APPLICATION OF HERSEY'S SITUATIONAL LEADERSHIP MODEL OF PROBLEM SOLVING AND DECISION MAKING FOR CRITICAL CARE NURSE MANAGERS

by

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has been approved

May 1996

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ACCEPTED:

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Associate Dean for Graduate Studies
DEDICATION

This thesis is dedicated to my parents, Joan and Pete, who made me believe that life is what you make of it and that one can accomplish anything they want with a little hard work. I would also like to thank my dear husband, John, for his unending love and encouragement in the completion of my Master’s program. Without his support, the road would have been much longer and lonelier. To my daughters, Angie and Carla, I thank you for your concern and understanding over the past year and not minding a few "late" dinners. Finally, I wish to thank my dear friend, Linda, for all her patience and assistance in furthering the completion of this thesis. Thank you for all the late night and very early morning support that you gave me during this process. Without your help, this thesis would never have been completed. You are the true meaning of a friend.
ABSTRACT

This descriptive research study was undertaken to determine if there was a common problem-solving and decision-making leadership style used by critical care nurse managers based in a health care setting in the Southwestern United States. An instrument designed by Drs. Hersey and Natemeyer was used to identify leadership styles used by the critical care nurse managers. The 12 item questionnaire determines leadership skills of problem-solving and decision-making. The questions posed were based on certain problem-solving and decision-making alternatives that the participant could elect to use in identifying ways to resolve work related problems. A specific style that was most commonly used by the participant was identified based on the four styles of problem-solving and decision-making developed by Hersey and Natemeyer. These four styles were broken down into quadrants. Quadrant 1(A) designated a High Task and Low Relationship style of problem-solving and decision-making. Quadrant 2 (B) designated a High Task and High Relationship style of problem-solving and decision-making. Quadrant 3 (C) designated a High Relationship and Low Task style of problem-solving and decision-making. Quadrant 4 (d) designated a Low Relationship and Low Task style of problem-solving and decision-making. The participants were placed in one of the styles based on their responses to the questions.

The most common style chosen by the critical care nurse managers was in Quadrant 3 (C). This identified the use of a Participative style of leadership where there is a high relationship and low task structure between the manager and subordinate. The second most common style chosen was Quadrant 2 (B). This
identified high task and high relationship structure between the manager and subordinate. The results of the two most common styles of problem-solving and decision identifies a collaborative style of management as both styles involve a high relationship structure. Training programs for health care managers could be developed that would focus on styles outside the normally used styles of problem solving and decision making to provide the managers with information on other leadership styles that could be used in problem solving and decision making.

The research literature reviewed in this study concentrated on problem solving and decision making information and theories. In addition, Situational Leadership and theories of management were also reviewed. The literature on Situational Leadership and different styles of leadership and problem solving focused on the difference of management styles used today than those used in previous decades. The recent trend in the management of personnel has focused on a participative style rather than an autocratic style of management. Management training that would assist in the development of nurse managers in problem solving and decision making is helpful in employee relations.
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CHAPTER ONE

THE PROBLEM

Introduction to the Study

There are many theories on leadership (Hersey and Blanchard, 1988; DePree, 1987; McAffee and Champagne, 1987). There are also many ideas on which traits make a good leader. Situational Leadership is a theory addressing managers' interactions with their subordinates.

The theory of Situational Leadership is that "the manager who is familiar with employees and the theory of Situational Leadership can effect gradual behavioral change that will make employees feel more empowered in their jobs and will benefit their organizations as well" (Hersey and Blanchard, 1988, 193).

Situational leadership addresses leadership traits of those managing or leading subordinates and the need to interact and provide direction based on the situation the subordinate and leader are facing. Hersey and Blanchard (1988) take a two dimensional approach to the theory of situational leadership and feel that when a leader is using this method he or she should address both the situation and the readiness of the followers and provide a clear direction for leadership.

This study examined the leadership behavior of critical care supervisors in a hospital based in a city in the Southwestern United States to identify problem solving and decision making leadership styles based on situations. The behavior styles were determined by a test given to the supervisors that was developed by Hersey and Natemeyer (1982) which determines problem solving and decision making based on a model that uses four styles of situational leadership.
Background of the Study

Managers' and leaders' behaviors can be described in various ways. Some managers could be labeled as "tough," while others could be labeled as "easy." There are many adjectives used to characterize the actions of managers when they are attempting to influence the behavior of others. However, it is not based as much on how the managers perceive themselves, but how they are perceived by others in their attempts to manage and influence (Hersey and Blanchard, 1988).

In management, the need for leadership of subordinates may determine the "efforts of people in the accomplishment of organizational goals" (Hersey and Blanchard, 1984, 21). Managers may need to adjust their leadership styles to account for subordinates' different levels of ability and willingness to complete different tasks.

The effectiveness of leaders and managers is determined by their ability to assist others in reaching their potential. "Leaders can delegate efficiency, but they must deal personally with effectiveness" (DePree, 1989, 16). The concepts of leadership and leadership practices are the subject of many discussions, writings, and teachings of many Human Resource and Educational services. It is important to find the most effective and productive way for managers to work with subordinates. Managers must determine their abilities to adapt to certain personal behaviors and knowledge bases of their subordinates as well as becoming familiar with their own methods of how they interact and manage based on a variety of situations (Hersey and Blanchard, 1984). Problem solving and decision making styles can be directly related to outcomes in personnel management. However, in any evaluation of problem solving styles for leaders, the readiness level of subordinates must also be assessed. Effective influencing
and understanding of subordinates can be developed by selectively knowing which style of leadership is most beneficial in each situation in which managers find themselves with their subordinates. There is no 'best' style of decision making or problem solving. If the style of the manager matches the "readiness" of others, it will be the appropriate style. The ability to be flexible and adaptive to the situation will ultimately affect the outcome. However, most managers have adapted to one style of leadership and are not aware of the need to manage according to the situation and the subordinate. Dealing with change, conflict, and the ability to promote each subordinate to reach his or her potential is a challenge for most managers (Hersey and Blanchard, 1984).

Leadership is an aspect of management that focuses on the interpersonal interactions between a leader and subordinates. The actions are usually directed toward the specific achievement of a goal. Achieving that goal can be directly related to the interpersonal communication and effectiveness of interactions between the employee and the manager (Depree, 1987).

**Purpose of the Study**

The purpose of this study was to apply Hersey and Natemeyer's (1982) problem solving and decision making model of situational leadership to health care managers based in a critical care setting of a hospital to determine if there is a common leadership behavior style that is utilized by health care managers. If a particular leadership style is found among these managers, educational offerings addressing specific situational leadership styles for health care managers can be developed which could enhance the effectiveness of their interactions with employees by addressing leadership styles that are outside their "normal" ways of directing and leading subordinates. This process could assist in the development
of a management or leader more versed in the use of leadership strategies to produce a more effective outcome for the employee as well as the organization.

**Statement of the problem**

Staff nurses at different stages of development need different leadership approaches (Reed, 1992). A model of supervision in which "the approach selected is matched to each individual's problem-solving skills should be highly effective in assisting nursing supervisors" (Reed, 1992, 64).

With the increasing autonomy of nursing practice, it would be a significant advantage to have nurses demonstrate flexibility, adaptability, and empathy in their work. Promoting growth of staff nurses to such a level of development should be a major goal of those responsible for supervising nurses. The ability to analyze problems and use a variety of strategies in problem solving with subordinates will assist supervisors in using specific models to match staff characteristics.

Nurse managers that are acting in positions of authority usually have limited training in leadership qualities and theories. Education for nursing administration has also not focused on the abilities of each nurse manager and identified areas of weakness and how to better promote interactions with subordinates for a more productive and focused outcome when addressing problem solving and decision making.

**Research Question**

This research answers the question: Is there a common problem solving and decision making leadership style for critical care nurse managers from a specific health care setting in a Southwestern city in the United States?
Theoretical basis of the study

A study of nurses, done in 1989 by Blankenship, Wilhoit, and Blankenship, found a statistical correlation between the head nurse's range of leadership style and the staff nurses' job satisfaction. The study determined that staff nurses most satisfied with their jobs worked with head nurses who had a wide range of leadership styles. On the other hand, the staff nurses least satisfied with their jobs worked with head nurses who had a limited range of leadership styles (Zurlinden et al., 1990).

Leadership style is defined as the consistent patterns of behavior which are exhibited by the manager and perceived by subordinates when attempting to influence the activities of people. These behaviors are developed over time and constitute what others learn to recognize as the leader's style or personality (Hersey et al., 1976).

According to the Situational Leadership model theory, managers should reduce task behavior (by allowing more autonomy and freedom of choice) and increase relationship behavior (by giving more emotional support and by acting as a facilitator rather than as a supervisor) as subordinates' levels of readiness increase. When a manager is addressing a specific task or problem with an employee, the solution and approach to the problem should be based on the situation, the ability of the employee, and the difficulty of the task (Hersey, 1984). How well are managers able to adapt their decision making and problem solving leadership styles to meet the needs of their subordinates and competently see the task to completion?

Situational Leadership is a management concept introduced by Hersey and Blanchard (1977) to help people, "whether they be managers, consultants, administrators, teachers, trainers or parents, be more effective in their everyday interactions with others" (Hersey et al. 1977, 2). Hersey and Blanchard (1988)
believe that managers can evaluate individual situations and their subordinates' level of "readiness" and, using the model, can select the appropriate leadership style. The readiness to solve problems or to make decisions depends on two major factors: the "ability" and "willingness" of the leaders (Hersey and Natermeyer, 1982).

The decision making and problem solving Style Inventory developed by Hersey and Natermeyer (1982) provides feedback to managers on how they behave in a problem solving or decision making situation. The extent to which the manager engages in "Directive" and "Supportive" behavior is their "style." Directive behavior is the extent to which a manager solves a problem, makes decisions, spells out the duties of others, and engages in telling them what to do, how to do, when to do it, where to do it, and who is to do it. Some substitute terms for directive behavior include task behavior, assertive behavior, and guidance. Supportive behavior is the extent to which a manager engages in two-way communication with others regarding the problem or decision and provides socioemotional support and facilitative behavior. Some substitute terms for supportive behavior include relationship behavior, discussion, and encouragement. (Hersey and Natermeyer, 1982).

A model was developed by Hersey and Natermeyer (1982) that identifies four types of situational leadership. The four types of situational leadership identify whether the leader is selling, telling, participating, or delegating when addressing his or her subordinates. Specific questions are asked of a participant and a common style of leadership is identified based on the answers to those questions. The results are relayed to a model that is designed to use the graphics of a bell-shaped curve that passes through four quadrants. One axis of the model represents task, (or directive) behavior, which is the degree to which the manager directs subordinates' behavior and tasks; and the other axis represents
relationship (or supportive) behavior, which is the degree to which the manager supports human factors such as morale, teamwork, and communication. The style of leadership should also be based on the maturity of the followers (or subordinates). Delegating style should be based on the ability and maturity of the subordinate to undertake the assigned task.

There are four styles of leadership that are evaluated in the Situational Leadership Model (as shown in Figure 1, Hersey and Blanchard, 1977).

S1 (high task/low relationship behavior);
S2 (high task/high relationship behavior);
S3 (high relationship/low task behavior); and
S4 (low relationship/low task behavior) (Handout, University Associates).

When a manager is using an appropriate style of decision making and problem solving, they will also be classified as either S1 - Authoritative (Telling), S2 - Consultative (Selling), S3 - Facilitative (Participative), or S4 - Delegative (Delegating).

In addition, there are four abbreviations that represent the four levels of follower readiness: R1 (low/immature readiness); R2 (low to moderate readiness); R3 (moderate to high readiness); and R4 (high/mature readiness). The problem solving and decision making Style Inventory also addresses an inappropriate match between the leader’s style and the follower’s readiness. If the style is inappropriate, the following addresses the resulting behavior:

S1 (Q1)- Coercing
S2 (Q2)- Manipulating
S3 (Q3)- Patronizing
S4 (Q4)- Avoiding (Handout, Center for Leadership Studies, 1982)
Figure 1
Hersey and Natemeyer’s Situational Leadership Model

STYLE OF LEADER

RELATIONSHIP BEHAVIOR

(TASK BEHAVIOR)

(MATURE OF FOLLOWER(S)

Source: Hersey et al. 1977, p.5

Although follower readiness is an important concept in Situational Leadership, it will not be examined in this study. Only the problem solving and decision making leadership styles of the managers will be determined.

