MANAGING THE TRANSITION FROM STAFF NURSE TO NURSE MANAGER-
CHANGE IN CLINICAL NURSE IDENTITY

By

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The career progression from staff nurse to nurse manager is a common promotional pathway. Yet, seldom are staff nurses who are promoted to managers prepared, either practically or psychologically, for the new role. This quantitative study tests data from 100 Nurse Managers using the Theory of Planned Behavior in combination with Maternal Role Attainment Theory as the theoretical framework for the study. The purpose of this descriptive study is to better understand the staff nurse to nurse manager transition process from the perspective of nurse managers themselves and to discover key barriers to, and enablers of, professional success. The findings suggest that successful role transition requires that a nurse manager relinquish the staff nurse role for the nurse manager role, decreasing the attachment to clinical nursing identity and behaviors. The nurse manager establishes management identity by self-definition and seeking models for new normalizations. The restructuring of goals, behaviors, and responsibilities impacts the nurse manager's attitude, job satisfaction and performance. In an era where the nurse manager is seen as vital in helping to stem the nation's escalating nursing shortage, understanding andremedying barriers to optimal performance is crucial.
INTRODUCTION

Traditionally, the healthcare environment has considered the progression from staff nurse to nurse manager to be a common promotional pathway for the expert nurse. Nurse managers are charged with the responsibility to assure not only quality of patient care but quality of work life for all staff (McGillis, Hall, & Donner, 1997) as well as organizational effectiveness and efficiency (Nicklin, 1995). The literature reveals a relationship between nurse manager effectiveness and nurse practitioner retention (Thyer, 1998). In a healthcare environment challenged by an alarming shortage of nurses – expected to increase to 29% by the year 2020—the nurse manager is seen as a critical management player (Heller, Drenkard, Esposito, Herr, Romano, Tom, & Valentine, 2004). A respectable effort has been made to describe the characteristics of a competent manager focusing on the perspectives of this new role (Allen, 1998), but not on the process to create a strong competent leader.

Despite the increasingly apparent need for competent nurse managers, little, however, is done to systematically prepare them for this role. To date most healthcare institutions have adopted a policy regarding the success of the nurse manager that resembles “survival of the fittest.” Although some healthcare institutions have instituted manager training programs for practitioners promoted to management, many nurses remain ill prepared for the role (Heller, et al., 2004). While a few nurse managers enjoy rich apprenticeship, most are left to fend for themselves (Ibarra, 2000).

The assumption of a management role in a healthcare environment is argued to require a new set of attitudes and beliefs, which includes rules about social norms that govern the new role (Van Maanen & Schein, 1979). While a few scholars have described the characteristics of a competent manager who transitions from practice to management and
have focused on the perceptions of this new role (Allen, 1998) we know little about the process necessary to create a strong and competent nurse manager.

Dykstra (2003) suggests that ill-defined transitions may cause role ambiguity, role confusion and role overload. Role confusion has been related to an erosion of self-confidence, which can lead to poor manager behaviors and loss of follower confidence (Allen 1998). Role stress has been shown to be associated with low productivity and poor performance (Hardy, 1978). Without forging a new identity through the process of role transition, the transitioning nurse manager, it has been observed, may be uncomfortable and ineffective in the new role (Robinson, Murrells, & Marsland, 1997).

The purpose of this descriptive study is to better understand the staff nurse to nurse manager transition process from the perspective of nurse managers themselves and to discover key barriers to, and enablers of, professional success. Relying on both management and human behavior literature that suggests the influence of a myriad of factors on role transition, a model is constructed to test the relationship between behavioral beliefs, social norms, self efficacy, attitude about management and clinical nurse identity commitment.

**RESEARCH QUESTIONS**

The staff nurse’s commitment to the clinical nurse identity may provide an insightful revelation as to why some staff nurses transition to nurse manager more effectively than others. The study examines several variables that predict attitudes about management that may cause an increase or decrease in the nurse’s commitment to a clinical identity.

Research Questions

What are the barriers of a successful transition from clinical staff nurse to nurse manager?
• What are the enablers of a successful transition from clinical staff nurse to nurse manager?

• Why do some nurse managers flounder while others flourish?

• Does the nurse manager's attitude toward management affect the identity commitment to clinical nursing?

• Does a staff nurse's behavioral beliefs about managers' behavior affect attitude about management?

• Do social norms affect a nurse's attitude about management?

• Does the self-efficacy of the nurse affect attitude about management?

To advance understanding about these questions the study is designed to describe the transition of staff nurse to nurse manager. The inquiry is guided by earlier research that emphasizes the importance of identity change in adjustment and adaptation to new roles. In particular, the earlier study was influenced by the work of Nicholson (1984) who catalogued stages of adjustment and Ibarra (1999), whose theory of adaptation through the use of possible selves has informed numerous managerial studies of transition in other contexts.

LITERATURE REVIEW

and informal socialization mechanisms that shape employee expectations and behavior in
early transitions at an individual level. An argument is made by Louis (1980) that employees
make sense of new experiences with regard to both unrealistic and unmet expectations of
transitions.

In contrast, there is a paucity of studies in the nursing science literature describing
the specific process of transition from staff nurse to manager. The small body of research
that does exist appears to focus on educational requirements, role stress and role overload
involving the nurse manager. A few authors such as Dykstra (2003) have written descriptive
papers discussing resources and support networks that enable a smooth transition to the role
of nurse manager. Dykstra, in an insightful anecdotal account of her own transition from
staff nurse to nurse manager, for example, describes the personal and organizational
challenges of transition.

