PERCEPTION OF NURSING EMPOWERMENT AND INTENT TO STAY

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ABSTRACT

Nursing turnover and the evolving nursing shortage has continued to receive much attention from health care organizations. It is predicted that there will be 1.2 million job openings in nursing by 2020. Work empowerment has been associated with organizational commitment and intent to stay in current job. The purpose of this study was to evaluate if there is a relationship between the perception of organizational structural empowerment and intent to stay. The theoretical framework utilized was Kanter's Structural Theory of Organizational Empowerment. The population for the study included 1,159 nurses in a large, nonprofit, Midwest medical center. Data was collected through an online survey with a response rate of 22.7%. The overall results demonstrated perceived moderate levels of structural empowerment. Higher structural empowerment scores were noted in the respondents indicating intent to stay. The research demonstrated a positive correlation between empowerment scores and intent to stay.

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I would like to thank my husband, Rob and my children, Adam and Kelsey, for their patience and continuing support and encouragement. Thank you to Rob and Kelsey who never complained about the hours spent away. Thank you to Adam for reading and editing countless papers as I worked my way through each course. They had faith in me even when I was lacking the confidence to complete the Master of Science program.

DEDICATION

This thesis is dedicated in honor of my brother, Craig Muscha, who was determined to live life to the fullest and knew the importance of living out ones dreams. I am eternally grateful for the opportunity to spend his last days with him and his beautiful family.

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CHAPTER ONE. INTRODUCTION

Background and Significance

Nursing turnover and the evolving nursing shortage has and continues to receive much attention from health care organizations, researchers, academic institutions, and healthcare accreditation organizations. It is predicted that there will be 1.2 million job openings in nursing due to growth and replacement by 2020 (American Association of Colleges of Nursing, 2012). Turnover of nursing staff is costly for an organization. The cost incurred for replacing a nurse results from the hiring process, training, and maintaining competency. According to the Joint Commission on Accreditation of Health Care Organizations (2004), the average cost to replace a registered nurse is approximately 100% of the nurse's annual salary. This translates to approximately $46,000 for a medical/surgical nurse and $64,000 for a critical care nurse. In 2007, keeping with the cost of inflation and factoring in the loss of productivity when training a new nurse, Jones (2008) estimated the cost to have increased to $82,000 - $88,000. The cost varied depending if an experienced nurse filled the position or a new nurse needing a longer orientation and with additional learning needs filled the position.

The national voluntary turnover rate for nursing in hospitals reported by PricewaterhouseCoopers' Health Research Institute in 2007 was 8.4% (2007). PricewaterhouseCoopers' Health Research Institute (PwCs' HRI) provides perspectives and analysis on trends affecting all health-related industries through primary research and collaborative exchange with executive decision makers in healthcare. (PricewaterhouseCoopers' Health Research Institute, 2007). A national retention survey representing 145 healthcare facilities in 31 states, reported that nurse turnover increased significantly to 14.2% in 2010. National turnover rate decreased to 11.2% for 2011 and increased to 13.1% from January 2012 to

December 2012 (Nursing Solutions, 2013). The 2007 national turnover rate for nurses who voluntarily left their positions within the first year was 27.1%. In 2010, first year turnover was down slightly at 26.2%. In 2007, nearly 23 % of the nurses employed in United States hospitals planned to leave their current job within the next year. For nurses over the age of 30, this figure was 33.64%. Almost 55% would not recommend the profession as a career choice. Despite first year turnover showing a decrease, the voluntary turnover rates for high performing nurses has increased from 3.7% to 4.3% between 2008 and 2010, leaving less expertise at the bedside. High performing nurses are defined as those within the top 20% of an organizations management system (PricewaterhouseCoopers' Health Research Institute, 2007, 2013). According to the Institute of Medicine (2010), baby boomer nurses are beginning to age out of the workforce, as recent health reform laws are expected to increase the demand for health care and increase the need for additional nurses. Baby Boomers are defined as the generation of Americans who were born following World War II, between 1946 and 1964 (US Census, 2011).

Turnover presents great concern as to how to keep adequate, competent nurses at the bedside. The American Association of Colleges of Nursing (2007) reported the national registered nurse vacancy rate in 2007 was 8.1%. High turnover rates have been associated with a decrease in patient safety. Nursing units with lower turnover have reported a lower number of incidents including medication error, patient falls, and increased patient satisfaction scores. Units with low turnover demonstrate workgroup cohesion and relationship coordination that correlates with increased work group learning (Bae, Mark, & Fried, 2010). According to the Joint Commission (2004), inadequate staffing levels have contributed to 24% of sentinel events – unanticipated events that result in death, injury, or permanent loss of function for patients. Other factors contributing to sentinel events include patient assessment, caregiver orientation and

training, communication, and staff competency. These factors all directly or indirectly relate to nursing turnover and the difficulty it presents in maintaining competent staff. Although indirectly related to turnover, organizational cost of sentinel events, patient falls, and medications errors, are not calculated into the reported cost of turnover.