The bell shaped curve that is found in the four quadrants of the model (see Figure 1) represents the leader’s adjustments in behavior as his or her subordinates develop higher readiness levels. The leader is either "telling, selling, participating, or delegating." The outcome of this study will determine if there is a particular problem solving and decision making style of leadership that is common among critical care managers based on Hersey and Natemeyer’s Situational Leadership model.
Significance of the study

Health care managers are usually promoted from the "ranks" of their peers and have usually had minimal experience in directing or leading others to achieve desired outcomes. They are chosen on their ability to complete their tasks and their ability to communicate with peers and upper administration. New health care managers may be using tools and experiences from past clinical practices to direct them in their style of leadership and management of subordinates.

Some health care settings may develop leadership training for those personnel in management positions. The effectiveness of training sessions in directing the managers to correctly and adequately work with their subordinates to produce the most effective outcome needs to be examined. Leadership education and training for health care managers from a critical care setting may not be focusing on the appropriate areas and topics to train them in directing their personnel.

If a common decision making and problem solving style of leadership is found in these managers (using Hersey’s and Natermeyer’s Style Inventory), an educational program developed specifically for managers working in this area could be developed that would address problem solving and decision making leadership styles that are not normally used, but might benefit both the employee and the manager in promoting a more structured and positive outcome of a given situation. This program could also benefit the productivity of both the employees and the managers since managers would be better informed on behavioral styles that would be best suited to address particular encounters with employees in promoting more positive interactions.
Operational Definition of terms

Critical Care Setting. Areas of a hospital that care for critical patients; to include both intensive care, coronary care, emergency room and neurological intensive care,

Decision Making. That part of the problem-solving process that entails evaluation of the alternative solutions and a choice among them of an effective remedial action (Bittel and Newstrom, 1990).

Leadership. Interpersonal influence exercised in a situation and directed, through the communication process, toward the attainment of a specific goal or goals (McAfee and Champagne, 1987, 303).

Manager. Supervisors directing the actions and evaluating the performance of clinical nurses in a critical care setting.

Management Process. Five functions that a manager provides an organization in directly addressing planning, organizing, staffing, directing or activation, and controlling (Bittel and Newstrom, 1990).

Problem solving. The process identifying "the gap that occurs between expected and actual conditions or results is analyzed systematically in order to find and remedy its cause" (Bittel and Newstrom, 1990, 129).

Assumptions and Limitations

It is assumed in this study that the nurse managers responding are answering honestly to the instrument used in this study.

This study may be limited in scope due to the sample size. The nurses completing the Situational leadership test are employees of a specific health care system in a city based in the Southwestern area of the United States. Their leadership styles may be limited to the type of managers specifically selected and trained by this health care group based on particular behaviors and attributes that
may not be common in the selection of managers in other health care settings
and hospitals. The study is further limited in its scope as only health care
managers in critical care settings were chosen to complete the test.

The researcher is also an employee of this health care system and has
contact with all respondents, which may influence some of the results of the
survey.

The scope of this study is limited as it only addresses the leadership
qualities of the managers and not the readiness of the followers. Outcomes of
actual effectiveness of problem solving and decision making leadership styles will
not be examined.

Organization of the Remainder of the study

Chapter two contains literature reviewed as it relates to leadership styles. It
also contains a more comprehensive look at Hersey’s Situational Leadership
Model and Hersey and Natermeyer’s Problem Solving and Decision Making Style
Inventory. Leadership among nursing managers and the use of situational
leadership in nursing is also examined.

Chapter three describes the research methodology used in this study. It
also addresses the source of data and the validity of the instrumentation. In
addition, it outlines the data collection and procedures used in the process.

Chapter four describes the findings of the study and contains a graph of
the results based on the four quadrants of situational leadership styles.

Chapter five includes an overview of the problem, the types of literature
reviewed, the methodology, and findings. Conclusions based on the results of
the findings are also included in this chapter. Recommendations for using the
results of the study and future research suggestions are also included in Chapter
five.
Appendix A is a letter to the subjects outlining the nature of the study.

Appendix B is a copy of the demographic questionnaire that was attached to Appendix A.

Appendix C is a copy of the Problem Solving and Decision Making Style Inventory Leadership test that was used in the study by the critical care nurse managers.

Appendix D is letters of request to Drs. Hersey and Natemeyer at the Center for Leadership Studies, Inc. and Mr. Barry Davis of HRD Press requesting permission to utilize the Problem Solving and Decision Making Style Inventory Test.
CHAPTER TWO
LITERATURE REVIEW

Introduction

The information on leadership is vast and encompasses a variety of topics. The literature used in this study that was specific to situational leadership addressed the variety of personnel types in the workforce. The literature addressing nursing leadership was limited, but provided some additional information to support the role of situational leadership in the health care environment. The research review is presented in five subgroups: leadership styles, situational leadership theories, problem solving and decision making styles, leadership styles in healthcare management, and situational leadership in health care.

Leadership Styles

Leaders ultimately are responsible for adapting their organization to change. They must build a sense of organizational direction in a way that builds confidence and increases employees’ commitment to the organization’s mission. Leaders serve a purpose and the people who have made it possible for them to lead. Leaders ask questions, keep promises, hold themselves accountable, and atone for their mistakes. Leadership styles range widely from a job, or task, centered orientation to a people, or relationship, centered one with many combinations in between. A style of leadership refers to the kind of approach a supervisor or manager uses in trying to direct, activate, stimulate, or otherwise provide a motivational atmosphere for employees (Daughtrey and Ricks, 1989).

Power is an essential component of leadership, involves a transaction
between leader and follower and is regarded as the wise use of power when transforming visions into reality (Bennis and Nanus, 1985). Bennis and Nanus (1985), outline four strategies for leadership and competency.

* Attention through vision;
* Meaning through communication;
* Trust through positioning; and
* The deployment of self

Without a leader’s vision, followers would have limited direction. A vision creates a focus or an agenda, outlines expectations, and states what is required of followers. Leaders must also be able to convince their followers that their visions are meaningful. An effective leader is skilled at communicating and meaning (Bennis and Nanus, 1985). Trust occurs because followers are able to predict the actions of their leaders. A leader needs to communicate integrity and to inspire follower commitment to the leader’s vision. Deployment of self involves self-improvement. Becoming an effective leader means addressing strengths and improving weaknesses. A person can have motivation without another person’s leadership. Leadership, however, “cannot succeed without motivation on the follower’s part” (Bittel and Newstrom, 1990, 269).

Leadership is an encounter that occurs with another person. It is an act that is high in labor content (Kouzes and Posner, 1993). Leadership is a relationship, one that is based on mutual needs and interests. The key to unlocking greater leadership is to understand relationships and build on credibility with employees. The credibility of leadership is what determines whether people will want to give a little more of their time, talent, energy, experience, intelligence, creativity, and support. There are many different definitions of leadership. One common definition is: “leadership is interpersonal influence exercised in a situation, and directed, through the communication process, toward the
attainment of a specific goal or goals" (McAfee and Champagne, 1987, 303). Leadership is a type of managerial activity that focuses on the interpersonal interactions between a leader and subordinates. Why are some leaders appointed, others elected, and others emerge? There are a number of possible explanations.

The traditional approach suggests that people become leaders as a result of two factors. The first is the accident of birth, as many people inherit leadership positions. The second factor is age or seniority; in some organizations people become leaders as a result of being the oldest person or having been with the organization the longest. In industrial settings, seniority often determines who gets promoted or placed into leadership positions (McAfee and Champagne, 1987).

The three basic approaches to leadership are: traits, behavioral, and contingency (Hellriegel et al., 1989). The Traits approach emphasizes the personal qualities of leaders and attributes success to certain abilities, skills, and personality characteristics. The Behavioral approach emphasizes leaders’ actions instead of their personal traits. This can involve the evaluation of structure, consideration, and how the leader operates. The Contingency approach emphasizes the importance of the situation, usually referred to as situational leadership. The three most prominent contingency theories would be the Fiedler, House, and Vroom and Jago models (Hellriegel et al., 1989). Fiedler focuses on the effective diagnosis of the situation in which the leader will operate. He emphasizes matching the correct leadership style to the situation. House suggests that leadership behavior is contingent on the characteristics of subordinates and the nature of the task. Vroom and Jago base their model on an analysis of how a leader’s style affects decision effectiveness and overall
effectiveness, and it suggests five leadership styles that managers can use in decision making.

During the 1800's, with the influx of immigrants from Europe, leaders were thought to be born and not made, largely because of their birth into noble or wealthy families. But that notion soon lost favor as researchers examined the traits of leaders. Social scientists had a problem agreeing on specific traits that were common to all leaders (Caroselli, 1990)

Theorists' views of what successful management is and should be has changed over the last one hundred years. In the 1900-1930s, scientific management theorists viewed the organization as a machine. Primary emphasis was on rapid and efficient production. Consistent rules and regulations led to a bureaucratic design of employee management. During the 1930s-1970s, the industrial revolution had resulted in great numbers of relatively unskilled workers performing very specialized tasks. The Hawthorn effect came into play at this time when a study was done to evaluate peoples' response to being studied and how it affected their motivation (Marquis and Huston, 1987).

Two motivational theories, Theory X and Theory Y, were also introduced by McGregor in 1960. Theory X is based on the traditional framework of management thinking that outlines the average human beings inherent dislike of work. Theory Y finds its roots in the assumption that the expenditure of physical and mental effort in work is as natural as play or rest (Bittel and Newstrom, 1990). Theory Y is being integrated more over the past decade than Theory X. McGregor, without making value judgments, simply stated that "in any given situation the manager's assumptions about people do affect motivation and productivity" (Marquis and Huston, 1987, 33). By the mid 1960s, a move was being made toward participative management and flexibility within the organization. However, by the late 1960s, there was some unrest about the
human relation approach to management in that it was time consuming and did not always result in organizational goals being met. Marquis and Huston (1987) note that until the late 1960s, leadership theory and management science developed separately.

Interest in specific techniques such as quality circles was part of a broader American fascination, starting in the late 1970s and early 1980s with Japanese management practices. This started the Theory Z of motivation. Hall and Goodale (1986) contrasted the following information on Theory Z (110):

<table>
<thead>
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<th>American</th>
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<tr>
<td>Lifetime employment</td>
<td>Short term employment</td>
</tr>
<tr>
<td>Slow evaluation and promotion</td>
<td>Rapid evaluation and promotion</td>
</tr>
<tr>
<td>Non-specialized career paths</td>
<td>Specialized career paths</td>
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<tr>
<td>Implicit control mechanisms</td>
<td>Explicit control mechanisms</td>
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<tr>
<td>Collective decision making</td>
<td>Individual decision making</td>
</tr>
<tr>
<td>Collective responsibility</td>
<td>Individual responsibility</td>
</tr>
<tr>
<td>Holistic concern for people</td>
<td>Segmented concern for people</td>
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There are two main models of motivational theory. They are: content theories and process theories.

The most widely recognized content theories of motivation are: Maslow’s needs hierarchy theory, Alderfer’s ERG theory, McClellan’s achievement motivation theory, and Herzberg’s two factor motivator hygiene theory (Hellriegel et al., 1989). These theorists attempt to explain the factors within a person that energize, direct, and stop behavior. Maslow’s theory identifies five levels of needs: physiological, security, affiliation, esteem, and self-actualization. Maslow’s hierarchy of needs motivational theory addresses the behavior of human beings based on their needs. The first of two principles of Maslow’s theory is that needs can be classified into five groups and arranged in a hierarchy;
when one need is satisfied, another need emerges to be satisfied. The most
basic needs are the physiological, or survival needs. The next is the need for
safety or security. Third, people need to interact with humans and have a sense
of belonging. The fourth level is the need for esteem. Finally, there is the need for
self actualization. The second principle of his theory is that since one’s needs
depend on what one already has, only unsatisfied needs can motivate human
behavior. Until the basic physiological needs are met, higher needs won’t
motivate behavior. However, several theorists argue that the theory does not take
into account the varying needs among cultures and individuals and that the
satisfaction of one need does not occur independently of other needs. One need
does not have to be completely satisfied before another need seeks satisfaction
(Daughtrey and Ricks, 1989). Maslow’s needs hierarchy has managerial
implications in that it specifically states the goals that people value and also
suggests the types of behavior that will fulfill various needs. He views unfilled
needs as motivators.

