The survey includes questions about your perceptions regarding your direct nurse manager's leadership characteristics. The survey also includes some demographic questions so that we are able to describe the general characteristics of the study participants. You must be working in your current unit/clinic for **more than 3 months** to be eligible to participate in the survey. Participation will take approximately 15 minutes of your time.

Decision to Participate and Benefits
Involvement in this study is entirely voluntary and you may refuse to answer any questions or share information that you are not comfortable sharing. You may withdraw from the study at any time during the data collection period by simply not mailing or submitting your survey responses to the researcher. There is no direct benefit to you from taking part in this study. However, it is hoped that the study will help us understand the relationship between leadership behaviors and development of trust among followers, which may potentially contribute to an enhanced leader-follower relationship overall.

Confidentiality and Risks
Completing the survey is totally anonymous. You will not be asked to provide your name, hospital ID number, or answer any personal identifier questions in any section throughout the survey. No one will be able to identify you or your answers, and no one will know whether or not you participated in the study. You will not be asked to identify your nurse manager as well. Collected surveys will be kept in a locked cabinet inside the researcher's private office and results will be stored in a password protected computer. There are no major foreseeable risks involved in participating in this survey, except for possible minimal discomfort in answering some of the survey questions.

Submitting Your Survey Responses

- If you completed the paper-based survey, please place it inside the provided envelope and send it to through the interdepartmental hospital mail to Hassan Zahreddine at MBC 73.
- If you completed the electronic survey through the link that you received through email, the survey will be automatically forwarded to the researcher.

Results

Once the study is completed, results may be shared on Athabasca University's website, with the university's faculty members, and with King Faisal Specialist Hospital and Research Centre's Research Advisory Committee. The study results may also be considered for publications in journals or periodicals in the future. If you wish to receive a summary of the results, please contact the researcher directly at the above contact details and a copy will be mailed or emailed to the address you provide.

Contacting the Researcher

If you have any questions about this study or require further information, please contact Hassan Zahreddine using the contact information above.

This study has been reviewed by the Athabasca University Research Ethics Board, and King Faisal Specialist Hospital and Research Centre's Research Advisory Committee. Should you have any comments or concerns regarding your participation in this study, please contact the Office of Research Ethics at 1-800-788-9041, ext. 6718 or by e-mail to rebsec@athabascau.ca.

By submitting or mailing the completed survey you acknowledge that you have provided your consent to participate and that:

- You understand the expectations and requirements of your participation in the research;
- You understand the provisions around confidentiality and anonymity;
- You understand that your participation is voluntary, and that you are free to withdraw at any time with no negative consequences;
- You are aware that you may contact the researcher or the Office of Research Ethics if you have any questions, concerns or complaints about the research procedures.

Thank you for your assistance in this study.

Appendix G

Athabasca University's Research Ethics Board Approval

Gmail Hassan Zahreddine <haszahreddine@gmail.com>

Certification of Ethics Approval
8 messages

gleicht@athabascau.ca <gleicht@athabascau.ca> Fri, May 20, 2016 at 2:58 PM
To: "Mr. Hassan Zahreddine (Principal Investigator)" <haszahreddine@gmail.com>
Cc: "Dr. Kimberley Lamarche (Supervisor)" <lamarche@athabascau.ca>, MelroseSherri <sherrim@athabascau.ca>, gleicht@athabascau.ca

Athabasca University
RESEARCH CENTRE

May 20, 2016

Mr. Hassan Zahreddine
Faculty of Health Disciplines
Athabasca University

File No: 22216

Expiry Date: May 19, 2017

Dear Hassan Zahreddine,

The Faculty of Health Disciplines (CNHS) Departmental Ethics Review Committee, acting under authority of the Athabasca University Research Ethics Board to provide an expedited process of review for minimal risk student researcher projects, has reviewed you project, 'Clinical Nurses Perceptions toward their Nurse Managers' Degrees of Transformational Leadership and Trust'.

Your application has been **Approved on ethical grounds** and this memorandum constitutes a ***Certification of Ethics Approval***. You may begin the proposed research.

AUREB approval, dated May 20, 2016, is valid for one year less a day.

As you progress with the research, all requests for changes or modifications, ethics approval renewals and serious adverse event reports must be reported to the Athabasca University Research Ethics Board via the Research Portal.

To continue your proposed research beyond May 19, 2017, you must apply for renewal by completing and submitting an Ethics Renewal Request form. Failure to apply for **annual renewal** before the expiry date of the current certification of ethics approval may result in the discontinuation of the ethics approval and formal closure of the REB ethics file. Reactivation of the project will normally require a new Application for Ethical Approval and internal and external funding administrators in the Office of Research Services will be advised that ethical approval has expired and the REB file closed.

When your research is concluded, you must submit a Project Completion (Final) Report to close out REB approval monitoring efforts. Failure to submit the required final report may mean that a future application for ethical approval will not be reviewed by the Research Ethics Board until such time as the outstanding reporting has been submitted.

At any time, you can login to the Research Portal to monitor the workflow status of your application.

If you encounter any issues when working in the Research Portal, please contact the system administrator at research_portal@athabascau.ca.

Appendix H

Percentiles for Individual Scores Based on Lower Level Ratings (US)

Percentiles for Individual Scores Based on Lower Level Ratings (US)

	II(A)	II(B)	IM	IS	IC	CR	MBEA	MBEP	LF	EE	EFF	SAT	
N =	12,118	12,118	12,118	12,118	12,118	12,118	12,118	12,118	12,118	12,118	12,118	12,118	
%tile	MLQ Scores									Outcomes			%tile
5	1.25	1.25	1.50	1.50	1.00	1.29	.25	.00	.00	1.00	1.50	1.00	5
10	1.75	1.75	2.00	1.75	1.50	1.75	.50	.00	.00	1.33	2.00	2.00	10
20	2.25	2.21	2.25	2.25	2.00	2.25	.75	.25	.00	2.00	2.00	2.50	20
30	2.50	2.50	2.75	2.50	2.50	2.50	1.11	.50	.25	2.33	2.50	3.00	30
40	2.75	2.54	3.00	2.75	2.75	2.75	1.37	.75	.25	2.67	2.75	3.00	40
50	3.00	2.75	3.00	2.75	3.00	3.00	1.62	1.00	.50	3.00	3.00	3.50	50
60	3.25	3.00	3.25	3.00	3.17	3.13	1.87	1.00	.75	3.00	3.25	3.50	60
70	3.50	3.25	3.50	3.25	3.25	3.25	2.25	1.25	.93	3.33	3.50	3.67	70
80	3.75	3.46	3.75	3.50	3.50	3.50	2.50	1.70	1.25	3.67	3.52	4.00	80
90	4.00	3.75	4.00	3.75	3.75	3.75	3.00	2.00	1.75	4.00	4.00	4.00	90
95	4.00	3.75	4.00	4.00	4.00	4.00	3.25	2.50	2.00	4.00	4.00	4.00	95