Research evaluating turnover rates has established that employee engagement and satisfaction in his or her work are important predictors of intent to stay with one's current job and organization (Laschinger & Finegan, 2005). According to PricewaterhouseCoopers' Health Research Institute (2007), most hospital executives believe that the nurse workforce is dissatisfied, but most do not believe this to be true of the nurses in their own organization. A landmark study by Kanter indicated that empowerment in work environments is likely to promote job satisfaction, engagement and increase intent to stay (Kanter, 1977). In another landmark study by Kim, Price, Mueller, and Watson (1996), Intent to stay was defined as the likelihood that an individual would continue employment with an organization.

Kanter considered work place power as one's ability to mobilize material resources and human resources to achieve the goals of the organization (1977). Power can be described as formal or informal. Formal power is defined as job specific characteristics and related to an individual's hierarchical position within an organization. Informal power is relationship based and is defined as the influence one can exert in the context of his or her relationships with others in the organization (Kanter, 1977). Nursing empowerment is a state in which the individual nurse has the ability to control his or her own professional practice, allowing for achievement of individual personal goals, while fulfilling professional nursing responsibilities that contribute to the success of organization (Laschinger, Finegan, Shamian & Wilk, 2001). According to Moore

and Hutchison, work settings that have empowerment structures increased employees' sense of respect, trust, and organizational justice (2007).

Investigating factors that correlate with increased empowerment should take precedence for healthcare organizations. Gaining understanding into the empowerment structures of an organization is the first step in the process to decrease nursing turnover, promote intent to stay, and decrease costs associated with staff turnover. In a national hospital survey done in 2013, 88.2% of the organizations surveyed perceived retention strategies as a key initiative for their organization to prevent turnover, yet 51.8% lacked a formal plan focusing on these strategies. It is essential for an organization to implement a plan to protect their human capital resources and investments (Nursing Solutions, 2013).

Statement of the Problem

The overall nursing turnover rates at the Midwest acute care hospital involved in the research project was reported as 14.5% from April 2011 to March 2012 in comparison to 11.8% from April 2010 to March 2011. Turnover is defined as the number of registered nurses and licensed practical nurses who were termed from the organization during the identified time period. Termed or turnover is defined as those nurses who left the organizations for any reason – voluntarily or involuntarily (Sanford Health, 2012). The percent is calculated by dividing the number of termed nurses by the number of active nurses. The number of active nurses is calculated by adding the total number of employed nurses on the last day of each month and dividing by the number of months in the reported period. Turnover rates on each individual unit do not include nurses who transfer to other units within the organization. The turnover rates on individual patient care units varied from zero to 26.5%. Despite tracking turnover rates on a monthly, quarterly, and annual basis, and with global retention efforts occurring in the

organization, this overall turnover rate represented a 2.7% increase over the 11.8% rate reported in the previous twelve months. According to PricewaterhouseCoopers' Health Research Institute, every percentage point increase in nurse turnover costs an average hospital approximately $300,000 annually (2007). This equates to an estimated cost increase of $810,000 for the organization involved in the study from 2011 to 2012.

Examples of current retention strategies utilized by the organization include specialty certification support, recruitment bonus, continuing education opportunities, opportunities for involvement on organizational and nursing committees, establishment of a nursing senate committee promoting shared governance, nurse residency program for new graduate nurses, and nursing recognition and awards programs. The list is not all-inclusive and does not include the retention strategies being utilized at the individual unit level.

Purpose of the Project

The purpose of this study was: 1) to evaluate the nurse's perception of empowerment in his or her job; 2) to assess intent of nurses to stay in the organization; and 3) to determine if there was a relationship between a nurse's perception of empowerment and his or her self-reported intent to stay in the organization. Kanter's Structural Theory of Organizational Empowerment was used as the research framework. Kanter's theory focuses on structures in an organization that foster empowerment of staff. The current research was designed to gain additional knowledge and understanding of the empowerment structures of the organization and how these structures affect both the individual's perception of formal and informal power in the organization and his or her intent to stay or leave the organization. The knowledge gained provides information needed to assist in the development of effective retention strategies and to decrease nursing turnover.