Alderfer’s ERG theory also suggests that individuals have a hierarchy of
needs, but instead of five categories of needs, Alderfer lists three needs and
identifies them as: existence needs, relatedness needs, and growth needs. He
feels that in addition to the unfilled needs as motivators, people also have a
frustration-regression process that motivates.

McClellan has proposed that there are three important needs that motivate.
They are needs for: achievement, affiliation, and power. His research has
focused mainly on ways that managers can develop subordinates’ desire to
achieve (Hellriegel et al. 1989).

Herzberg’s motivator-hygiene has two unique features. First, the theory
stresses that some job factors lead to satisfaction, whereas others can only
prevent dissatisfaction. Second, it states that job satisfaction and dissatisfaction
do not exist on a single continuum (Hellriegel et al., 1989). The first set of factors, motivational factors, address the work itself through recognition, advancement, and responsibility. These are usually referred to as extrinsic factors. The second set of factors, hygiene factors, includes company policies, administration, technical supervision, salary, working condition, and interpersonal relations. These are usually referred to as intrinsic motivators. Herzberg’s Two Factor theory identified two dimensions: dissatisfiers, which he called “hygiene, or maintenance, factors,” and satisfiers, or motivators. The needs areas identified were: physiological, safety, social, esteem, and self-actualization. In Herzberg’s view, certain conditions about a job itself tend to cause satisfaction when they are present and to serve as motivators. Their absence, however, does not prove highly dissatisfying. This theory could be useful to management when hiring and recruiting. They should examine the workplace, its administrative and supervisory practices, and its salary and benefits plans. In addition, the design of jobs and job content will be an important motivating factor to potential employees.

The four best known process theories of motivation are: expectancy theory, equity theory, reinforcement theory, and goal setting theory (Hellriegel et al., 1989). Process theories attempt to describe and analyze how personal factors interact and influence each other to produce certain kinds of behavior.

Many leaders operate with a preferred style of leadership. The most typical leader can be classified within three distinct types. The first type is autocratic or directive. These leaders exert a strong influence through sternness and discipline. While this is not always the “friendliest” method of leading, it can be quite effective. The second type is Laissez-faire. This style of leadership is essentially a leaderless style since the leader relinquishes his or her role of being in charge and allows subordinates to make their own decisions and solve their own problems as much as they can. The guidance of a firm leader is essential in this style as well
as a skilled group of employees. The third type of leadership style is Democratic or consultative. In this style group members are encouraged to contribute ideas and take pride in knowing that their ideas are valued. This style does promote camaraderie among employees, but may not work in every situation and can be the most difficult for a manager.

In selecting an appropriate style of leadership, a manager should have a keen sensitivity to the individuals and circumstances involved. A leadership approach can be selected from a continuum of styles that range from strictly autocratic to purely participative. The best choice of style is one that most nearly matches the personality of the individuals involved and the circumstances of the situation. The emotional maturity of the subordinate is also a factor to be considered. The more mature the individual, the more likely that the participative style will be appropriate. Leadership styles vary greatly. For managers to choose a leadership style, they must choose one that is most appropriate for them. In order to do that, one must examine three forces: (1) forces in the manager: what values, personalities and abilities does the person have that will influence leadership styles? (2) forces in the subordinate: the technical skill of the workers, how the workers feel about the manager, and the readiness of the employees will influence the leadership style (3) forces in the situation: this represents the organization itself and the leadership style of the organization. Organizations have values, traditions, and accepted practices. All these elements will contribute to the corporate forces that will influence the leadership style (Daughtrey and Ricks, 1989). Bernhard and Walsh (1985) note that the styles of leadership used by a leader is dependent on three forces. These forces determine the amount of control a leader used in relating to members of a group. "They are found (1) within the leader, (2) within the group members, and (3) within the situation" (Bernhard and Walsh, 1990, 55).
The main task of leadership is to energize followers to take actions that support higher corporate purposes and not their own self interests. Companies can lack the focus, energy, commitment, and creativity that come from appeals to deeper values (Badarocco and Ellsworth, 1989). Transactional leadership is leadership that is based on a fairly straightforward exchange between the leader and followers. If the subordinate performs well, and the leader rewards them, the leader uses a participatory style, and the subordinates come up with good ideas. This type of leadership is routine, in the sense that it is directed mainly towards bringing subordinate behavior in line with organizational goals. Transformational leadership has a more profound effect on subordinates as the leader instills a true commitment to a project, a department, or an organization by giving them a new vision. The leader decisively changes the beliefs and attitudes of followers to correspond to this new vision. Transformational leaders are usually good at aspects of clarifying paths to goals, and rewarding good performance. There are three qualities that set transformational leaders apart from their transactional colleagues:

* Intellectual stimulation
* Individualized consideration
* Charisma (Johns, 1992).

Research evidence suggests that such leaders are perceived as especially effective by subordinates in stimulating both satisfaction and effort (Hater and Bass, 1988).

James MacGregor Burns (1978) stresses the moral character of leadership. He distinguishes values driven leadership which he calls "transforming" and "transcending" leadership. Leaders exchange money, power, status, and "perks" for the actions they want their followers to take. Burns writes:
Leadership occurs when one or more persons engage with others in such a way that leaders and followers raise one another to higher levels of motivation and morality. Their purposes, which might have started out as separate but related...become fused. Power bases are linked not as counterweights but as mutual support for common purpose. Transforming leadership ultimately becomes moral in that it raises the level of human conduct and ethical aspirations of both leader and led, and thus it has a transforming effect on both.... Transcending leadership is dynamic leadership in the sense that the leaders throw themselves into a relationship with followers, who will feel "elevated" by it and often become more active themselves, thereby creating new cadres of leaders. (Burns, 1978, 4)

The art of leadership "requires us to think about the leader-as-steward in terms of relationships, of assets and legacy, of momentum and effectiveness, of civility and values" (DePree, 1987, 10). Effective influencing and understanding develop largely from good relationships among the members of the group.

Leadership occurs "when particular individuals exert influence upon others in an organizational context...Leadership involves status differences as well as role differences, and leaders are almost always granted higher status than those who serve as followers" (Johns, 1992, 334). Leadership involves interaction between leaders and followers, and both parties actually have the capability to influence each other. Some leadership styles that are effective might be the results, rather than the causes, of subordinate behavior.

Some people are leaders for the mere fact that they were in the right place at the right time. Other leaders possess characteristics that determine leadership ability. One researcher found that "no single trait was correlated with leadership in all cases. However, some traits were found to be highly correlated with leadership"(McAffee and Champagne, 1987, 304). "Five most frequently cited traits are:

1. Intelligence
2. Dominance
3. Self-confidence

4. Energy, activity

5. Task-relevant knowledge" (McAffee and Champagne, 1987, 304).

In addition, other traits and qualities are being addressed by contemporary leadership theorists. Some of those leadership qualities are:

- Develops teams
- Energizes
- Shares Knowledge
- Investigates
- Enlivens
- Organizes
- Is mature
- Is ethical
- Envisions
- Follows through
- Communicates
- Actualizes
- Is intelligent
- Welcomes change

"Is self confident" (Caroselli, 1990).

In addition to communicating vision to employees, good managers must also empower their employees. "Leaders must give up direct control of all decisions to gain true team control of the process" (Paulson, 1991, 124).

Empowering leaders also promotes training. By promoting life long learning and cross training a leader can build a team that is flexible enough to move forward. "If there is no learning, there is no empowerment" (Paulson, 1991, 126).

What is known about leadership is that it does not result merely from the individual traits of leaders: it also must involve attributes of transactions between those who lead and those who follow. "Leadership is not automatic, but it is a very important component of the organizational culture and appropriately identifies what occurs in successful organizations" (AORN, 1993, 9).

Closely related to the question of how much influence a leader has is the issue of power. Successful managers can influence others either by persuasion
or by power. If used properly, it can make things happen, coalesce people and purpose for the good of the organization. A leader who makes a positive difference will use four different types of power: sense of obligation, belief in expertise, identification, and perceived dependence. All of these are made apparent to others by the communication process (Carroselli, 1990).

Researchers have identified at least five sources of a leader’s influence (McAffee and Champagne, 1987, 308).

The five sources of power are:

- Reward Power
- Punitive Power
- Expert Power
- Referent Power
- Legitimate Power

Reward power refers to an individual’s ability to provide attractive rewards. However, reward power is not inherent in a supervisory role. It is only effective if the supervisor has the authority to influence such areas as wages, promotions, working conditions, etc. In addition, supervisors have little reward power if the subordinates do not desire the rewards being offered.

Punitive power relates to one’s ability to punish an individual for a shortcoming. Supervisors gain this type of power as they demonstrate their ability to use this type of power effectively. Once they are given greater authority, they can determine the amount and type of rewards and penalties they can give to subordinates.

Expert power originates from the knowledge, information, and ability a person possesses. Expert power is a source of influence that may or may not be available to a given manager. It is derived from employee perceptions and usually cannot be delegated to an individual by top management.
Referent power results from employees wanting their boss to like, identify, or respect them, and from subordinates' loyalty to their leader. It may be based on the subordinates' respect for their supervisor.

Legitimate power results from the belief that someone has a legitimate right to influence and direct behavior. Legitimate power derives from cultural values held by most persons that say that persons in positions of authority have certain rights. However, some organizations have given power to someone only to find that subordinates were unwilling to accept that person's authority as legitimate.

Studies have shown that effective leaders rely mainly on expert and referent power. In most cases, these have been found to be positively correlated with subordinate performance or satisfaction (McAfee and Champagne, 1987).

An impediment to effective leadership is not recognizing that the possession of power can pose a threat to the employees. "As a result, staff members are frequently more sensitive to the leaders' behavior than leaders are to the behaviors of staff members. When this occurs, leaders find that even their best intentions can be interpreted as malevolent" (AORN, 1993, 10).

Leaders "who understand and know how to use power are more effective than those who do not or will not. To successfully influence the behavior of others, the leader should understand the impact of power on the various leadership styles...Since power biases your leadership styles, using them appropriately can enhance your effectiveness as a situational leader" (Hersey, 1984,77).

**Situational Leadership Theories**

In situational leadership, leaders strive to match their leadership styles and approaches to specific situations and to the personalities of the staff. This contingency style maintains that leaders will be successful in a particular situation only if three factors are in balance. Bittel and Newstrom (1990) outline these three
factors as (1) the extent of rapport, (2) the nature of the job to be done, and (3) the amount of real power invested in the supervisor by his or her superiors. "The success of the leader depends less on technique than on the creation of enthusiastic attachment and deep-seated trust between the leader and members of the staff" (AORN, 1993, 9).

Research has found that a leader's behavior could be categorized as either task-oriented or employee-oriented (Hersey, 1984). Additional studies have attempted to determine whether one is better than the other. Fiedler (Hall and Goodale, 1986) has argued that both task-oriented and people-oriented leaders can be effective, but in different situations. Situational favorableness is determined by the leader's relationship with subordinates, the degree to which the task to be performed is structured, and by the amount of position power a leader possesses. Fiedler (Hall and Goodale, 1986) believes that leaders should adjust the situation to meet their own leadership style. Others disagree, and argue that a team style management is always the best. Others suggest that managers should clarify paths so that employees can achieve organizational and individual goals and summarize that no one approach to leadership is best, but that everything depends on the characteristics of the subordinate and the work environment (McAfee and Champagne, 1987).

Situational theories of leadership specifically refer to the setting in which influence of subordinates occurs. This setting includes the nature of the subordinates being led, the nature of the task they are performing, and characteristics of the organization. There are three leadership theories that consider situational variables that seem likely to influence leadership effectiveness. They are: Fiedler's contingency model, House's Path Goal Model, and the Vroom Jago model (Hellriegel et al., 1989).
Fiedler and his associates developed the first contingency model of the leadership process. His model is different from the traits and behavioral models of leadership by specifying that a group’s performance is contingent upon both the leader’s motivational system and the degree to which the leader controls and influences the situation. There are three contingency variables that can cause eight situations of group effectiveness. These variables are group atmosphere, task structure, and leader’s position power.

Fiedler developed the least preferred co-worker (LPC) scale (see Figure 2) to measure leadership style. Individuals are asked to first think about all the people whom with they have worked and then to identify the individual with whom they have least worked well. Low LPC leaders describe their least preferred co-worker in negative terms and are classified as task-oriented. High LPC leaders give a more positive description of their least preferred co-worker, are sensitive to others, and are classified as relationship-oriented.