Other authors (Forbes and Hallier, 2006; Jackson-Gray, 2003; Meleis, Sawyer, Im,
Messias, & Schumacher, 2000) characterize movement to management as eliciting feelings
of stress, role confusion, role ambiguity and role overload. Forbes and Hallier (2006)
explore the emerging role of the first-line manager, pointing out the skills, knowledge,
competencies and training needs required of the person making the transition from staff nurse
to first-line nurse manager. Their study, conducted with a sample of 26 first-line managers
promoted from staff nurse, suggests that the transition creates an ever changing role
producing challenges that compromise performance due to demands placed on managers
from non-nursing functions. Those managers also report decreased satisfaction with their
professional roles and a desire to have more balance between personal and professional roles.
Several researchers address the need for transitioning nurse managers to develop new identities. Ewens (2003) found long term success will be dependent on the workplace providing the scope and flexibility for integration of new identities into self concepts and predicted nurse manager transitioning will be successful only if organizations address the legacy of rigid hierarchies found in nursing that constrain creativity. In another study Ewens (1998) reports that nurses become more comfortable in their new roles as adaptation to the new role occurs, as the role and self concept become integrated and a new advanced professional nurse emerges.


Few scholars, however, have explored the process of the transition from staff nurse to nurse manager by specifically isolating barriers and enablers of successful transition. This study relies on literature in the behavioral sciences focusing specifically on identity and behavioral prediction models to identify these determinants.

Theory of Planned Behavior

Ajzen and Madden's 1986 Theory of Planned Behavior (Figure 1), the successor to the Theory of Reasoned Action (Fishbein & Ajzen, 1975), has guided numerous studies (Chatzisarntis, Hagger, Smith & Phoenix, 2004; Greenslake & White, 2005; Rhodes & Courneya, 2003) in disparate disciplines. The model is aimed at predicting behavior and behavioral intentions, and patterns human action as influenced by behavioral, normative and
control beliefs. Control beliefs were later relabeled by Fishbein as self-efficacy. These variables were found to provide very good discrimination between stages of change in Armitage and Arden’s study of 2002. The theory states that human action is guided by three categories of beliefs:

- Behavioral Beliefs
- Normative Beliefs
- Control Beliefs

![Figure 1: Model of Ajzen's Theory of Planned Behavior, Ajzen, 2001](#)

Attitudes and subjective norms of referent groups are suggested to exert their effects upon behavior through intentions (Rhodes & Courneya, 2003) in studies done by Ajzen and Madden (1986). This theoretical model shows human action and effort during behavioral change to be guided by three beliefs. Beliefs about the likely outcome of behavior are termed behavioral beliefs that guide human action and effort through attitudes.

The three determinates of the framework are: 1) the person’s behavioral beliefs, either positive or negative, about performing the behavior; 2) subjective norms that reflect
perceived societal pressure to perform or not perform the behavior; and 3) the perceived behavior control that reflects the extent to which the person perceives the behavior to be under volitional control. The central premise of the theory is that people make decisions rationally by systematically using accessible information.

Beliefs about the likely outcomes of behavior are called behavioral beliefs and they guide human behavior through attitudes. Attitudes reflect a psychosocial evaluation of the object or behavior such as good/bad, harmful/beneficial, and pleasant/unpleasant (Ajzen, 2001). Beliefs about normative expectations of others are termed normative beliefs and they guide human behavior through subjective norms. Subjective norms reflect the influences that the individual’s referent group may exert on the execution of the behavior. The referent group in the case of the nurse manager may be the vice president for nursing, the staff, and the nurse manager’s significant other. The perceived behavioral control, or for the purpose of this study the self-efficacy, reflects the perceived ease or difficulty associated with the execution of the behavior.

In Ajzen’s (2001) work the concept of self-efficacy was added to behavioral control. The concept of self-efficacy refers to the individual’s feelings of confidence about the ability to perform a behavior (Bandura & Locke, 2003). In a study of classroom teachers, it was found that teachers with strong self-efficacy in their ability to help their students learn were found to work hard, persist when frustrated, learn effective teaching strategies and engage in problem solving (Bandura, 1997). In contrast, the same study showed teachers with low self-efficacy were more likely to give up when frustrated and to lack motivation in the face of difficulty. Frustration experienced by nurse managers who lack self-efficacy may be
associated with a decreased motivation to complete the transition from staff to management role.

**Maternal Role Attainment Theory**

Rubin (1984) introduced the Theory of Maternal Role Attainment (MRA), a process leading to a new mother's achievement of maternal role identity. The construction of maternal identity is a result of extensive psychosocial work during pregnancy, incorporating the new maternal identity into her self system. Attitudinal changes accompany the process as roles or parts of her life that are incompatible with motherhood are relinquished. A transition to motherhood may be facilitated or inhibited by the woman's beliefs, attitudes, and societal conditions (Meleis et al., 2000); a staff nurse's beliefs, societal conditions and self-efficacy may facilitate or impede the transition to nurse manager.

Rubin (1984) describes the enormity of change accompanying the transition to motherhood as an exchange of a known self in a familiar world for an unknown self in an unknown world. The transition to motherhood is a volitional experience, motivated by attitudes and aspirations of becoming the ideal mother (Rubin, 1984). Orientation toward the ideal is searching for models of new and desirable attitudes and abilities to incorporate into a new self identity. Staff nurses transitioning into a management role may quest for the same result of a new identity, through acquisition of new attitudes about management. Affecting this attitude may be their behavioral beliefs about the role of manager, social norms being exerted about their manager role and self-efficacy about the management role.

**Hypothesis**

The model in Figure 2 depicts the hypothesis that the influences of behavioral beliefs, social norms and self-efficacy on attitude about management creates a change in the clinical
identity of the staff nurse transitioning from staff nurse to nurse manager. The framework to support and test the hypothesis is constructed from the Theory of Planned Behavior and from Maternal Role Attainment Theory. Each of these theories describes a change in behavior leading to a transition of self-identity. The constructs of the model are defined in the next section.