CHAPTER TWO. LITERATURE REVIEW

Empowerment

An extensive review of the literature revealed many studies related to empowerment in nursing. Much of the research has been done by Laschinger and colleagues (Laschinger & Havens, 1996; Laschinger, Finegan, Shamian & Wilk, 2001; McDermott, Laschinger, & Shamian, 1996; Laschinger & Finegan, 2005). A synthesis of the literature by Rao (2012) found that although the term *empowerment* was commonly referenced in the literature, it is very difficult to achieve. Only a few of the studies have looked directly at empowerment and its relationship to turnover or intent to stay in an organization (Nebb, 2006; Sourdif, 2003; Lacey, Cox, Lorfing, Teasley, Carroll, & Sexton, 2007; Hill, 2011).

A brief presentation of Kanter's Structural Theory of Organizational Empowerment will be introduced in the literature review because much of the research relates to her theory. Kanter's theory will be discussed in detail in chapter three. Kanter's work on the Structural Theory of Organizational Empowerment originated in the 1970's in the field of business (Kanter, 1977). Kanter believes that empowerment structures of an organization are needed for individuals to achieve their goals within the organization (1977). These empowerment structures include opportunity, information, support, resources, formal power, and informal power.

Minimal research was initially done to test Kanter's theory. Because of the women's movement, interest in power structures was stimulated. Since the nursing profession being predominately female, nurses became more involved in empowerment research (Erickson, Hamilton, Jones, & Ditomassi, 2003). Chandler was the first nurse researcher to test Kanter's theory in nursing (Laschinger & Haven, 1996). The previous research in 1986 demonstrated a relationship between low perceived power and the nonempowering nature of the environment.

The results led to the conclusion that managers needed to move from having power over nurses to adopting a philosophy of empowering nurses (Erickson, Hamilton, Jones, & Ditomassi, 2003).

Additional research looking at empowerment continued into the 1990's. This interest continues to be sparked by the push for hospitals to achieve Magnet status. Magnet recognition provides a template for supporting nurses. The Magnet environment promotes professional growth and partnerships in care (Lacey, et al, 2007). Magnet designation is an award given by the American Nurses Association to hospitals that satisfy a set of criteria designed to measure the strength and quality of their nursing. Magnet hospitals are characterized as delivering excellent patient outcomes, nurses having high levels of job satisfaction, low staff nurse turnover, appropriate grievance resolution, and nursing involvement in data collection and decision-making in patient care delivery. Magnet organizations value staff nurses, have open communication between health care team members, involve nursing in shaping evidence-based nursing practice, encourage and reward them for advancing in nursing practice, and have an appropriate personnel mix to attain the best patient outcomes and staff work (American Nurses Credentialing Center, 2013).

Laschinger, Almost, and Tuer-Hodes (2003) utilized Kanter's model to link workplace empowerment, Magnet hospital characteristics, and job satisfaction using secondary analysis of three previous studies. The purpose of the study by Laschinger and colleagues was to identify factors, such as those found in Magnet hospitals that attract and retain committed and qualified nurses. The identified factors can then be put in place to enhance professional practice and patient safety. The Conditions of Work Effectiveness Questionnaire-II was used for all three studies. The study demonstrated greater access to workplace empowerment structures resulting in higher perception of autonomy and greater control of the practice environment. Access to

resources including materials, supplies, and equipment had the greatest impact on autonomy and control over practice. The perception of informal power had the greatest influence on nurse/physician relationships. Armstrong, Laschinger, and Wong (2008) were able to replicate the results of the afore mentioned study by Laschinger and associates. Armstrong, Laschinger, and Wong surveyed 300 registered nurses working in acute care hospitals across Ontario. The study demonstrated that access to empowerment structures and having an environment that supported professional practice influenced patient safety.

Kanter's theory was also tested by Davies, Laschinger, and Andrusyszyn (2006) examining self-reported perception of empowerment, job tension and job satisfaction in a random sample of nurse educators in central Canada working in a general hospital units or in the in-service education department. The role of nurse educators was multifaceted with the expectations of teaching, counseling, facilitating nurses, and research. The complexity of the nurse educator role caused confusion among nursing staff, administrators, and educators about role expectations. The increased need for more bedside nurses added to the stress of the educator role. Educators in today's environment are challenged to continuously orient new hires and maintain the competency of nursing staff. Staff development is often the target of budget cutting strategies, adding to the stress of the role. In the study by Davies and associates, the Condition of Work Effectiveness Scale was used to measure empowerment structures and the Jobs Activity Scale was used to measure formal power structures in the work environment. The results demonstrated that clinical nurse educators had a high perception of access to opportunity and information directly related to their position in the organization. Consistent with previous studies utilizing Kanter's theory, the results demonstrated that access to work empowerment structures resulted in lower levels of job tension (Davies et al., 2006).