![Figure 2: Fiedler's LPC Scale](image)

Source: Hellriegel et al., 1989, 279
However, some critics have questioned the use of LPC, arguing that better measures of leader behaviors are needed. They say that the model does not take into account the fact that leaders can influence both the task structure and group atmosphere because of their knowledge of the situation. They argue that the task can be modified by the leader and therefore is not a dependent variable in the model. Thus, the leader of a group that engages in a highly unstructured task can use his or her style to give the task some structure.

There are several managerial implications for this model. Both relationship motivated and task motivated leaders perform well in certain situations but not in others. Outstanding managers at one level who get promoted to another level may fail at the higher level because their style does not match the demands of the situation. Also, leaders cannot be described as always good or always poor; instead they perform well in some situations but not in others. In addition, leaders’ performance depends both on their motivational bases and the situation. Therefore, an organization can affect leadership by changing the reward system for the manager or by modifying the situation itself. The leaders themselves can also do something about their situations. Leaders can be taught how to become better leaders by utilizing a programmed learning text that instructs the leader how to match his or her LPC level with the situation (Hellriegel et al., 1989).

House’s path-goal model of leadership (Hellriegel et al., 1989) is based on the expectancy theory of motivation and suggests that in order to be effective a leader must select a style most appropriate to the particular situation.

This model (see Figure 3) essentially states that a leader should try to enhance subordinates satisfaction with their jobs and increase their performance level. It identifies the ability of the leader to make job satisfaction easier to obtain and increase subordinates’ satisfaction by clarifying the nature of the task, reducing impediments to successful task completion, and increasing the
opportunities for subordinates to obtain job satisfaction. The path-goal theory asserts that a leader’s behavior will be viewed as acceptable to subordinates if is seen as either an immediate source of satisfaction or is instrumental to future rewards (McAfee and Champagne, 1987). The model identifies four distinct types of leadership behavior: supportive leadership, directive leadership, participative leadership, and achievement oriented leadership. In contrast to Fiedler, who believes that it is easier for leaders to change the situation than to change leadership styles, House believes that the same leader can practice these four styles at varying times and in different situations.

Figure 3 The Path-Goal Leadership Model

Source: McAfee and Champagne, 1987, 319

The Vroom-Jago leadership model focuses on the role played by leaders in making decisions. It indicates that various degrees of participative decision making is appropriate in different situations. It explains worker motivation as a
matter of choices (Daughtrey and Ricks, 1989). In contrast to Fiedler’s model, this one assumes that a leader can change his or her style and that the leader must be flexible enough to change styles. It is also assumed that the leader can choose a leadership style along a continuum ranging from highly autocratic to high participative.

Figure 4 The Vroom-Jago Decision Tree

<table>
<thead>
<tr>
<th>QR</th>
<th>Quality requirement:</th>
<th>How important is the technical quality of this decision?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR</td>
<td>Commitment requirement:</td>
<td>How important is subordinate commitment to the decision?</td>
</tr>
<tr>
<td>LI</td>
<td>Leader's information:</td>
<td>Do you have sufficient information to make a high quality decision?</td>
</tr>
<tr>
<td>ST</td>
<td>Problem structure:</td>
<td>Is the problem well structured?</td>
</tr>
<tr>
<td>CP</td>
<td>Commitment probability:</td>
<td>If you were to make the decision by yourself, is it reasonably certain that your subordinate(s) would be committed to the decision?</td>
</tr>
<tr>
<td>GC</td>
<td>Goal congruence:</td>
<td>Do subordinates share the organizational goals to be attained in solving this problem?</td>
</tr>
<tr>
<td>CO</td>
<td>Subordinate conflict:</td>
<td>Is conflict among subordinates over preferred solutions likely?</td>
</tr>
<tr>
<td>SI</td>
<td>Subordinate information:</td>
<td>Do subordinates have sufficient information to make a high quality decision?</td>
</tr>
</tbody>
</table>

Source: Hellriegel et al., 1989, 259
This model uses four criteria by which a leader's decisions making behavior can be evaluated: decision quality, subordinate commitment, time, and subordinate development. A decision tree (see Figure 4) provides solutions combining leader styles and problem attributes through a series of complex equations.

The validity of this model is still being challenged and evaluated. If it is proven to be a valid tool, it will further encourage the training of future managers in diagnosing situations correctly and selecting the best leadership style for those situations. This should allow for timely and effective decisions.

Based on an analysis of Fiedler's theory, and on the consideration and initiating structure theories, another way of looking at leadership has been proposed by Hersey and Blanchard. A tridimensional leadership effectiveness model emerged that stated no one leadership behavior or style is effective in every situation. Situational favorableness determines the effectiveness of leader behavior. The situation is most favorable for leadership when leader-member relations are good, the task is structured, and the leader has strong position power (Johns, 1992). The forces within the leader, the group members, and the situation all affect the decision on which leadership style a leader should use (Bernhardt and Walsh, 1990).

Hersey's situational leadership model utilizes the theories to specifically outline the factors that should be considered in utilization of the situational theories. Like Fiedler's model, Hersey's model examines the subordinate in the situation. Situational leadership is based on "an interplay among (1) the amount of task behavior a leader provides; (2) the amount of relationship behavior a leader provides; and (3) the readiness level that followers demonstrate in performing a specific task or activity" (Hersey, 1984, 57-58).
Hersey identifies the ability of managers to use both task behavior and relationship behavior to influence their people. These two individual behaviors are separate and distinct. It is also important for leaders to have a high concern for both end results and people. In order to capitalize on this concern, a variety of leadership styles are needed to adapt to the different situations or problems a leader faces. The leadership styles are correlated with a continuum of follower readiness. In information provided by Hersey (1984), he did not feel that a single continuum, like a autocratic or democratic continuum, portrayed different leader behaviors and therefore a more usable framework was necessary.

First, task behavior and relationship behavior were placed in separate dimensions of a two dimensional graph. Second, four quadrants were constructed on the graph to identify four basic leadership styles. The four quadrants were divided into areas that outlined the descriptors for each of the leadership styles (see Figure 5). They are:

- S1 - Telling
- S2 - Selling
- S3 - Participating
- S4 - Delegating (Hersey, 1984).

The readiness of the followers is also identified as a distinctive feature in determining task completion.

Readiness is defined as how a person performs a particular task. A low readiness level (R1) means that a worker is both unable and unwilling to perform a particular task. This would call for a high-task and low relationship style (S1), which would be the "telling" style. Most workers in this area do not have the skills and have no desire to learn the task and need closer supervision with firmer controls. Highly competent workers who are also willing to take responsibility for
their tasks (R4) might prefer the freedom to work on their own. This combination of skill and willingness greatly reduces their need for direction and support (S4).

Figure 5  Hersey’s Situational Leadership Model

Source: Daughtrey and Ricks, 1989, 332

To measure leadership style, Hersey and Blanchard have developed an instrument called Leader Effectiveness and Adaptability Description or LEAD. It is available in two forms -- The LEAD-self and the LEAD other. These tools "measure style, style range, or flexibility, and style adaptability or effectiveness" (Bernhard and Walsh, 1990, 69).
Although situational leadership can be a useful tool in leadership and management, there are theorists who are not supportive of this style. Some of the concerns address the problem that "most managers simply aren’t very good at switching styles" (Baddarocco and Ellsworth, 1989, 6). Most people are creatures of habit, and the ability to switch styles can be limited for many managers. If a manager works with subordinates on solving problems, they will come to know the manager well. Most people will have a difficult time masking their true beliefs and feelings when addressing others in a difficult or vexing personnel issue. This transparency will make situational leadership even that much more difficult. Managers who readily adapt their styles in ways that are inconsistent with their personalities risk being perceived as inconsistent, and possibly insincere, hypocritical, and manipulative. Inconsistency may lead to erroneous perceptions and expectations by followers as it may be less clear what the leader stands for and wants. This could potentially erase critical values of trust, loyalty, and fairness (Badaracco and Ellsworth, 1989). Situational leadership balances a style of management with trust and the readiness of followers to adapt to certain management styles.

**Problem Solving and Decision Making Styles**

Problems in organizations can occur because of change. The situation becomes a problem when gaps are revealed because there are differences between expected outcomes and actual outcomes. Problems in organizations demand a solution if the organization is to function productively. Problems have a variety of characteristics. Pokras (1995) identified some of these characteristics that could lead to problems as: incomplete communication, unknown information, inaccurate information, confusion, hidden emotions, different viewpoints, changing impressions, balanced dilemma, and persistency of the situation. In the approach to solving these problems, a decision is needed to propel the
organization forward. There are various ways of identifying problems as well as ways of making decisions on how to react to the problem. They are as varied as the situation and in the personnel involved. However, there are several theories that specifically address how to identify problems and decision making processes that can be used in the resolution of these problems.

A problem will exist when there is a gap in expected outcome and in what really happens. Problems should be approached systematically, with the ultimate goal of removing their cause. There is a deep connection between problem solving and decision making. A decision is always needed in the choice of the problem's solution. "In many ways, problem solving is decision making" (Bittel and Newstrom, 1990, 114). A manager should be alert to potential problems.

Problem solving should follow a systematic approach by first starting to identify the problem. Information should be collected that is relevant to the problem including possible causes. The most likely causes should be reviewed. Solutions for removing the causes should be examined and the pros and cons of each identified. The best solution should be identified and a plan of action developed that addresses the problem and outlines needed resources to address a positive outcome. Daugherty and Ricks (1989) identified key factors identified by several theorists in decision making. They are: 1) be aware of the problem, 2) state the problem, 3) develop alternatives, 4) evaluate alternatives, 5) choose and implement decision, and 5) evaluate the decision.

"A decision is a choice. Decision making is the process of choosing between two or more alternatives" (Daughtrey and Ricks, 1989, 89). Most management decisions are concerned with resources and processes, including people, plant, equipment, strategies, production schedules, work processes, maintenance, and compensation.
There are three common models used to describe decision making. They are the rational, bounded rationality, and political models (Hellriegel et al., 1989). Each of these models addresses the decision making situations and processes experienced by managers. All three models are used to cover the complexity and range of these situations.

The rational model holds that "the outcomes of decision making are alternatives that have been intentionally chosen to bring maximum benefit(s) to the organization" (Hellriegel et al., 1989, 390).

The bounded rationality model suggests that decision makers desire to be rational but suffer from cognitive limitations, habits, and biases.

The political model states that the organizational decisions reflect the desires of individuals to satisfy their own interests and that the decision is a function of the distribution of power in the organization.

In the decision making process, there are several steps that assist in making the final decision. A manager should first be aware of a problem in order to solve it. Before the problem can be solved, it must be identified and clearly stated. Alternatives should be examined and evaluated. An alternative should be chosen and implemented. It is then the responsibility of management to evaluate the decision and compare the expected outcome with the actual results.

Managerial decision making is a complex process that begins with a recognition or awareness of problems and concludes with an assessment of the results and which actions resulted in the resolution of the problem. A good decision will take into account the fact that there is more that one way of doing things. Managerial decision making is characterized as unending flows and crosscurrents of decisions. Intuition and creativity are likely to be important in addressing the most difficult of decisions. Decision making, unlike problem solving, does not have to be systematic. A management decision can be based
on mathematical decision making, which involves a mathematical, statistical, or quantitative approach to aid the decision maker. A decision tree can be used that identifies alternate solutions and possibilities. Another method of decision making involves cost benefit analysis that adds all the costs of implementation and equates them with the value of services that can be provided to the community. Not all decisions are based on logic. Some management decisions are based on hunch. Many authorities believe that the best decisions come from an approach that uses a combination of logic and hunch (Bittel and Newstrom, 1990).

A variety of factors can affect and influence decisions. Authority to make decisions is delegated to different levels of management. Boundaries of decision making with the organization will affect actual decisions made by managers. Company policies and procedures will also affect the outcome of decision. The process for making a decision will also be affected by the time available. Managers frequently experience ethical dilemmas when making decisions. They are part of the day to day life of managers. Many ethical issues involve factors that make the choice of right or wrong less clear. Managers should keep in mind: who their decision is affecting, what the costs and benefits are, who has rights, and what the decision rules are (Hellriegel et al, 1989).

Decision making can be divided into two approaches that involve only one person making a decision or a group decision making process. The group process could be identified as the Vroom-Jago Model of decision making (see Figure 5). Pokras (1995) has identified eight tools that are usually used in a team approach for facilitating a decision. They are: 1) Informal discussion, 2) Brainstorming, 3) Elimination, 4) Weighing against goals, 5) weighing against consequences, 6) prioritizing, 7) combination, and 8) criteria matrix.