FIGURE 2
Model of Hypothesized Role Transition

CONSTRUCT DEFINITIONS

Independent variables predicting the degree of change in staff nurse identity, the dependent variable, are behavioral beliefs, normative beliefs and self-efficacy. Attitude about management may be influenced by the independent variables and may have an affect on the degree of clinical identity the nurse exhibits.

Behavioral Beliefs

Behavioral beliefs are the degree to which one has a favorable or unfavorable evaluation or appraisal of the behavior in question (Ajzen, 2001). In the case of the nurse manager, beliefs about the managerial role may have an impact on the clinical nurse identity.
commitment. Behavioral beliefs can guide human action and facilitate the change of behavior through beliefs about the impact of the behavior (Ajzen, 2001). Analogous to a woman in transition to motherhood, the staff nurse who is in transition to management may believe that by becoming the nurse manager he or she may be able to make a significant contribution to the discipline of nursing. Such a belief could influence the change in self identity. In opposition, those staff nurses transitioning to manager, who believe they are not making a significant contribution, may cling to their clinical nurse identity.

Normative beliefs

Normative beliefs are perceived social pressure to perform or not perform the behavior (Ajzen, 2001). People seek a positive self evaluation. Such self evaluation is derived, in part, from incorporating the perceived evaluation of significant others. The more a person is committed to an identity, the more significant others will support the identity. In the case of the MRA, mothers report not being able to make the transition without the perceived confidence of their husbands (McVeigh, 1997). Nurses who are transitioning to a management role and attempting to relinquish some of their clinical identity may need the strong support of their social and professional network.

Self-Efficacy

Self-efficacy is the third independent variable that influences the staff nurse’s belief about whether the behavioral change can be attained. This involves beliefs about the presence of factors that may facilitate or impede a new behavior. Self-efficacy as postulated by Bandura (1997) refers to the belief in one’s ability to successfully perform a particular behavior. Bandura states that self-efficacy relates to self perceptions of one’s behavioral competency or ability to perform specific actions in particular situations. Self-efficacy is tied
to one’s perceived skills and confidence to execute the behavior. The effort expended to bring the transition to a successful conclusion is likely to increase self-efficacy (Azjen, 2001). For instance, if two staff nurses set out on the same course of transition to management, the staff nurse with more confidence that the journey can be successful is more likely to persevere than the staff nurse with less confidence.

**Attitude**

In this study, the role of attitude is tested to ascertain if attitude has statistical effect on the dependent variable, commitment to clinical nurse identity. Attitude is the feeling that one has toward a behavior. In the case of the nurse manager it is the feeling that the nurse manager has about the satisfaction of fulfilling the nurse manager role. The more emotionally aroused one is with respect to identity, the more importance, centrality or commitment one attaches to it (Miller & Rahn, 2002). A person’s attitude toward a behavior is a function of his or her salient beliefs about that behavior (Fishbein & Middlestadt, 1995). During the transition the nurse assesses personal beliefs, self-efficacy and social norms in order to form an attitude about management. This self-assessment may also be present in the woman who is transitioning to motherhood, assisting her in forming her attitude about motherhood.

**Identity Commitment to Nursing**

Central to this model is the construct of identity commitment. Like the word identity, the construct “identity commitment” is used in a variety of ways. In a study by Miller and Rahn (2002), identity commitment is conceived as the psychological strength of a person’s connection to a public object. Stryker and Serpes (1994) use the term affective commitment or psychological centrality when describing the concept of identity commitment.
In research done by Burke and Reitzes (1991) identity commitment is viewed as salient when it is invoked and distinct from psychological centrality. Burke and Reitzes (1991) conceive identity commitment as the sum of forces that lead individuals to maintain congruence between their identity and the influence of others around them. These investigators present two bases of commitment; cognitive commitment referring to the reward: cost ratio of maintaining an identity and socioemotional commitment referring to the degree to which the individual’s relationships with others depend on occupying a particular identity. In the case of this study commitment would be the importance that the nurse manager attaches to clinical identity or the significance that the nurse invests in the nurse persona. Nurses may accomplish identity by commitment to the socially recognized and meaningful categories of nursing (Miller & Rahn, 2002).

Nurses may pursue careers in nursing because of a “calling” they have experienced. The art of nursing is a very passionate calling, suited for individuals committed to the relief of human suffering. Men and women who feel the need to touch others during life changing events find themselves drawn to this profession, where the benefit is a deep sense of personal fulfillment. Nursing has been described as one of few professions requiring a high level of sustained emotional commitment. The staff nurse transitioning to manager role may find it difficult to release the passionate commitment for nursing to gravitate toward less passionate pursuit of management.

**Hypotheses**

\( H1: \) The is a direct positive relationship between attitude about management and behavioral beliefs about nursing management

\( H2: \) There is a direct positive relationship between social norms about management and the attitude about management.
H3: There is a direct positive relationship between self-efficacy and attitude about management

H4: There is a direct inverse relationship between attitude about management and identity commitment to clinical nursing

Moderators

Role models have long been used for the purpose of behavioral learning where self becomes a series of reflected appraisals of self compared with or modeled upon significant others (Rubin, 1984). Rubin’s theory of MRA states that women copy the practice and customs of other women or experts at the onset of pregnancy, and throughout the motherhood transition. Copying a successful role model provides stability to the role at a time of the uncertainty (Rubin, 1984). Role modeling is reported to increase satisfaction with role performance, positive self concept and greater personal happiness (Mercer, 1995). It is thought that the transition to nurse manager by the staff nurse may be moderated by the presence of a role model. During the acquisition of the new role of nurse manager the use of the role model could assist in the release of clinical identity, exchanging the known for the unknown. The role model serves as a guide for expectations of the uncertain course of the managing experience (Rubin, 1984) providing order in knowing what to expect.