In a study involving 4,584 nurses in multiple facilities in multiple states, perception of empowerment was compared between pediatric and non-pediatric nurses (Cox, Teasley, Lacey, Carroll, & Sexton, 2007). Study results demonstrated that pediatric nurses reported a higher perception of unit support, positive workload, and overall satisfaction compared to nurses working on non-pediatric units. Perception of manager support was low in all groups. The researchers recommended that enhanced communication and visibility on the units by nurse managers might influence nurses' perception of manager support (Cox et al., 2007). No other studies directly comparing the difference in self-reported results of nurses caring for different patient populations were found.

Intent to Stay

Intent to stay has been defined as the likelihood that an individual will continue employment with an organization (Kim, Price, Mueller, & Watson, 1996). Intent to stay has been demonstrated to be a good predictor of turnover (Nebb, 2006). Empowerment was shown to be impact nurses' health and wellbeing as well as an important determinant of organizational commitment, job satisfaction, and turnover (Nebb, 2006). Three studies were identified in the literature that directly assessed intent to stay and variables that affect intent to stay. Sourdif (2004) utilized the Organizational Dynamics Paradigm for Nurse Retention as the framework for the study. Sourdif surveyed a convenience sample of 221 nurses from a large university hospital. A second study by Nebb (2006) utilized Kanter's model to look at empowerment structures and their impact on intent to stay. The regional study included a population of 147,320 registered nurses across the state of Florida. Questionnaires were sent to a random sample of 500 nurses, with a response rate of 42%. Both Sourdif's and Nebb's studies demonstrated that satisfaction at work correlated highly with intent to stay. Satisfaction was related to professional satisfaction,

satisfaction with administration and work cohesion (Sourdif, 2004; Nebb, 2006) which directly correlated with Kanter's empowerment structures of opportunity, information support, resources, formal power, and informal power.

A third study by Kovner, Brewer, Greene, and Fairchild (2009) of newly licensed nurses between January and April of 2006, used a revised version of Price's Theory on turnover that demonstrated work attitudes, job opportunity outside the organization and pay were predictors of job satisfaction and organizational commitment. Low job satisfaction and the lack of organizational commitment led to job searching and lack of intent to stay in the organization. National boards of nursing were contacted for names of registered nurses who were newly licensed from September 2004 to August 2005. Data collection was done through a cross-sectional survey mailed to 14,512 licensed registered nurses across the nation between January and April 2006. Surveys were not returned by 6,005 of the nurses. An additional 4,402 respondents did not meet the participation criteria of being newly licensed nurses. To eliminate possible heterogeneous error the study was further limited to a sample of 1,933. The instrument used for the study measured 22 multi-items. Five of the measures assessed work attitudes and behaviors, fifteen measures assessed attitudes regarding work-related conditions, and two items measured employee affective dispositions. Intent to stay was measured with a four-item Likert scale. The respondents were 92% female, 80% white non-Hispanic, 81.6% had no children living at home, and 52% were married. Findings demonstrated that those who worked mandatory overtime and had higher workloads were less satisfied with their jobs. Those who worked voluntary overtime and reported higher importance of benefits were more satisfied with their jobs. Respondents working eight-hour shifts, working on a general medical-surgical floor, working full-time, and rating the importance of benefits higher were more likely committed to

the organization (intent to stay). Mandatory overtime, having children at home, and non-local job opportunities all demonstrated a negative effect on organizational commitment. One limitation of the study identified by the researchers was that patient load and overtime had not been included in previous intent models. Therefore, it is not known if patient load and overtime were more important to newly licensed RNs compared to the RN workforce in general. One limitation identified in all three of the above studies was that actual turnover rates were not measured and used to evaluate if there was a correlation with self-reported intent to leave (Sourif, 2004; Nebb, 2006; Kovner et al., 2009).