A manager’s ability and readiness to intervene is an essential condition when granting autonomy to subordinates in decision making. This also could
open the door to errors. Managers must know when their subordinates are in situations in which the risk of a serious mistake or error is high. They need not act in each of these situations, but they must know when these situations occur so that they can decide whether or not to act (Badaracco and Ellsworth, 1989).

Effective problem solving depends upon the quantity and quality of information upon which analysis and judgments are made.

**Leadership Styles in Health Care Management**

According to Douglas and Bevis (1979), there are many health care organizations (or components of these organizations) managed by nurses in which they do not have preparation in management. They suggest that this could hamper the delivery of health care services in keeping pace with clinical advances.

Nursing process is the strategy most often employed by nurse-leaders to set and attain goals. Additional strategies exist that will enable nurse-leaders to move a group toward goal setting and goal attainment. These strategies...are organizing, teaching-learning, decision making, changing, managing conflict, and evaluation. These strategies are useful processes that may enhance the nurse-leader’s effectiveness as leader. In fact, since they indicate behaviors that can be used to move a group toward goal attainment, the strategies themselves are part of a theory of nursing leadership. (Bernhard and Walsh, 1990, 82)

Health care organizations share a common goal to promote, maintain, and restore the health of clients. Leadership within these organizations will greatly influence the direction and acceptance of personnel intimately involved in the daily operation. Choosing a leadership style that promotes and develops the mission of the organization, while continuing to provide direction to personnel, should be foremost in the minds of those in management.
In order to effectively motivate employees to the mission of the organization, "nurse managers must consider not only their own managerial style, but also the staff members' personal characteristics, competence, level of functioning, and the particulars of the situation" (Simendinger et al., 1990, 136). The leader serves the crucial role of seeing that the right work gets done at the right time, that it flows well, and that the proper pace, coordination and desired impact is reached.

Most nurses are female, and role conflicts are common. A woman must maintain heavy responsibilities. For many, the frustration over role contradictions and the atmosphere often present in an autocratic system are too much to endure. Many potential nursing leaders leave the field because of some of these problems and barriers. The problem of role conflicts in an autocratic system can be reduced by a greater emphasis on leadership in nursing education and service (Tomey, 1988).

Tomey (1988) recognizes that nursing is not particularly recognized for the leaders it produces. She suggests that leadership is a quality often lacking in the nursing profession. The reasons she states are:

Nursing seems to attract people who rank lower in self-esteem and initiative and higher in submissiveness and need for structure than people in other occupations. Schools of nursing have placed little emphasis on teaching leadership, and what education has been offered has often been taught in an apprenticeship manner. Moreover, the autocratic leadership style, so prevalent in nursing, does not foster leadership in others. Instead, it contributes to the belief that nurses are paid to follow orders rather than to think. (Tomey, 1988, 182)

As a role model, the nursing leader can reduce the autocratic atmosphere and some of the role conflicts.

The education of nurses has traditionally emphasized the study of knowledge and skills of patient care and assumed that the graduate could
function in management and leadership roles with minimal preparation. This preparation is generally expected to be provided by the employer, who probably anticipated that the graduate would be able to function in a leadership capacity from the first day of employment with some orientation and routine familiarity. "Nurses are promoted through the bureaucratic hierarchy to lower, middle, and higher management positions on the basis of nursing care skills rather than administration and managerial knowledge and ability" (Douglass and Bevis, 1979, vii). Schools and agencies that teach nursing management and leadership principles for utilization in nursing practice will produce a more flexible and skilled nurse.

The term nurse manager is applicable to every level of nursing, whether as a staff nurse, head nurse, supervisor, or administrator, and varies from direct care of clients to responsibility for those persons providing direct care. Staff nurses often function in lower managerial positions. Douglas and Bevis (1979) suggest that the most effective managers are those who can use the scientific, technical, and behavioral models to the best advantage for client, worker, and organization.

Simendinger et al. (1990) noted the importance of visionary nurse leaders in the hospital setting. Nursing leaders will need to be enthusiastic and dynamic in their collaborative efforts with other health care providers to provide for the mission of their organization.

Shaping a future for employees involves creating a vision of the future and then molding the culture to achieve that vision. "Leadership is a crucial component in moving nursing from powerlessness to empowerment. Nursing leaders direct the present and shape the future. Directing the present requires that the leader knows and understands the culture of the organization as it exists now" (AORN, 1993, 10).
Situational Leadership in Health Care

Zurlinden et al. (1990) believe that "...many nurses leave their positions because of poor management...front-line managers, head nurses play an important part in retention...In short they're in a position to make their nurses feel like valued human beings... and nurse managers can help retain nurses by using situational leadership" (Zurlinden et al. 1990, 47).

Selecting a leadership style is a two way process. "The behavior of the employees influence the leadership style of the manager, and the style selected by the manager influences employee behavior. Before a leader selects a style, individual characteristics and behavioral patterns of the employee must be considered" (AORN, 1993, 51).

Situational leadership can show a manager how to deal with people and situations effectively and flexibly. All employees, even nurses, come to work with unique skills, experience, education, and a desire to do a good job. Using Situational Leadership, a nurse manager can assess each nurse's needs and predict which leadership behaviors will help that nurse get the job done with maximum performance and respect. It can also assist in predicting which leadership behaviors will help turn around a nurse who performs below the manager's expectations.

Given the increasing autonomy of nursing practice, it would be a significant advantage to have managers who demonstrate flexibility, adaptability and empathy in their work. In 1992, Reed noted that the promotion towards this growth of staff nurse to such a level of development should be a major goal of those with the duty of supervising those type of nurses. Nurses are at different stages of development in their professional role, and each one should be dealt with in a manner that is specific to their needs and requirements based on the situation. "...While it is useful for you to have insight about your leadership style, it
is even more important that you know how consistent this perception is with how your behavior is perceived by others" (Hersey et al., 1976, 40).

"Theories of situational leadership discuss the impact that the manager’s leadership style has on employee behavior. The leader behavior influences employee behaviors of:
* motivation,
* production,
* satisfaction,
* turnover, and
* absenteeism" (AORN, 1993, 51).

In 1987, Teasley suggested that Situational leadership "promotes with better quality patient care, the professional development of one’s staff -- and the leader’s competence" (Teasley, 1987, 113). Regular review for managers on their behavior in terms of the situation can help strengthen their answers of judgment and flexibility responses.

Leadership requires the ability of a nurse manager to develop rapport with the staff and to apply appropriate persuasion and influence to obtain willing cooperation in pursuing organizational goals. In situational leadership leaders strive to match their leadership styles and approaches to specific situations and to the personalities of the staff. "The success of the leader depends less on technique than on the creation of enthusiastic attachment and deep-seated trust between the leader and members of the staff" (AORN, 1993, 9).

If a nurse leader chooses to use a tridimensional leadership effectiveness model (as outlined in Hersey’s model), he/she must "first analyze the readiness of her client. Readiness in this model refers to the willingness to engage in the task, and the client’s ability to do so successfully. The degree of readiness exhibited by
the client determines the behavior of the nurse-leader" (Bernhard and Walsh, 1990, 81).

There is no one best style of leadership for all people in all situations. In 1990 Simendinger et al. noted the importance that a leader should place in knowing or learning how to assess both the people and the situation that they are supervising. It is important to identify the need to balance both the task and the socioemotional needs of the staff.

Many managers in health care are experiencing pressures, constraints, and challenges in the delivery of quality health care.

Instead of existing from crisis to crisis, managers can take action, achieve results, and increase collaboration among staff to achieve unit and organizational goals. Middle managers in health care settings are confronted daily with constant change, cost containment, need to increase productivity, new technology, and staff turnover. Staff members are confronting the same issues as managers, and may be increasingly concerned with issues of job satisfaction, job security, and low morale. Concerns of managers and staff are often shared, although not always in ways that can promote effective cooperative functioning. Managers can act in flexible ways to build employee participation, commitment, and action for results. (Keenan et al, 1990, 19)

**Summary**

In summary, nursing leaders and managers can be effective by systematically considering the expertise, confidence, and willingness of each staff member and also by appropriately noting and addressing the needs of the particular facts of a given situation. There are many theories on leadership used by individuals and companies in approaching personnel management. Situational leadership is the process of identifying the strengths and weaknesses of both the manager and the subordinate before deciding on the approach needed to resolve an issue.
Problem solving and decision making are not unique to the nursing environment. Managers in all aspects of business and human relations frequently address the need to individually make a decision or seek the assistance of their subordinates in resolving problems. In addressing each specific situation, the manager must understand his or her capacity for problem solving, and identify the readiness of his or her followers to assist in the problem solving or to accept the decision of the leader.
CHAPTER 3
METHODODOLOGY

Introduction

The purpose of the study was to apply Hersey and Natemeyer’s (1989) Problem Solving and Decision Making Style Inventory model to determine if there is a common problem solving and decision making leadership style that is common to health care managers.

Identification of Research Methodology

The method chosen for this research study was the descriptive method.

Descriptive research utilizes various forms of survey, cross-sectional, longitudinal, and cross-sequential approaches to gathering data. The strength of the descriptive research design is in the exploratory capability it provides. This feature has resulted in significant contributions to developing fields, such as the educational and training of adults. (Merriam and Simpson 1995, 72)

An advantage to using the questionnaire (test) chosen by the researcher, was "the opportunity for ... validation of questions in advance of conducting the study" (Merriam and Simpson 1995, 71). The test used was developed and utilized by Hersey and Natemeyer (1989) to determine problem solving and decision making styles.
Description of the Methodology

In order to determine if there is a common problem solving and decision making leadership style among the participants, the researcher used Hersey and Natemeyer's (1989) problem solving and decision making style inventory. The inventory (see Appendix C) consists of 12 situational statements to which the user must choose a response from among four answers with various alternative actions that could be taken based on the individual situations. The test is designed to measure self perception based on four styles: 1) Authoritative (telling), 2) Consultative (selling), 3) Facilitative (participating), or 4) Delegative (delegating) (Hersey and Natemeyer, 1982). Answers are plotted on a graph that delineates directive or supportive behavior. "(Directive) Task behavior is plotted from low to high on the horizontal axis. (Supportive) Relationship behavior is plotted from low to high on the vertical axis. This makes it possible to describe leader behavior in four ways" (Hersey 1984, 35). The leadership styles are divided into quadrants representing the "four styles of leadership: telling, selling, participating, and delegating" (Zurlinden et al. 1990, 49) The highest score would outline the primary style of decision making and problem solving used most comfortably by that particular manager.

The model that is utilized (see Figure 1) combines follower readiness with leader behavior to determine leadership based on problem solving and decision making styles.

The participants in the study completed the test that Hersey and Natemeyer use in their inventory questionnaire and the results were reviewed to determine if there was a common leadership style among the group tested.
Sample and Population

The sample selected for this study was comprised of 34 health care nurse managers in critical care units from a specific health care group in a city based in the Southwestern portion of the United States. Participants were identified based on their work environment being in either an Emergency Room, Coronary Care Unit (CCU), a Surgical Care Intensive Care Unit (SCICU), a Pediatric or Neonatal Intensive Care Unit, or an Adult Intensive Care Unit (ICU).

These participants are faced with similar patient care issues and therefore the study was limited to managers working only in these areas of a hospital.

Participation was voluntary and could have been terminated at any time prior to, during, or after the testing process. Confidentiality was maintained in that all information that was received was reported throughout as group data only.

Participants were informed that return of the completed test constituted consent to participate in the study (Appendix A). Permission for obtaining access to these managers was secured through Human Resources at the parent health care system center. A letter of informed consent identified each of these points for the participants and also outlined the anonymous structure of the process. A demographic survey identifying characteristics of each of the participants was included with the test given to the participants (Appendix B). A letter of consent was sent to Dr. Hersey at the Center for Leadership Studies and to Mr. Davis at HRD to obtain copies of the test (Appendix D).