Educational preparation is also considered a possible moderator of role transition. It is postulated that the apprentice preparation of the diploma nurse effects the transition differently from the critical thinking approach of the more highly educated staff nurse. Rubin (1984) finds that formal preparation of the new mother, like parenting classes and transitioning to motherhood are related to positive self esteem and happiness, suggesting that type of preparation may impact the transition. Collegiate preparation, emphasizing critical thinking skills, may prepare the staff nurse for the transition to nurse manager.
METHODOLOGY

The following section describes the study sample and analysis methods used to complete the study.

Sample

A convenience sample of 100 nurse managers was obtained by distributing 250 questionnaires to first-line managers comprised of a purposeful population of Nurse Managers in two tertiary care hospitals, located in two Mid-Atlantic States. The survey was disseminated by either placing a study explanation letter, survey and pre-addressed stamped envelope in the hospital mailboxes of first-line hospital nurse managers or sending other potential participants the same material via United States Postal Service. The respondents were instructed to return the completed questionnaire to the researcher in the pre-addressed stamped envelope. There was no harm or benefit to the participant and the return of the questionnaire constitutes permission to use the data returned. The participants are guaranteed anonymity by the investigator.

A total of 125 questionnaires (50%) were returned and 100 met the criteria for analysis. The 100 participants were comprised of 97 females and 3 males ranging in age from 21 to 70. All participants were employed as full- time nurse managers at the time of the study. Participants each had 1 to 25 years’ experience in nursing management or as a nurse manager and had been registered nurses for 10 to 30 years. Each participant managed delivery of direct patient care.

Participants had a variety of educational backgrounds that included three of the four entry into practice levels of nursing education—diploma, associate degree in nursing or baccalaureate in nursing. No participants held Doctor of Nursing (ND) preparation. Graduate
education varied and can be seen in Table 1. All of the participants were staff nurses before they assumed the position of nurse manager. A total of 56% of the participants identified the presence of a role model after whom their management behavior was patterned.

### Table 1
Selected Demographics of Study Population

<table>
<thead>
<tr>
<th>Age (yrs)</th>
<th>Number</th>
<th>Sex</th>
<th>Number</th>
<th>Basic Education</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>31-40</td>
<td>19</td>
<td></td>
<td></td>
<td>Diploma</td>
<td>34</td>
</tr>
<tr>
<td>41-50</td>
<td>53</td>
<td>Male</td>
<td>3</td>
<td>Associate</td>
<td>27</td>
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<tr>
<td>51-60</td>
<td>26</td>
<td>Female</td>
<td>97</td>
<td>Baccalaureate</td>
<td>39</td>
</tr>
<tr>
<td>61-70</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Daily Patient</th>
<th>Number</th>
<th>Role Model</th>
<th>Number</th>
<th>Highest Education</th>
<th>Number</th>
</tr>
</thead>
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<tr>
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<td>Yes/ No</td>
<td></td>
<td>Diploma</td>
<td>3</td>
</tr>
<tr>
<td>&lt;25</td>
<td>31</td>
<td></td>
<td></td>
<td>Associate</td>
<td>24</td>
</tr>
<tr>
<td>26-50</td>
<td>32</td>
<td>Yes</td>
<td>56</td>
<td>Nursing Bachelors</td>
<td>33</td>
</tr>
<tr>
<td>51-75</td>
<td>22</td>
<td>No</td>
<td>44</td>
<td>Bachelors Other</td>
<td>14</td>
</tr>
<tr>
<td>76-100</td>
<td>3</td>
<td></td>
<td></td>
<td>Nursing Masters</td>
<td>10</td>
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<td>101-125</td>
<td>6</td>
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<td></td>
<td>Masters Other</td>
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<td>126-150</td>
<td>3</td>
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<td></td>
<td>Nursing Doctorate</td>
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<td>151-175</td>
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<td></td>
<td></td>
<td>Doctorate, other</td>
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<tr>
<td>&gt;200</td>
<td>2</td>
<td></td>
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</tr>
</tbody>
</table>

Note: > 75 denotes ambulatory care setting
Study Variables

All the scale items were directly borrowed or adapted from literature for the purpose of the study constructs. In addition, some changes were made after the survey was field tested. Table 2 provides the univariate statistic for the construct and the intercorrelations among them.

### TABLE 2
Descriptive Statistics and Intercorrelations for the Study Constructs

<table>
<thead>
<tr>
<th>Construct</th>
<th>ID</th>
<th>ATTM</th>
<th>SE</th>
<th>SN</th>
<th>BB</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical nurse identity (ID)</td>
<td>1.00</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude of Management (ATTM)</td>
<td>-.648**</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td>2.3</td>
<td>.51</td>
</tr>
<tr>
<td>Self Efficacy</td>
<td>-.212*</td>
<td>.289</td>
<td>1.00</td>
<td></td>
<td></td>
<td>4.0</td>
<td>.67</td>
</tr>
<tr>
<td>Social Norms</td>
<td>-.137</td>
<td>.335*</td>
<td>.330**</td>
<td>1.00</td>
<td></td>
<td>3.09</td>
<td>.64</td>
</tr>
<tr>
<td>Behavioral Beliefs</td>
<td>-.679**</td>
<td>.630**</td>
<td>.289</td>
<td>.123</td>
<td>1.00</td>
<td>2.9</td>
<td>.90</td>
</tr>
</tbody>
</table>

A scale designed by Burke and Reitzes (1991) was used to capture the degree to which the nurses making the transition perceived their identity commitment to clinical nurse identity. The construct was measured with three items on a 5 point scale. A total of four items were dropped because of low loadings. The reliability for identity was measured at 0.81.