Additional research looked at the relationship of support, workload, and intent to stay comparing Magnet designated hospitals, Magnet-aspiring hospitals, and non-Magnet hospitals (Lacey, et al, 2007). Magnet designation is awarded to hospitals that demonstrate the eight attributes recognized as being essential to quality care. These attributes include: 1) support for education, 2) clinically competent nurses, 3) positive nurse-physician relationships, 4) autonomy in nursing practice, 5) an organizational culture that values concern for the patient, 6) nurses having control of and over nursing practice, 7) adequate staffing of nurses, and 8) high quality nurse manager support (Laschinger, Almost, & Tuer-Hodes, 2003). Magnet defines high quality nurse manager support as 100% of the nurse managers on individual units having at least a baccalaureate degree in nursing. The future Magnet educational requirement for nurse managers is moving towards a master's degree as the minimum. Magnet eligibility requires the Chief Nursing Officer to possess a master's degree and have either a master's or baccalaureate degree in nursing. The Magnet recommendation is to have 80% of all nursing staff to be baccalaureate prepared by 2020. Magnet-aspiring hospitals must have an action plan and demonstrate progress toward meeting the 80% goal for all nurses having a baccalaureate or graduate degree

by 2020 (American Nurses Credentialing Center, 2013). Lacey's research demonstrated that the Magnet program was meeting the intended goal of improving work environments. Nurses of Magnet designated hospitals demonstrated higher perceptions of support, intent to stay, and nurse satisfaction. As might be expected, Magnet-aspiring hospitals demonstrated higher perceptions in all areas of empowerment then non-magnet hospitals. The authors of the study predicted that as the push for improved patient outcomes continues, more facilities will seek the status of Magnet designation (Lacey, et al, 2007).

A study done by Hill in 2010 looked at the differences between clinical bedside nurses (CBNs) and advance practice nurses (APNs) using a cross-sectional, descriptive, comparative design. The purpose of the Hill's study was to understand the impact of the variables of work satisfaction, intent to stay, desires of nurses in the workplace, and financial knowledge of retirement on income in relationship to nursing retention in the acute care setting. A convenience sample of 95 nurses was used in a 371-bed acute care hospital in the Midsouth. The results demonstrated that CBNs and APNs had similar scores across each variable assessed. Significant correlation was found between work satisfaction and intent to stay. Financial knowledge scores were low in both groups. No differences were found between the CBNs and APNs group in desires in the workplace including: acknowledgement of efforts, respect from peers and supervisors, a voice in all-important decisions, kindness of peers and supervisors, opportunity for social activity, honest feedback, and opportunity for growth. Items designed to measure these variables were assessed on a five point Likert scale ranging from one (strongly disagree) to five (strongly agree). The mean scores for all variables ranged from 3.4 to 4.6 in both groups. Opportunity for growth scored the highest overall mean score between the two groups with the APNs group scoring 4.6 and the CBNs group scoring 4.5. Opportunity to

socialize scored lowest (3.4) for both groups. The results demonstrated that high levels of work satisfaction correlated with higher intent to stay within the profession. The data also suggested that relationships are important to work satisfaction and intent to stay. The Hill suggested that organizations direct resources towards the development of relationships among coworkers and supervisors in the study. The participation of only 31 nurses in the APNs group in comparison to 64 nurses in the CBNs group was identified as a limitation to the study (Hill, 2011).

Summary

Empowerment was shown to be fundamental to nurses' health and wellbeing as well as an important determinant of organizational commitment, job satisfaction, and turnover (Nebb, 2006). As previously stated, work settings having empowerment structures increased employees' sense of respect, trust, and organizational justice (Moore & Hutchison, 2007). These concepts have been repeatedly validated in research utilizing Kanter's structural theory of organizational empowerment and utilizing the Conditions of Work Effectiveness Questionnaire–II to assess perception of empowerment structures. In a synthesis of the literature, Rao concluded that although the term empowerment is commonly referenced in the literature, it is very difficult to measure and achieve (2012).

In summarizing the literature, there has been multiple research studies utilizing Kanter's model to evaluate the degree of impact that structural empowerment has on nursing job satisfaction, performance, stress, and patient safety. The belief that these structural empowerment characteristics are present in Magnet hospitals has been demonstrated. There is little research correlating intent to stay with empowerment structures. In addition, no studies were found that compared self-reported intent to stay with actual measured turnover statistics. The current study will add to the body of knowledge related to intent to stay and empowerment

and will provide a future opportunity for direct comparison of self-reported intent to stay and actual measured turnover statistics.

CHAPTER THREE. THEORETICAL FRAMEWORK AND RESEARCH DESIGN

Framework

Kanter's Structural Theory of Organizational Empowerment provided the framework for the current study (Figure 1). The framework was derived from Kanter's work in the field of business (1977). Most nursing research utilizing Kanter's Structural Theory of Organizational Empowerment began in the 1990's (Laschinger, 1996; Laschinger, Finegan, Shamian, & Wilk, 2001; Nebb, 2006).