Instrumentation

The instrument used in this study was the Problem Solving and Decision Making Style Inventory based on Hersey’s Situational Leadership Model (Figure 1). The 12 item questionnaire (Appendix C) was designed to determine the leadership skills of problem solving and decision making for the critical managers used in the test sample. The questions asked were statements based on certain
problem solving and decision making leadership situations. The participant had
to choose among 2 (two) answers that outlined various alternative actions that
could be taken to each stated situation. The participant had to decide which of
the statements in each pair most reflects the way they would approach problems
and make decision. A total of three (3) points were allocated between the two
alternative statements in each pair. Points were to be allocated on their
judgement of how well each statement described how they tended to behave in
that type of situation. The most points were to be assigned to the statement in the
pair that was more characteristic of their problem solving and decision making
style. The numbers assigned to each pair had to total three (3). There were four
different types of statements that were classified as either A, B, C, or D. Their
were a total of six statements from each category. After completion of the test,
the results were compiled by the author and the points assigned to each of the
four areas (A through D) were totaled. Totaled scores assigned were plotted on
a form identifying quadrants based on totals for each area (A through D). The
total points for each area (A through D) was placed in the appropriate quadrant.
The four quadrants were as follows:

Quadrant 1 (One) designated a High Task and Low Relationship style of
problem solving and decision making.

Quadrant 2 (Two) designated a High Task and High Relationship style of
problem solving and decision making.

Quadrant 3 (Three) designated a High Relationship and Low Task style of
problem solving and decision making.

Quadrant 4 (Four) designated a Low Relationship and Low Task style
problem solving and decision making (Hersey and Blanchard, 1988).

The quadrants listed were all placed in a cubicle. Quadrant 1 was the total
from the "A" category and was placed in the lower (R) right hand corner;
Quadrant 2 was the total of the "B" category and was placed in the upper (R) right hand corner; Quadrant 3 was the total of the "C" category and was placed in the upper (L) left hand corner; and Quadrant 4 was the "D" category and was placed in the lower (L) left hand corner. The horizontal axis of the cubicle determined either low (D and C) or high (A and B) directive, or task behavior, and the vertical axis determined either low (D and A) or high (C and B) supportive, or relationship behavior. A bell shaped curve normally outlines the styles of leadership for each quadrant. Quadrant 1 is also called S1 and is more of a "Telling" type of leadership style. Quadrant 2 is also called S2 and is a "Selling" type of leadership style. Quadrant 3 is also called S3 and is a "Participative" type of leadership style. Quadrant 4 is also called S4 and is a "Delegating" type of leadership style.

The highest score represents the primary style used in decision making and problem solving by the participant. Other styles that have a score of 6 or more are considered a secondary style. Although the participant may not be as comfortable with these styles as with their primary style, they will use these styles to a moderate extent. The Inventory also identifies a style range for both the participant's primary and secondary styles. These areas represent a leader made decision, a collaborative decision, or a follower made style of decision making. The Style Inventory provides feedback on how each participant would behave in a problem solving or decision making situation. The extent to which they engage in "Directive" or "Supportive" behavior is their "style" (Hersey and Natemeyer, 1982).

The behavior style is also broken down into inappropriate and appropriate quadrants. In the appropriate model of behavior style, quadrant A is telling, quadrant B is selling, quadrant C is participating, and quadrant D is delegating. In the inappropriate model of behavior style, quadrant A is coercing, quadrant B is manipulating, quadrant C is patronizing, and quadrant D is avoiding. The appropriate style depends on the a match between the leader's style and the
followers readiness. Follower readiness can also be plotted on the horizontal axis and identified as able to make the decisions (left) to unable to make the decision (right). However, this test does not measure that process.

The validity of the study could have faced an internal threat of biased selection of the subjects. The subjects all worked in the same parent corporation as the author and were selected with the assistance of the director of each unit.

A bias on selection of candidates could have resulted as the directors were consulted on participants from their critical care areas.

**Data Collection Procedures**

Data was collected by means of the self-administered Hersey and Natemeyer's Problem Solving and Decision Making Style Inventory instrument. Each participant received a letter of agreement of participation (see Appendix A), a demographic survey (see Appendix B), and the inventory instrument (Appendix C) for collection of the data. The inventory instrument contained instructions, and the testing sheet. Both the demographic sheets and the tests were identified with an identical number that was placed in the upper right hand corner. These numbers correlated with a number assigned to each participant. This ensured the ability of the author to track whether the participants had returned the survey. The tests and the demographic sheets were also stamped "Return" so the participants could identify which papers to return to the author. The participants were instructed to mail the results of the survey to the author by a certain date. A self addressed, interoffice envelope was included with the test for each of return. Test numbers were identified and a follow up phone call was done for each participant who had not returned the test by a specific date.

The responses were individually plotted on the Problem Solving and Decision Making Model inventory (see Figure 1) and a total for each basic style of
decision making and problem solving was determined by the totals of each quadrant. The results of individual inventory’s completed by each participant was confidentially returned with a thank you letter and an explanation of their profile analysis for determining decision making and problem solving.

The researcher made direct contact with each participant to establish the researcher’s responsibility, appreciation, and sincerity.

The evaluator then noted the total number of participants’ "primary scores" based in each quadrants and identified any patterns or variances.

This information was forwarded to the Director of Human Resources Development and Leadership of the particular organization in which this survey was conducted.
CHAPTER FOUR

PRESENTATION AND ANALYSIS OF THE DATA

Introduction

Critical care nurse managers and directors (n = 34) from a specific health care system in the Southwestern United States were sent Hersey and Natemeyer's Problem Solving and Decision Making style inventory. A total of 22 participants returned the survey for a 62% participation rate. However, one individual incorrectly completed the survey, and therefore neither the demographic information or the answers were used in the study. A copy of the style inventory questionnaire, directions, and a demographic survey (which was included with the questionnaire) can be found in Appendixes C, A and B (respectively).

The survey was used to answer the research question: Is there a common problem solving and decision making style used by critical care nurse managers in a specific health care setting based in the Southwestern United States?

The presentation of data is in order of each survey question. The results of the demographic survey are presented in Tables 1 through 7. The results of the questionnaire are presented in Tables 8 through 12. A total number identifying the participants' responses is noted for each demographic question as well as a percentage breakdown of responses for each question. Total points for each question of the survey are also noted on the following pages along with pie charts representing the primary, secondary, third, and fourth styles of problem-solving and decision making most commonly chosen by the participants. These are identified through the quadrant system (A through D) that is used by Hersey and Natemeyer in the questionnaire instrument. Information is also included that
identifies styles of leadership based on answers selected by the participants and combining quadrants identified in those answers.

A breakdown of the quadrants identified as the problem solving and decision making used by the research participants and its relation to portions of the demographic survey was also done using a standard mean scoring system and a chi square analysis.
TABLE No. 1

DEMOGRAPHICS DATA

<table>
<thead>
<tr>
<th>Question</th>
<th>Number of Responses</th>
<th>% of total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Age:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-25</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>26-30</td>
<td>3</td>
<td>14%</td>
</tr>
<tr>
<td>31-35</td>
<td>5</td>
<td>22%</td>
</tr>
<tr>
<td>41-50</td>
<td>12</td>
<td>54%</td>
</tr>
<tr>
<td>51-60</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>over 60</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Sex:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>21</td>
<td>95%</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td><strong>3. Years in Nursing:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 5 years</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>5 - 10 years</td>
<td>4</td>
<td>19%</td>
</tr>
<tr>
<td>11 - 15 years</td>
<td>3</td>
<td>14%</td>
</tr>
<tr>
<td>16-20 years</td>
<td>3</td>
<td>14%</td>
</tr>
<tr>
<td>over 20 years</td>
<td>10</td>
<td>48%</td>
</tr>
<tr>
<td><strong>4. Years as a critical care manager:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 5 years</td>
<td>7</td>
<td>32%</td>
</tr>
<tr>
<td>5 - 10 years</td>
<td>9</td>
<td>40%</td>
</tr>
<tr>
<td>11 - 15 years</td>
<td>4</td>
<td>18%</td>
</tr>
<tr>
<td>16-20 years</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>over 20 years</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td><strong>5. Years with current Health Care System:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 5 years</td>
<td>3</td>
<td>14%</td>
</tr>
<tr>
<td>5 - 10 years</td>
<td>5</td>
<td>23%</td>
</tr>
<tr>
<td>11 - 15 years</td>
<td>8</td>
<td>36%</td>
</tr>
<tr>
<td>16 - 20 years</td>
<td>4</td>
<td>18%</td>
</tr>
<tr>
<td>over 20 years</td>
<td>2</td>
<td>9%</td>
</tr>
</tbody>
</table>
6. Area currently working:

<table>
<thead>
<tr>
<th>Area</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical ICU</td>
<td>4</td>
<td>14%</td>
</tr>
<tr>
<td>Multi ICU</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Cardiovascular ICU</td>
<td>3</td>
<td>11%</td>
</tr>
<tr>
<td>Pediatric ICU</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>Neuro ICU</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>Neonatal ICU</td>
<td>8</td>
<td>28%</td>
</tr>
<tr>
<td>Medical ICU</td>
<td>5</td>
<td>18%</td>
</tr>
<tr>
<td>Emergency Delivery</td>
<td>3</td>
<td>11%</td>
</tr>
</tbody>
</table>

Table No. 2
Age of Respondents

There were no responses for the first and last categories of age. The most frequently occurring age of participants was 41 to 50 years (11 participants / 52%). The second most common group was those participants in the 36 to 40 year old range.
Table No. 3
Sex of Respondents

Of the 22 participants, 95% were female.

Table No. 4
Years in Nursing

The results of this tabulation identifies 45% of the participants being in the nursing profession over 20 years.
The results identify over 42% of the participants having experience as a critical care nurse manager for 5 to 10 years. Only 2 participants (approximately 9%) have had over 15 years of experience as a critical care manager. The second largest group (32%) had been a critical care manager for less than 5 years.
Over 71% of the participants have been with their current health care system for 15 years or less. Only 2 participants (approximately 10%) have been with their current health care system for over 20 years. The largest percentage (36%) had been with their current health care system between 11 to 15 years.
Table No. 7
Area currently working

AREA CURRENTLY WORKING

- NEONATAL ICU: 28%
- SURGICAL ICU: 14%
- MEDICAL ICU: 18%
- MULTI ICU: 4%
- CARDIOVASCULAR ICU: 7%
- NEURO ICU: 7%
- PEDIATRIC ICU: 7%
- ER: 11%

The largest percentage of the respondents (28%) identified the area in which they were currently working as the Neonatal ICU.

DECISION MAKING STYLES

In reviewing the questionnaire answers of the 21 participants that completed Hersey and Natemeyer's Problem-Solving and Decision-Making style inventory, the primary, secondary, third and fourth types of problem solving and decision making most commonly used were identified. The frequency of using those methods outlined by Hersey and Natemeyer that identify Quadrants A, B, C, and D of problem solving and decision making is noted in the following pie charts.
The most common primary choice of problem solving and decision making for the critical care managers was in the C Quadrant. This quadrant was chosen about 56% of the time as the primary choice of style for problem solving and decision making. This quadrant addresses the manager’s use of a Participative style of leadership where there is a high relationship and low task structure between the manager and subordinate in problem solving and decision making.
The second most common choice of problem solving and decision making for critical care managers was in the B Quadrant. This area was chosen about 46% of the time as the secondary choice of style for problem solving and decision making. This quadrant addresses the manager’s use of a Selling style of leadership where there is a high task and high relationship structure between the manager and subordinate in problem and decision making.
The third most common choice for problem solving and decision making style for critical care managers was in the D Quadrant. This area was chosen about 36% of the time by the participants as the third choice of style for problem solving and decision making. This quadrant addresses the manager's use of a Delegating style of leadership where there is a low relationship and low task structure between the manager and subordinate in problem solving and decision making.
Table No. 11
Least common style for problem-solving and decision-making

The least common choice of problem-solving and decision-making styles for critical care managers was in the A Quadrant. This area was chosen about 61% of the time by the participants as the style that was least preferred in problem solving and decision making. This quadrant addresses a manager’s use of a Telling style of leadership where there is a high task and low relationship structure between the manager and subordinate in problem solving and decision making.

In reviewing the results of the questionnaire, Hersey and Natemeyer identify both the primary and secondary styles of problem solving and decision making. They also suggested comparing the point totals of A and B, B and C, and C and D. The total for A and B represents Leader made decisions; B plus C represents Collaborative decision making; and C plus D represents Follower made decisions.
This process was done using the results of the questionnaire. The results are shown in Table 12:

Table No. 12
Primary combined scores

<table>
<thead>
<tr>
<th>PRIMARY TYPE CHOSEN</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>C and D QUADRANTS</td>
<td>38%</td>
</tr>
<tr>
<td>A and B QUADRANTS</td>
<td>0%</td>
</tr>
<tr>
<td>B and C QUADRANTS</td>
<td>48%</td>
</tr>
</tbody>
</table>

The most common style of management identified by the participants' answers to the questionnaire was in the decision making quadrants of B/C. This style was chosen 48% of the time. These two areas represent an overall Collaborative style of management for the participants of the questionnaire.