The independent variables were measured with 32 items on a 5 point scale. A confirmatory factor analysis was performed producing an acceptable fit: CHI=133, CFI=0.93, SRMR = 0.5 and RMSEA=0.12. All estimated loadings were substantially and statistically significant (values > 0.6 and p<.001) indicating convergent validity. The estimated correlation shown in Table 2 demonstrates evidence of discriminant validity.
Method of analysis

The analysis of the data was accomplished in three distinct steps, Exploratory Factor Analysis (EFA) using SPSS and AMOS, confirmatory factor analysis (CFA), and Structural Equation Modeling (SEM) using AMOS to analyze the proposed hypotheses.

Measurement Model analysis

Exploratory factor analysis. EFA was employed using SPSS with principal axis factoring and promax rotation to perform factor extraction on the items specifically assigned to constructs. The use of EFA was to determine acceptable levels of reliability along with convergent and discriminant validity to each construct. The results of this method produced items that loaded high on the expected construct and some that loaded low and were cross loaded. Items that cross loaded were iteratively trimmed, with focus on reliability. After a series of this iterative process and trimming of some items, 5 constructs were extracted.

Confirmatory factor analysis. Prior to testing the hypothesized model, a measurement model was constructed to assure that all the measures corresponded to the constructs with acceptable reliabilities and demonstrating convergent and discriminant validity. The measurement model was estimated using CFA and produced a model with the following fit statistics: CHI 171, CFI=0.92, RNSEA=0.10, SRMR=0.06, NFI=0.87. The fit statistics suggest the hypothesized measurement model is a good fit for the study measures.

Variance extraction was then calculated and is displayed in Table 3. The factor loadings in Table 3 are statistically significant with t-values > 2 (p<.05) and large loadings greater than 0.45. In addition, the composite reliabilities are greater than 0.70 and the variances extracted are greater than or equal to 0.50. These measurements indicate strong discriminant validity and good evidence of data reliability.
The measurement model suggests the constructs have reasonable properties and are appropriate for analysis and interpretation.

### TABLE 3
Factor Loadings and Measurement Properties of Study Constructs

<table>
<thead>
<tr>
<th>Item</th>
<th>Loading</th>
<th>t-value</th>
<th>Variance Extracted</th>
<th>Highest R²</th>
<th>Average R²</th>
<th>Reliability</th>
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<td>Clinical Nurse Identity</td>
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<tr>
<td>I1</td>
<td>0.71</td>
<td>8.75</td>
<td>0.56</td>
<td>0.71</td>
<td>0.56</td>
<td>0.80</td>
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<tr>
<td>I4</td>
<td>0.70</td>
<td>8.60</td>
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<td>I11</td>
<td>0.84</td>
<td>11.67</td>
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<tr>
<td>Self-Efficacy</td>
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<tr>
<td>SE 1</td>
<td>0.95</td>
<td>14.70</td>
<td>0.86</td>
<td>0.90</td>
<td>0.86</td>
<td>0.95</td>
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<tr>
<td>SE 5</td>
<td>0.90</td>
<td>11.39</td>
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</tr>
<tr>
<td>SE 6</td>
<td>0.94</td>
<td>14.64</td>
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<tr>
<td>Behavioral Beliefs</td>
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<td></td>
<td></td>
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<tr>
<td>BB 1</td>
<td>0.84</td>
<td>12.29</td>
<td>0.83</td>
<td>0.91</td>
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<td>BB 2</td>
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<td>14.21</td>
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<tr>
<td>BB3</td>
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<td>Social Norms</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>SN 1</td>
<td>0.81</td>
<td>11.78</td>
<td>0.50</td>
<td>0.63</td>
<td>0.46</td>
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<tr>
<td>SN 3</td>
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<td>5.98</td>
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<td>SN 7</td>
<td>0.76</td>
<td>10.32</td>
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<tr>
<td>Attitude Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AM 2</td>
<td>0.87</td>
<td>12.82</td>
<td>0.53</td>
<td>0.47</td>
<td>0.46</td>
<td>0.71</td>
</tr>
<tr>
<td>AM 3</td>
<td>0.69</td>
<td>8.60</td>
<td></td>
<td></td>
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</tbody>
</table>

Notes: Loading represent the standardized estimates produced by AMOS. T-values are all significant at $p < 0.05$. Variance extracted is based on formula of Fornell and Larcker (1981) Highest R2 is the highest variance shared between the construct. Average R2 is the average variance shared between this construct and is computed as the square of the average of the squared correlations. Reliability is based on the formula of Fornell and Larcker (1981).
Structural Equation Model of the Study

Using AMOS a structural model was constructed of the hypothesized model using latent constructs adjusted for measurement error. For the purpose of comparing the intercorrelations, composites were calculated taking the average of the items loading for that particular construct for the confirmatory factor analysis. The intercorrelation among the composite variables is shown in Table 2 with values that range between 0.12 and 0.64, another evidence of discriminant validity.

Overall model testing and goodness of fit. The estimated coefficients of the model (Table 4) were analyzed for goodness of fit. The initial model provided the following fit statistics: CHI=125, $p=0.00$ NFI=0.89, CFI=0.94, RMSEA=0.09 and SRMR=0.07. Adjusting for measurement error was accomplished by fixing the error variance of each construct to the difference of the observed and true variance; this provides more accurate interpretation of construct relationships and interpretation of the hypothesized model. A respecified model produced the following fits statistics: CHI=118, $df=70$ NFI=0.90, CFI=0.96, RMSEA=0.08 and SRMR=0.06. Table 4 shows the initial and final coefficients that are graphically displayed in Figure 3.
These statistics determined that the model in Figure 3 was suitable for analysis and provided an acceptable representation of the data.