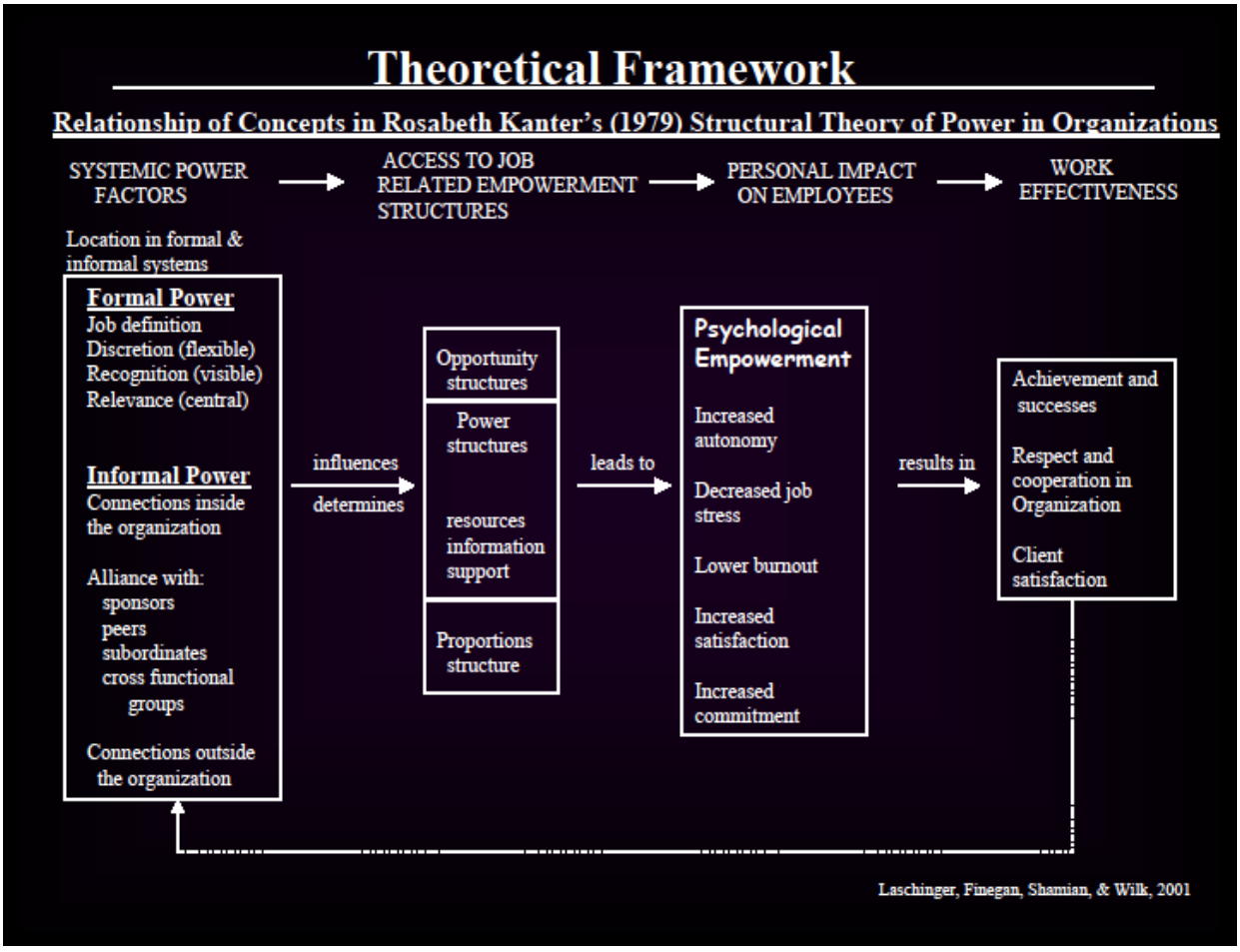

Figure 1. Kanter's Structural Theory of Organizational Empowerment –used with permission from Laschinger, 2011

The assumptions of Kanter's theory demonstrate that attitudes and behaviors toward work do not result from individual personalities only. Attitudes and behaviors also develop in

response to situations within the organization and an individual's position in the organization (1977). Power is one determinant of organizational behavior. Kanter defines power as "the ability to get things done, to mobilize resources, and to get and use whatever it is that a person needs for the goals he or she is attempting to meet" (Kanter, 1977, p.166). Kanter believes that power or structural empowerment originates from three separate sources: formal power, informal power, and organizational empowerment structures. Structural empowerment is impacted by the extent to which employees have access to these empowerment structures in his or her work environment. Kanter supported the belief that one's position in an organization determines ease of access to empowerment structures. These empowerment structures influence psychological empowerment and assists employees to reach organizational goals (Kanter, 1977).