The most frequently occurring combined score for A/B Quadrants (Leader made decisions) answers is 17 (19%). The total scores chosen in the A/B Quadrants range from 11 (3 participants), to 28 (1 participant). Over 80% of the participants had total scores in this area of 18 or less.

The most frequently occurring combined score for answers identifying B/C (Collaborative) Quadrants is 22 (33%). The total scores for the B and C Quadrants range from 16 (1 participant) to 27 (1 participant).

The most frequently occurring combined score in answering those questions that identified the C/D (Follower made decisions) Quadrants is a three
way tie of 18, 19, and 23. Each of these numbers are represented 3 times by the participants in the questionnaire (14% for each number) and approximately 67% of the responses had total scores of the B/C (Collaborative decisions) Quadrants between 21 and 23.

The average mean combined score for the A/B Quadrants (Leader made decisions) was about 16. The average mean combined score for the B/C Quadrants (Collaborative made decisions) was 22. The average mean combined score for the C/D Quadrants (Follower made decisions) was approximately 19. The higher scores in the last two categories represent managements’ problem solving and decision making styles that are utilized in the process of making the decisions when addressing subordinates.

Each of the demographic questions were then compared to variables representing the A/B, B/C, and C/D Quadrants for any relationships that would be statistically significant. The following information represents the results of those comparisons.

A breakdown was done comparing the age of the participant to the frequency of A/B (Leader made decisions) choices in problem solving and decision making to identify a mean between the variables. The mean of those selecting A/B answers for the questionnaire is noted to be very similar among all age groups. However, those in the age group of 36 to 40 years had the highest mean score of 19.

The age of those completing the questionnaire was reviewed to determine mean scores in selection of a B/C (Collaborative decision) answer. The mean scores of those choosing B/C answers for the questionnaire based on the age of the participants is similar (19 to 22) through out the age groups, but is slightly higher (23.2) among those participants between 36-40 years of age. However, the
frequency of those choosing a B/C answer was more common among the participants who were 41 to 50 years of age.

A similar comparison of mean scores was made by identifying the age of a participant's selection to those choosing a C/D (Follower-made decision) answer. The mean for C/D answers is between 16 to 20 for all age groups. However, those in the age groups of 41 to 50 more frequently chose the C/D answer. Those in the age group of 36 - 40 had the lowest mean (16) of C/D answers.

Years in nursing was also examined to compare the mean scores to each of the 3 choices A/B (Leader-made decisions), B/C (Collaborative made decisions), and C/D (Follower-made decisions). In comparing those choosing A/B (Leader-made decisions) answers based on the number of years the participants have been in the nursing profession the mean scores were quite varied. The highest mean score of 26 was noted for a participant who had been in the nursing profession for less than 5 years and the lowest mean score of 13 was from the largest percentage of participants; those who had been in the nursing profession for over 20 years. In comparing years in nursing to those choosing B/C (Collaborative decisions) answers, similar mean scores were discovered across the age groups with only a 2 point variance (21 to 23) noted. The lowest mean score from a participant in choosing a C/D (Follower-made decision) answer was 10. This was from a participant who had been in the nursing profession for less than 5 years. The highest mean score of 22 was chosen by the largest percentage of the group completing the questionnaire. This area is represented by those who had been in the nursing profession for over 20 years.

The number of years the participants had been with their current healthcare system was also compared to the frequency and mean scores of the answers in choosing an A/B, B/C or C/D answer. The mean scores for those
choosing an A/B (Leader made decision) answer, was between 14 and 20. The largest group of participants were those who had been with their current health care system for 11 to 15 years. This group had a mean of approximately 14.

Those choosing B/C (Collaborative-decisions) answers based on the number of years each participant has been in their current health care system identified mean scores that were very close for all groups with a variation of approximately 2 points (21 to 23.3).

Those choosing C/D (Follower-made decisions) answers based on the number of years each participant has been in their current health care system showed a variation of the mean scores between 16 and 21.4. The largest group of participants (7) had been with the Health Care System 11-15 years and their mean score was 21.4.

A breakdown of the primary style of problem solving and decision making by the participants years as a critical care manager was done to see if there was a relationship between the primary style of problem solving and decision making chosen by the participants and years as a critical care manager. The largest group of participants (9) had been critical care managers for 5 to 10 years. Among those 9 participants, approximately 67% chose C/D (Follower-made decisions) for their primary style. However, 47% (10) of the participants chose B/C as their primary style. A chi-square analysis indicated no statistical significance among the differences.

A comparison of the primary style of problem solving and decision making based on the number of years they had been with their current health care system was done to determine if there was any relationship between the primary styles and the years they had been with their current health care system. A number of participants had been with the system for 11 to 15 years and 62% chose their primary style as C/D (Follower-made decisions). None of the participants in the
11 to 15 year group chose A/B (Leader-made decisions) as their primary style. The largest group of participants, 47% (10), chose B/C (Collaborative decisions) as their primary style. The chi-square analysis identified no statistical significance among the differences.

A breakdown of the primary style of problem solving and decision making by the age of the participants to determine if there was a relationship between the primary style of problem solving and decision making chosen by the participants and the age of the participants. The largest group of participants (11) were between the ages of 41 to 50 and they chose the Follower made (C/D) answers over 54%. However, the most frequently chosen answers were in the Collaborative (B/C) category and that was chosen by 10 participants (47%). While the decision making style varied somewhat by the age of the participants, a chi square analysis indicated that these differences were not statistically significant.
Summary

This research was a descriptive study undertaken to determine if there was a common problem solving and decision making style of leadership for critical care nurse managers in a specific health care setting based in the Southwestern United States. To provide an answer for this question an instrument developed by Drs. Hersey and Natermeyer (1982) that identifies specific types of problem solving and decision making was sent to 34 critical care nurse managers of this specific health care setting.

There were several limitations to the scope of the study due to a small sample size as only critical care nurse managers of a particular health care setting were given the instrument to complete as part of the research process. The scope of the study was also limited as it only addresses the problem solving and decision making leadership qualities of the managers and not the readiness of the followers. Outcomes of actual effectiveness of problem solving and decision making were not examined.

The purpose of this study was to determine if there was a common problem solving and decision making leadership style used by these managers. If a particular style is determined, educational offerings could be developed that would enhance leadership styles that are outside the manager’s "normal" way of directing and leading subordinates. This process could assist in the development of a manager or leader more versed in the use of leadership strategies to produce a more effective outcome for the employee as well as the health care
organization. The significance of the study could result in the development of better tools and resources for critical care nurse managers in promoting a more structured and positive outcome of a given situation. This could benefit the productivity of both the employees and the managers as they would be better informed on behavioral styles of problem solving and decision making that would be best suited to address particular encounters with employees to promote a more positive interaction.

The literature reviewed related to leadership styles, problem solving and decision making processes, and specifically, Hersey’s Situational Leadership Model. Literature pertaining to leadership in Health Care and situational leadership as it relates to nursing was also reviewed.

In Situational Leadership, the leaders strive to match their leadership styles and approaches to specific situations and to the personalities of the staff. Research conducted indicates that a leaders’ behavior could be categorized as either task-oriented or employee-oriented. Identifying different behaviors in the manager and the readiness of followers are important in situational leadership.

Problems in organizations demand a solution if the organization is to function properly. There are various ways of identifying problems as well as ways of making decisions on how to react to the problem. Managerial decision making is a complex process that begins with a recognition or awareness of problems and concludes with an assessment of the results and which actions resulted in the resolution of the problem.

Situational leadership can show a health care nursing manager how to deal with people and situations effectively and flexibly. Nurses are at different stages of development in their professional role, and each one should be addressed in a manner that appreciates their needs and readiness. The strengths and
weaknesses of both the leader and the subordinate must first be examined before choosing the approach needed to resolve an issue.

**Conclusions**

In reviewing the results of Hersey and Natemeyer’s Problem Solving and Decision Making questionnaire, a consistent pattern was revealed regarding the decision making process used by the critical care nurse managers. Over 56% of the nurse managers chose Quadrant C as their primary choice. This quadrant represents a participative style of management that is being used most frequently by these managers in their problem solving and decision making processes. The C. Quadrant identifies a high relationship and low task leadership style between manager and subordinate. It also identifies a facilitative style and would suggest that the managers are consulting their subordinates with decision making and problem solving in the critical care areas they are working. In the profile analysis of the questionnaire results each participant’s management style inventory for directive or supportive behavior in a problem solving and decision making situation is also identified. Quadrant C, the most frequently chosen area among this group of participants, would identify a high supportive, low directive behavior style between the managers and subordinates.

The second most common style of decision making and problem solving was in the B Quadrant, which identifies a Selling, or consultative, style of leadership. This quadrant was chosen about 46% of the time as the secondary choice of style of leadership and addresses a high task and high relationship structure between the manager and subordinate. The B Quadrant also identifies a high supportive, high directive style between the managers and subordinates. This would also suggest that the managers are involving the subordinates in the decision making process.
The test also revealed a pattern in reviewing the combined scores for both A/B (Leader-made decisions), B/C (Collaborative decisions), or C/D (Follower-made decisions). The most common score was in the B/C category. This suggested that a Collaborative style of management was most frequently chosen by the participants in decision making and problem solving. The least used style of decision making was a "telling," Leadership-made decision, type of management. This would suggest that the managers are not using an autocratic type of management style in which all decisions are made by the manager with little or no input by subordinates, but choosing to use a more Collaborative style of problem solving and to involve their subordinates in decision making. The average mean score of those choosing A/B (Leader-made decision) answers was 16. The average mean score of those choosing B/C (Collaborative decision) answers was 22. The average mean score of those choosing C/D (Leader-made decisions) answers was 19. The highest mean scores are represented by those choosing the B/C answers. However, the highest score (28) came from a participant that chose the A/B (Leader-made decision).

Of the 22 participants who completed the questionnaire, 100% (22) completed the demographic information sheet. One participant did not accurately compete the test. Therefore, the demographics and the questionnaire results for this participant were excluded. Of the 21 participants included in the research, 20 (95%) were female.

In reviewing the demographics of the study, most critical care managers were in the 40 to 50 year old range (11 participants / 52%). In addition, 45% had been in the nursing profession for over 20 years. This would suggest a familiarity of working within the nursing environment. An area not examined during the study was any previous experience that the participants might have had as a nursing manager in an area outside critical care.
Over 42% of the participants have been a critical care manager for 5 to 10 years. Only 9% (2) have had over 15 years of experience as a critical care manager. Over 71% of the participants had been with that specific health care system for 15 years or less. Only 2 participants had been with the health care system for over 20 years.

In comparing the ages of the participants to the style of problem solving and decision making, an analysis shows the youngest age group favoring a more Delegative style of management as their mean scores were highest in the C/D (Follower made decision) category. In comparing an increase in age with chosen management styles, a trend is seen in the support of a more collaborative style of management style as the age of the of the participant increased. However, the mean scores for those supportive of a collaborative style of management were higher for those in the middle of the age range. The lowest mean scores in identifying leader behavior among all age groups (except the 36 to 40 year olds) were those in the leader-made decision (A/B) quadrant. The lowest mean score among those in the 36 to 40 year olds category was in the follower-decision (C/D) quadrant.

Due to the large percentage of females (95%) completing the survey, no analysis was completed based on gender.

No statistically significant relationships between styles of leadership behavior and years in nursing could be identified based on mean scores for those participating. However, the highest mean score average, based on years in nursing, was in the B/C (Collaborative decision) category.

**Recommendations**

The findings from this study could be used to outline training courses related to the age of the manager. The research indicates that a more delegative
style of problem solving and decision making is used by the younger managers. This style allows for the employees to become more responsible for their own problem solving and decision making. As the age of the manager increases, the style of management transcends into a more participative style of management with problem solving and decision making being accomplished with involvement from both the manager and the employee. Managers in the higher age categories might need to learn a more delegative style of problem solving and decision making. This could also be an opportunity for the younger managers to learn other styles of participative and leader made decisions management that might be more appropriate in specific situations.