TABLE 4  Estimated Coefficients for the Nomological Relationships

<table>
<thead>
<tr>
<th>Variables</th>
<th>Initial Coefficient</th>
<th>Final Coefficient</th>
<th>t-value</th>
<th>$R^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attitude</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Beliefs</td>
<td>0.923</td>
<td>0.923</td>
<td>6.75</td>
<td>.89</td>
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<tr>
<td>Social Norm</td>
<td>0.439</td>
<td>0.439</td>
<td>4.169</td>
<td></td>
</tr>
<tr>
<td>Self Efficacy</td>
<td>-0.257</td>
<td>-0.257</td>
<td>-2.70</td>
<td></td>
</tr>
<tr>
<td><strong>Identity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude</td>
<td>-0.858</td>
<td>-0.858</td>
<td>5.480</td>
<td>.74</td>
</tr>
</tbody>
</table>

Note all coefficients are estimate standard coefficients. Bold coefficients have $p < .05$
RESEARCH FINDINGS

After determining that the model fit was acceptable, the findings were analyzed as follows.

**Structural Coefficient and Hypothesis Testing**

Table 4 displays the estimated coefficients of the proposed model. The results suggest that three of the four hypothesized relationships are supported. In addition, identity and attitude are statistically significantly related at $R^2 = .74$ and $R^2 = .89$, respectively.

With regard to H1, behavioral beliefs have a strong direct relationship to attitude ($\beta = 0.923, p < .001$). When the nurse believes that transitioning to manager is an effective change and when weighing the pros and cons of being a manager, feels it is beneficial to become a manager, there is a strong positive relationship to attitude.

Likewise, the effect of social norms on attitude is significant, but not quite as strong as are behavioral beliefs ($\beta = 0.439, p < .001$). Social norms, when defined as what others who are deemed influential by the transitioning nurse think about the transition to nurse manager, have a positive influence on the nurse’s attitude about managing.

Results of testing the third hypothesis suggest that self-efficacy significantly influences the attitude of the nurse about transitioning to manager ($\beta = 0.257, p > .05$). This effect, however, is not consistent with the predicted effect. The effect of self-efficacy on attitude is negative, not positive. The new nurse manager is confident about the ability to lead and manage, but the reality of stress and the complex workload may erode that confidence.
The last tested effect was that of attitude on identity. The effect is negative and strong ($\beta=-0.858 \ p>0.001$). As the nurse’s attitude about management improves, attachment to clinical nurse identity decreases.

The moderators selected for testing included basic educational preparation level, presence of a graduate degree and the presence of a role model. The only moderator that has a statistically significant effect is the presence of a role model. When the data were split into two groups, role model or no role model, the model produced an invariant result with model fit statistics as follows: $\text{CHI}=438$, $\text{NFI}=0.91$, $\text{CFI}=0.90$. The model is not significantly different from the baseline model in terms of fit ($p$-value =0.37). Table 5 shows the coefficients of the moderating effect of role model.

**TABLE 5**

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Final Model</th>
<th></th>
<th>No Role Model</th>
<th></th>
<th>Yes Role Model</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Coefficient</td>
<td>T value</td>
<td>$R^2$</td>
<td>Coefficient</td>
<td>T value</td>
<td>$R^2$</td>
</tr>
<tr>
<td>Attitude</td>
<td>0.923</td>
<td>6.75</td>
<td>.89</td>
<td>0.796</td>
<td>5.352</td>
<td>.68</td>
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<tr>
<td>Behavioral Beliefs</td>
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<td>4.169</td>
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<td>Social Norms</td>
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</tr>
<tr>
<td>Identity</td>
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<td>-5.480</td>
<td>.74</td>
<td>-0.789</td>
<td>-2.834</td>
<td>.61</td>
</tr>
</tbody>
</table>

Note all coefficients are estimate standard coefficients. Bold coefficients have $p<0.05$

When tested for moderation effect, entry into practice preparation and presence of a graduate degree lack effect and are not statistically significant.

**DISCUSSION**

The purpose of this descriptive study is to better understand the staff nurse to nurse manager transition process from the perspective of nurse managers themselves and to discover key barriers to, and enablers of, professional success. This study also seeks to
describe what effect the attachment to a clinical identity has on the transition. The findings offer initial insights that could inform nurse executives addressing the recruitment of nurse managers.

The transition to nurse manager is a major career development, requiring an evolution from a known, current reality to an unknown new reality. A transition of this magnitude requires restructuring goals, behaviors and responsibilities to achieve a new conception of self (Barba & Selder, 1995). Transitions may be facilitated or inhibited by a person's beliefs, attitudes, social norms, preparation and knowledge (Meleis, et al., 2000).

The study may provide predictors of a successful transition, using theoretical and pragmatic considerations; two variables were selected and will now be discussed each in turn. If attitude toward management is strong stemming from beliefs about positive behavioral outcomes as well as confidence in the support of important others, nurse managers will be more likely to reduce their staff nurse identity. Conversely, lower assessments of efficacy and control, less reassuring beliefs about behavioral outcomes and lower perceptions of social support that sequentially and negatively affect attitude about management create a strong clinical nurse identity.

**Attitudes about management.** The ability of the staff nurse to make the transition to nurse manager is argued to require a change in identity (Hill, 1992). Staff nurses, who have a strong psychological connection to nursing and caring for patients, may be reluctant to cease to provide direct patient care (Dykstra, 2003). Two of the independent variables, social norms and behavioral beliefs, are statistically significantly and positively correlated to attitude about management. It appears that nurses engaging in the transition to management exhibit positive beliefs about their promotion, perhaps feeling that they could make a
significant contribution to the improved clinical outcome of the patients in the new role, consistent with beliefs about nurses being caring and called to their work.