Kanter's theory (1997) identified four organizational empowerment structures that are critical for growth of structural empowerment. These structures include access to information, support, access to resources, and an environment that provides opportunity to learn and grow. Kanter defined these structures:

- *Information* means an access to knowledge, data, and the expertise required for one's job.
- *Support* refers to feedback, guidance, and emotional support from peers.
- *Resources* mean having the ability to acquire necessary materials, supplies, and equipment, to carry out the work of the organization.
- *Opportunity* is defined as expectations for growth and mobility and future prospects (Kanter, 1977).

In addition, Kanter's theory indicates that both formal power and informal power influences access to the four empowerment structures (Kanter, 1977). Kanter defines formal and informal power:

- *Formal power* is defined as the visibility and relevance of one's role in the organization and the flexibility it offers.
- *Informal power* refers to the relationships and networks developed within an organization and outside of the organization.

The theory expresses that the burden of powerlessness of individuals is related to inadequate exposure to the four empowering workplace structures (Kanter, 1977). Empowerment has been demonstrated to increase work effectiveness, increase motivation, decrease levels of burnout, increase job satisfaction, and increase organizational commitment (Davies, Laschinger, & Andrusysyzn, 2006).

Research Question and Research Hypothesis

The research question for the study was Do perceived formal power, perceived informal power, and perceived access to work empowerment structures have a positive impact on intent to stay? The research hypothesis was:

Perceived formal power, perceived informal power, and perceived access to work empowerment structures have a positive relationship with intent to stay.

Conceptual and Operational Definitions

The variables in the study were assessed using the *Conditions of Work Effectiveness Questionnaire- II* (CWEQ-II). The variables included opportunity, support, information, resources, formal power, informal power, global empowerment, structural empowerment, and intent to stay. These variables were assessed using the *Conditions of Work Effectiveness*

Questionnaire- II (CWEQ-II) and four intent to stay questions. The CWEQ-II is a self-reported questionnaire. The CWEQ-II subscales measure the individual's perception of each of Kanter's organizational empowerment structures; opportunity, support, information, resources, formal power and informal power and includes two global empowerment questions. The subscales are scored on a 5-point Likert scale with responses ranging from 1 to 5 indicating "none" to "a lot" and some questions self-reported on the 5-point Likert scale ranging from 1 to 5 indicating "no knowledge" to "know a lot".

The following conceptual and operational definitions provide an understanding of variables used as well as how the variables were measured in the study:

- *Opportunity* was conceptually defined as a sense of challenge and the chance to learn and grow within the organization. Also included was the autonomy one has in his or her current position. The operational definition was the score obtained on the CWEQ-II opportunity subscale. Score range is from 1 to 5 with higher scores representing a perceived stronger access to opportunity (Laschinger, Finegan, Shamian, & Wilk, 2001).

- *Information* was conceptually defined as the technical knowledge, data, and expertise required for one's job. Included were access to data and information at both the job level and the organizational level (Laschinger, 1996). The score obtained on the information subscale score on the CWEQ-II defined information operationally. The score range is from 1 to 5 with higher scores representing a perceived stronger access to information (Laschinger, Finegan, Shamian, & Wilk, 2001).
- *Support* was conceptually defined as the guidance and feedback that enhances one's effectiveness in the organization. Included was feedback from one's supervisors, peers

and subordinates (Laschinger, 1996). The operational definition of support was the score obtained on support subscale of the CWEQ-II. The score range is from 1 to 5 with higher scores representing a perceived stronger access to support (Laschinger, Finegan, Shamian, & Wilk, 2001).

- *Resources* were conceptually defined as the ability to acquire necessary materials, supplies, equipment, and money to do one's job. Included was the necessary time and personnel to accomplish the goals of the organization (Laschinger, 1996). The operational definition of resources was the score obtained on the resource subscale of the CWEQ-II. The score range is from 1 to 5 with higher scores representing a perceived stronger access to resources (Laschinger, Finegan, Shamian, & Wilk, 2001).
- *Formal power* was conceptually defined as having a job that one considers relevant and central to the organization, which offers flexibility and visibility in the organization. Formal power provides the individual with the autonomy needed to be innovative and creative in his or her role (Kanter, 1977; Laschinger, 1996; Laschinger, Finegan, Shamian, and Wilks, 2001). The formal power subscale score obtained on CWEQ-II operationally defined formal power. Score range is from 1 to 5 with higher scores representing a stronger perception of power (Laschinger, Finegan, Shamian, & Wilk, 2001).

- *Informal power* was conceptually defined as a personal sense that evolves from the relationships and networks developed with supervisors, peers, and subordinates. Included are the relationships both inside and outside the organization (Kanter, 1977; Laschinger, 1996). Informal power was operationally defined as the score obtained on the informal power subscale on the CWEQ-II. Score range is from 1 to 5 with higher

scores representing a higher perception of informal power (Laschinger, Finegan, Shamian, & Wilk, 2001).