Nurse managers involved in the research study that had been in nursing for the longest period of time also had scores less varied than the nurse managers who had been nurses for less than 5 years. This could outline a training need for nurse managers with limited nursing experience and provide them with the opportunity to become more assured and consistent with their problem solving and decision making processes. It could also outline a training process for the nurse managers who had been in nursing a longer period of time to enhance their flexibility in management styles.

Nurse managers who had been with their current health care system for 11 to 15 years had overall mean scores of approximately 21 in the C/D (Follower made decision) category. This identifies that those managers who have been with their current health care system for a longer period of time are seeking input form their subordinates in their problem-solving and decision making processes.

This research study also outlines the need to employ training that involves Leader made decisions for all critical care managers. The research shows that a Leader made decision style of leadership is used the least among all the managers who participated in the questionnaire. A leader made decision is useful
in a high task, low relationship type of problem solving and decision making and is sometimes necessary in reaching a decision based on the situation. If managers are not accustomed to using this style of leadership, it may be difficult for them to utilize. Training that provided the participants of this research study opportunities to identify these specific situations and the process necessary to accomplish the needed decisions would be helpful.

The researcher would like to recommend that future studies include the use of Hersey and Natemeyer’s instrument for the subordinates in the critical care settings of the managers to determine problem solving and decision making skills that they are most comfortable in using themselves. This instrument could determine if the types of problem solving and decision making being used by the managers are complimentary styles to the “readiness” of the subordinates.

Training that would involve all styles of problem solving and decision making for managers and subordinates could be integrated into this specific health care system. This training would assist in providing a flexible management style for the leadership as well as understanding the readiness of the subordinates in both problem solving and decision making in day to day situations that require a management intervention.

The researcher would also like to recommend that this testing instrument (questionnaire) be given to all managers of the specific health care system used in the study. This would provide a bigger picture of overall management styles for this particular organization as this study identified only critical care nurse managers. Mission statements and philosophies of most industries are promoted through the management styles of managers within each organization. Programs to train managers in areas that are outside their normal ways of operation would provide for a more rounded style when addressing problem solving and decision making as well as day to day operations of that organization.
REFERENCE LIST


Dear Participant,

Thank you for agreeing to participate in this test for my Graduate studies thesis. This test will take you approximately 7-10 minutes to complete. In addition to the test, you will find a short demographic sheet. A compilation of the demographics from this sheet will be used to determine any similarities of leadership styles based on the answers of each area. Your assistance in completing both the test and demographic sheet will be helpful in identifying results for my thesis.

The actual test you will be taking is used in the determination of a style inventory for problem solving and decision making. I will complete the scoring of the tests. The results of your test and a tool that is used for data interpretation will be sent to you so you may identify your leadership style for problem solving and decision making. The overall information from the tests will be incorporated into my thesis on an accumulated summary basis to ensure individual privacy of results.

Thank you for your assistance with this project. If your past studies have included the completion of a thesis for a graduate program, I am sure you can appreciate the enthusiasm that I have to complete this paper! Please don’t hesitate to contact me if any further information is needed.

Sincerely,

Jean M. Herges
Manager of Regional Supervisors
Samaritan Air Evac
APPENDIX B

Demographic Survey of Participants
DEMOGRAPHICS INVENTORY

1. My age is:
   ____ 20-25
   ____ 26-30
   ____ 31-35
   ____ 36-40
   ____ 40-50
   ____ 50-60
   ____ over 60

2. Sex:
   ____ Female
   ____ Male

3. Years in Nursing:
   ____ Less than 5 years
   ____ 5 - 10 years
   ____ 11 - 15 years
   ____ 16-20 years
   ____ over 20 years

4. Years as a critical care manager:
   ____ Less than 5 years
   ____ 5 - 10 years
   ____ 11 - 15 years
   ____ 16-20 years
   ____ over 20 years

5. Years with current Health Care System:
   ____ Less than 5 years
   ____ 5 - 10 years
   ____ 11 - 15 years
   ____ 16 - 20 years
   ____ over 20 years

6. Area currently working:
   ____ Surgical ICU
   ____ Medical ICU
   ____ Cardiovascular ICU
   ____ Pediatric ICU
   ____ Neonatal ICU
   ____ Multi ICU
   ____ Emergency Delivery
   ____ Neuro ICU
APPENDIX C

Hersey and Natemeyer’s

Problem Solving and Decision Making Instrument
Developed by Paul Hersey and Walter E. Nateseiner

This instrument provides feedback on your own perception of your problem-solving and decision-making styles.

INSTRUCTIONS

On the following page are twelve pairs of statements. Decide which of the statements in each pair most reflects the way you approach problems and make decisions. Allocate 3 points between the two alternative statements in each pair. Base your point allocation on your judgment of how well each statement describes how you tend to behave. Assign the most points to the statement in the pair that is more characteristic of your problem-solving or decision-making style.

Allocate the points between the first and second statements in one of the following ways:

\[
\begin{array}{c}
3^A \\
0^B \\
\end{array}
\quad \text{or} \quad
\begin{array}{c}
2^C \\
1^D \\
\end{array}
\quad \text{or} \quad
\begin{array}{c}
1^B \\
2^C \\
\end{array}
\quad \text{or} \quad
\begin{array}{c}
0^A \\
3^D \\
\end{array}
\]

Be sure that the numbers assigned to each pair add up to 3.
When involved in problem-solving or decision-making situations with others, I usually:

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>A</td>
<td>Provide specific instructions for resolving the problem.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>Ask for input from others to help solve the problem.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>C</td>
<td>Share ideas and attempt to reach consensus on a decision.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>Provide an opportunity for others to make the decision.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>B</td>
<td>Ask for input from others to help solve the problem.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>Facilitate discussion and am supportive in problem solving.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>A</td>
<td>Make the decision and act firmly and decisively in its implementation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>Provide an opportunity for others to make the decision.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>A</td>
<td>Provide specific instructions for resolving the problem.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>Facilitate discussion and am supportive in problem solving.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>B</td>
<td>Discuss the decision with others and attempt to gain their commitment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>Provide an opportunity for others to make the decision.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>A</td>
<td>Make the decision and act firmly and decisively in its implementation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>Share ideas and attempt to reach consensus on a decision.</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>B</td>
<td>Ask for input from others to help solve the problem.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>Let others take the major responsibility for solving the problem.</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>B</td>
<td>Discuss the decision with others and attempt to gain their commitment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>Share ideas and attempt to reach consensus on a decision.</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>A</td>
<td>Provide specific instructions for resolving the problem.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>Let others take the major responsibility for solving the problem.</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>A</td>
<td>Make the decision and act firmly and decisively in its implementation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>Discuss the decision with others and attempt to gain their commitment.</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>C</td>
<td>Facilitate discussion and am supportive in problem solving.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>Let others take the major responsibility for solving the problem.</td>
<td></td>
</tr>
</tbody>
</table>
By examining your scores for A, B, C, and D, you can identify your perception of the relative emphases you place on the four Problem-Solving and Decision-Making Styles (telling or authoritative, selling or consultative, participating or facilitative, and delegating or delegative).

The highest score represents your Primary Style, which tends to be the most comfortable for you. Other styles that have a score of 6 or more are considered your Secondary Style(s). Although you may not be as comfortable with these styles as with your Primary Style, you use these styles to a moderate extent.

Your Style Range includes both your Primary and Secondary Styles. Compare the point totals of A and B, B and C, and C and D. The total for A and B represents Leader-Made decisions; B plus C represents Collaborative decision making; and C plus D represents Follower-Made decisions.

\[
\begin{align*}
A + B &= \text{Leader-Made Decisions} \\
B + C &= \text{Collaborative Decisions} \\
C + D &= \text{Follower-Made Decisions}
\end{align*}
\]

**DISCUSSION**

There is no "best" style for problem solving or decision making. The appropriate style for you depends on the "readiness" of others involved. If your style matches the readiness level of others with whom you are interacting, it is appropriate.

The following designations from the model are used for the four possible *appropriate* styles.

- **S1** - Authoritative (Telling)
- **S2** - Consultative (Selling)
- **S3** - Facilitative (Participating)
- **S4** - Delegative (Delegating)

If there is not a match between the leader's style and the follower's readiness, the style is *inappropriate* and the following designations from the model may apply:

- **Q1** - Coercing
- **Q2** - Manipulating
- **Q3** - Patronizing
- **Q4** - Avoiding

Readiness to solve problems or to make decisions depends on two major factors:

- **ability**, the extent to which one possesses the necessary knowledge or skill to make the decision or to solve the problem, and
- **willingness**, the extent to which one possesses the necessary confidence, commitment, and motivation to make the decision or to solve the problem.

To evaluate your scores and to determine the appropriate style to use, you must assess the levels of readiness of others involved. The four levels of readiness, corresponding to the four problem-solving and decision-making styles, are defined and shown under the matrix below.

R1 = Unable to make the decision or solve the problem and either unwilling or insecure.
R2 = Somewhat able to make the decision or solve the problem, but willing or motivated.
R3 = Able to make the decision or solve the problem, but unwilling or insecure.
R4 = Able to make the decision or solve the problem and willing or motivated.
SCORING INSTRUCTIONS
Add the scores that you have assigned to the six A items and record the total in the A box below. Repeat the same procedure for the B, C, and D items. As a check on your addition, make sure that the numbers in the four boxes add up to 36.

TOTALS
\[ A + B + C + D = 36 \]

PROBLEM-SOLVING AND DECISION-MAKING MODEL
Transfer your scores for A, B, C, and D above to the corresponding boxes below.

PROFILE ANALYSIS
The Style Inventory provides feedback on how you behave in a problem-solving or decision-making situation. The extent to which you engage in "Directive" and "Supportive" behavior is your "style." These two dimensions are defined below.

Directive behavior is the extent to which you solve the problems, make the decisions, spell out the duties of others, and engage in telling them what to do, how to do it, when to do it, where to do it, and who is to do it. Some substitute terms for directive behavior include task behavior, assertive behavior, and guidance.

Supportive behavior is the extent to which you engage in two-way communication with others regarding the problem or decision and provide socioemotional support and facilitative behavior. Some substitute terms for supportive behavior include relationship behavior, discussion, and encouragement.
APPENDIX D

Letter of Request for Test Permission Use
February 2, 1996

Jean M. Herges
16662 S. 18th Way
Phoenix, AZ 85048

Mr. Barry Davis
HRD Press
22 Amherst Road
Amherst, MA 01002

Dear Mr. Davis,

I am writing to request permission to use the Problem Solving and Decision Making Style Inventory developed by Drs. Hersey and Noremeyer as a part of my Graduate studies thesis. My thesis addresses the problem solving and decision making styles used by critical care nurse managers in a hospital based setting of a hospital in the southwestern United States. I would like to use your tool to determine if their is a common style of problem solving and decision making among the group that I will be testing.

All results will be published in a summary format and the confidentiality of the participants will be maintained throughout the study.

Permission to use your tool as part of my graduate study program would be very much appreciated. Thank you in advance for your considerations.

I would be happy to answer any questions you might have regarding this process if needed. Please feel free to contact me at 602-273-9304 (w), or 602-460-6675 (h).

Sincerely,

Jean M. Herges
Graduate student
Ottawa University
Phoenix, AZ
February 2, 1996

Jean M. Herges
16662 S. 18th Way
Phoenix, AZ 85048

Mr. Barry Davis
HRD Press
22 Amherst Road
Amherst, MA 01002

Dear Mr. Davis,

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I would be happy to answer any questions you might have regarding this process if needed. Please feel free to contact me at 602-273-9304 (w), or 602-460-6675 (h).

Sincerely,

Jean M. Herges
Graduate student
Ottawa University
Phoenix, AZ
Jean Marie Herges is a native of the state of Minnesota. She received her diploma of Nursing in 1976 from Fairview Hospital School of Nursing in affiliation with Augsburg College in Minneapolis, Minnesota. She moved to Phoenix, Arizona in 1977 and has been active in the nursing profession for 20 years. She is currently the Manager of Regional Supervisors for Samaritan Air Evac in Phoenix. From 1989 to 1991 she served as National President of the National Flight Nurses Association. In 1991 she resumed her collegiate studies and received a Bachelor of Arts degree in Health Care Administration from Ottawa University in 1993. In 1994 she entered the Graduate Program in Human Resources at Ottawa University. Jean resides in Phoenix with her husband, John Roberts, and two step daughters, Angelina and Carla.