With regard to social norms, also positively correlated with attitudes about management, it appears that when others with potential influence on the attitudes of the nurse manager have a strong and positive image and appreciation of the managerial role the nurse’s attitude is positively impacted. It could be interpolated from the data that nurse managers with a positive attitude about management are surrounded by influential people who have no ambivalence or confusion about the role of the nurse manager. The participants in the study report perceptions that subordinates, superiors and significant others endorse the new role and support their decision to pursue management. If the nurse manager role were to lack legitimacy among critical constituencies it could result in a deleterious effect on the recruitment of high potential nurse managers and on their retention.

Contrary to the third hypothesis, in this study self-efficacy is statistically significantly and negatively correlated to attitude about management. Rubin (1984) identifies a period of mourning experienced by a new mother after the baby is born. Similarly, a new nurse manager may feel less efficacious during the transition to nurse manager as the breadth and depth of the workload, challenging interpersonal relationships, and scarcity of positive feedback about management performance emerge. Confidence and a sense of accomplishment may be replaced with disappointment, fatigue and frustration.

Commitment to clinical nurse identity. The ability of the staff nurse to make the transition to nurse manager is argued to require a change in identity (Hill, 1992). In this study staff nurses who have a positive attitude toward management exhibit a weaker psychological connection to caring for patients, shown by the negatively correlated
relationship between attitude about management and attachment to clinical identity. This study suggests that nurse managers who lack a positive attitude about management retain a strong commitment to staff nurse identity. The nurse managers successfully making the transition did not carry their clinical care giver identity commitment into the managerial arena.

The findings suggest the need for two specific levels of education for the transitioning nurse manager; one focused on managerial knowledge, skills and competencies and the other on the nature of relinquishing the role of the staff nurse for the role of the manager. New nurse managers could be coached through the feeling of “being” of management. Bandura (1997) argues not just critical cognitions, but “feelings,” influence attitudes and behaviors. When the new nurse manager has a sense of being in the new role, a sense of comfort emerges and the transition can be considered successful.

**Moderators.** The concept of role model is used in the study as a moderator. There is a significant positive difference between the groups when a role model is used. The relationship between attitude about management and clinical nurse identity is stronger in the group identifying the use of a role model. Role models may provide guidelines about how nurse manager behavior is enacted. Nurses in this study have role models that they perceive help them formulize the expectations of the nurse manager role. Nurses transitioning to management may find learning from a role model, not only a benefit to acquire good skills, but a comfort when navigating new terrain.

Educational preparation did not have a statistically significant impact in this study. It could be postulated that the self perception of success or the satisfaction gained from the transition is not rooted in education aimed at clinical care.
IMPLICATIONS

This study suggests that more consideration regarding the selection and training provided to nurse managers might heighten commitment to the role and improve performance. Nurse managers are customarily selected on the basis of their performance and tenure as clinicians rather than on the basis of their attitudes, beliefs and skills particular to management. Unlike most other work contexts where management is recognized to require formal preparation and lifelong learning, nurse managers are expected to learn the role “on the job.” The findings suggest that there are important differences in the attitudes and beliefs that motivate excellence in nursing and those that drive high performing managers. The study proposes that an outstanding staff nurse does not necessarily make an effective and satisfied manager. In addition, the study suggests that attitude assessment in the nurse manager selection process might help to distinguish those individuals capable of the identity adjustment required in the transition from staff nurse to nurse manager. It also highlights the need for systematic preparation and continued educational opportunities for the nurse manager to navigate the identity adjustment.

Role models provide support while a new nurse manager shifts from staff nurse to nurse manager that helps achieve a sense of harmony, confidence, and satisfaction in the role. Guidance and assistance in selecting a role model as an integral component of the promotion process could significantly improve the staff nurse’s successful role transition.

The critical role of nurse managers in today’s challenging healthcare environment is increasingly apparent. Their full and spirited commitment to the job is required if the nursing profession, now facing an escalating decline in numbers, can be expected to rebound and to meet the nation’s growing healthcare demands. The implications of our study are clear. The
profession needs to rethink how nurses are managed and who is chosen to transition into the role.

LIMITATIONS

A limitation of this study is the size of the sample. Although the sample mirrors the gender and age of the population of nurse managers, the sample size of 100 does not allow for extensive generalization of the findings.

Compounding the small sample, the anonymity of study precluded the researcher from returning to the participants for clarification of any item not clearly answered. Another limitation is the limited geographical distribution of the sample. All of the study participants are from hospitals in the Mid-Atlantic area of the country. Since none of the hospitals held magnet status or practiced self governance at the time of the data collection, no testing for that effect could be done.

FUTURE RESEARCH

Recommendations for future research include exploring how blending values of management and values of nursing may contribute to successful transition from staff nurse to nurse manager. Research that contrasts the attitudes and beliefs of nurse managers who have received guidance from role models and managerial education with those who have not is suggested.

Another concept not researched in this study is the effect of culture on the transition to nurse manager. The philosophy of the nurse executive may influence the staff nurse during the transition, with the endorsement of role models. In addition, a study that examines how differences in educational preparation related to areas other than clinical care impact the transition from staff nurse to nurse manager could be helpful.
APPENDIX A
Survey Explanation Letter

Date

Dear Nurse Leader,

You are being asked to participate in a research study about enablers and barriers of the transition from clinical nurse to nurse leader. You were selected as a possible participant because you are a registered nurse who has been promoted to role of nurse leader from staff nurse. The purpose of this study is to better understand the transition the clinical nurse travels on the road to nursing leadership. Researchers at Case Western Reserve University, Cleveland, Ohio, are conducting this study.

To participate in this research, please complete the enclosed confidential survey and return it to us using the enclosed postage-paid envelope. It should take no longer than 15-20 minutes to complete. By doing this, you are consenting to be a part of this study. As a token of my appreciation, I would be happy to send you a summary of my results.

I want to assure you that your participation is completely voluntary. There are no foreseeable risks or direct benefits to participating in this study. Whether you choose to participate in the study or not will not affect your job or standing within your hospital or place of employment. You will have access to the final research results, if you choose, and those findings may contain insights that could be of benefit to you in the future in your work.

I want you to know that no one in your organization will ever have access to your individual responses or have the ability to trace your individual response. Our University’s review board is responsible for protecting human participants, regulatory agencies, and sponsors and funding agencies (contact: CWRU-IRB@Case.edu). Other than the researcher listed below, only the University’s review board can choose to have access to the individual responses.

If you have any questions please feel free to reach me at the phone/email contacts provided below.

Sincerely yours,

Pamela Hudson
515 Eaton Way
West Chester PA
610-696-6981
Pchudson@verizon.net
APPENDIX B
Survey Tool

By responding to this survey, you are affirming your consent to participate in this research project. No additional paperwork is required. Your individual responses will always remain completely confidential.

Nurse manager is one who manages healthcare providers caring for patients on a daily basis.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. I will always think like a nurse.  
2. I have held firmly to what I believe a nurse should do.  
3. I am unlikely to change my views about being a clinical nurse.  
4. My views about what nurses should do will change.  
5. My beliefs about bedside nursing are firmly held.  
6. I am unlikely to alter my views about clinical nursing.  
7. Regarding clinical nursing, my values will never change.  
8. I have definite views about how nurses should behave.  
9. My ideals about clinical nursing will never change.  
10. My role as a staff nurse was more meaningful than my nurse manager role.  
11. I am sure that the values I hold about nursing are right for me.

**Beliefs about my behaviors as nurse manager, Azjen 2004**

1. I believe I make a contribution every day as the nurse manager.  
2. I believe I have more impact on patients care in the management role.  
3. For me, doing the job of the nurse manager is positive.  
4. I believe I make a positive impact on the lives of patients as a nurse manager.  
5. Agreeing to be the nurse manager was good for my career.  
6. Being the nurse manager allows me to make a significant contribution to the patients.

**Self Efficacy, Bandura 1994**

1. I have the talent to be a good nurse manager.  
2. I know I have the talent for the nurse manager role.  
3. I am confident that I can be the nurse manager.  
4. I have the skills necessary to be a competent nurse manager.  
5. I feel I am qualified to be the nurse manager.  
6. I feel confident that I am a good nurse manager.

**Attitudes about nursing management**

1. I do not miss the gratification I got while taking care of patients.  
2. I find meetings are informative and pleasurable.  
3. I do not miss my role as a staff nurse.  
4. Coming to work each day as the nurse manager is fun.  
5. Being the nurse manager allows me to network with people I would never have met as a staff nurse.  
6. I am not sad when I do not take care of patients.  
7. I do not miss being in the clinical nurse role.  
8. As a staff nurse I would socialize with the other staff, but now they do...
not ask me to go out to have fun with them.

9. It was not difficult for me to let go of my clinical responsibilities.

10. I am satisfied with my role as the nurse manager.

11. I enjoy wearing street clothes to work.

12. I enjoy nursing management.

Social Norms about being a nurse, Azjen, 2004

1. Nursing managers outside of the organization supported my decision to move into nursing management.

2. My parents were proud when I was promoted into a nursing management role.

3. The nursing staff on my unit encouraged me to become the nurse manager.

4. My clinical peers encouraged me to step up and be the nurse manager.

5. Management inside my organization supported my decision to become the nurse manager.

6. Physicians encouraged me to become a nurse manager.

7. My significant other supported my decision to move into nursing management.

8. I was encouraged by my family to be nurse manager.

DEMOGRAPHICS

Please indicate you answer by checking the appropriate response:

9. My sex is:
   - Male
   - Female

10. My age is:
    - 20 – 30 years
    - 31 – 40 years
    - 41 – 50 years
    - 51 – 60 years
    - 61 – 70 years
    - Greater than 70

11. My original nursing education was:
    - Diploma
    - BSN
    - Associate Degree

12. Highest degree attained:
    - Diploma
    - Associates in Nursing
    - Bachelors in Nursing
    - Masters in Nursing
    - Masters in other discipline
    - Bachelors in other discipline
    - Doctorate in Nursing
    - Other doctorate

13. I have been a nurse manager for:
    - 0-11 months
    - 1 to 5 years
    - 6 to 10 years
    - 11 to 15 years
    - 16 to 20 years
    - 21 years to 30 years
    - 31 to 40 years
14. I have been a nurse for:

[ ] 0-11 months  [ ] 1 to 5 years  [ ] 6 to 10 years
[ ] 11 to 15 years  [ ] 16 to 20 years  [ ] 21 years to 30 years
[ ] 31 to 40 years  [ ] 41 to 50 years  [ ] 51 to 60 years

15. I work in an enterprise with magnet status:

[ ] YES  [ ] NO

16. Nursing uses shared governance at my enterprise:

[ ] YES  [ ] NO

17. The following best describes the setting I work in:

[ ] Outpatient clinic  [ ] Physician office  [ ] Hospital
[ ] Marketing and Sales  [ ] Other

18. My area of responsibility has an average daily census of ________________.

19. Before I assumed the role of nurse manager my title was __________________ and I was working on ____________________ unit.

20. In my career, I have experienced the guidance of a management mentor to use as a model for my management behavior.

[ ] YES  [ ] NO

21. I work in an environment in which patient care is delivered each day.

[ ] YES  [ ] NO
REFERENCES


Thyer, G. 1998. Dare to be different: Transformational leadership may hold the key to reducing the nursing shortage. *Journal of Nursing Management*, 11: 73-80.