- *Structural empowerment* was conceptually defined as the ability to mobilize resources to get things done. Included was access to opportunity, information, support, resources, formal power, and informal power needed to promote positive employee outcomes. Structural empowerment was operationally defined as the summed score of all subscale scores obtained on the CWEQ-II. Scores range from 6 to 30. Higher scores represent stronger perception of working in an empowered work environment. Scores ranging from 6 to 13 are described as low levels of empowerment, 14 to 22 as moderate levels of empowerment, and 23 to 30 as high levels of empowerment (Laschinger, Finegan, Shamian, & Wilk, 2001).
- *Global empowerment* was conceptually defined as perception of empowerment in one's job used as a validation index. Global empowerment is defined as the sum and average of the two global empowerment items at the end of the CWEQ-II. Scores range is from 1 to 5 (Laschinger, Finegan, Shamian, & Wilk, 2001). Higher scores represent a stronger perception of working in an empowered environment.
- *Intent to stay* was conceptually defined as an individual's self-reported plan to stay at his or her current job. The operationally definition of intent to stay was the self-reported score on the four intent to stay questions developed by Kim, Price, Mueller, and Watson (1996).

Methodology

The descriptive, correlational study was conducted at a Midwest tertiary hospital. The hospital is licensed for over 500 adult and pediatric beds and is physically located on two

campuses. The population for the study was comprised of 1,159 licensed registered nurses and licensed practical nurses currently employed in the organization. The sample included registered nurses and licensed practical nurses employed full or part-time on outpatient units, medical-surgical units, procedural areas, adult critical care units, pediatric intensive care unit, and one neonatal intensive care unit.

Approval was obtained from North Dakota State University Institutional Review Board and from the organization's Office of Nursing Practice. A letter of support was received from the Chief Nursing Office of the organization indicating agreement of participation from the nurse leaders of each patient care unit involved in the study.

Instruments used in the study included two self-report scales and a demographic questionnaire. The Conditions of Work Effectiveness Questionnaire II (CWEQ-II) developed by Laschinger, Finegan, Shamian, and Wilks (2001) was used. The CWEQ-II is a 19-item questionnaire based on Kanter's structural theory of organization empowerment (Kanter, 1977). The instrument is a self-reported questionnaire, with a 5-point Likert scale ranging from "none" to "a lot" and "no knowledge" to "know a lot". The questions were divided into six subscales. The subscales measured the individual's perception of each of Kanter's organizational empowerment structures: opportunity, support, information, resources, formal power, and informal power. Two additional items, measuring global empowerment, were also included for construct validation purposes. Score were calculated for each of the subscales by averaging the scores of the questions for each subscale. The structural empowerment score was calculated by summing the subscale scores. Scores could range from 6 – 30, the higher the score the higher the perception of empowerment. Scores ranging from 6 – 13 are described as having low levels of perceive structural empowerment. Scores of 14 to 22 indicate moderate levels of perceived

structural empowerment and scores of 23 to 30 demonstrate perceived high levels of perceived structural empowerment. Previous studies have reported Cronbach's alpha reliability coefficient of 0.93 for the CWEQ-II total score and subscale reliabilities from 0.70 to 0.89 (Laschinger, Finegan, & Shamian, 2001). The construct validity of the CWEQ-II has been substantiated using confirmatory factor analysis and demonstrated high correlation with the global measures of empowerment (Laschinger, Almost, & Tuer-Hodes, 2003). A previously validated four-item questionnaire developed by Kim, Price, Mueller, and Watson (1996) was utilized to measure intent to stay on the job. The questions examined an individual's self-reported intent of planning to leave, liking to leave, plan to stay, and under no circumstances plan to leave voluntarily. Demographic information collected included gender, age, educational level, job classification, years of nursing experience, years at current job, years with organization, and unit specific information (Kim et al., 1996).

With the assistance of the department of nursing practice, an online survey was sent out to all nursing staff on the listserv within the organization. An introductory statement on the cover page of the survey explained the purpose of the study and the questionnaires. Participants were informed of the voluntary and confidential nature of the study. Completion of the survey implied consent. Participants were assured that the data would be reported in aggregate form only. Participants were asked to complete the questionnaires online. The participants had the opportunity to end the survey at any time without the data utilized. Survey data was only reported on surveys that were completed in their entirety.

CHAPTER FOUR. RESULTS

Data Analysis

Data collection was completed through the online survey from April 1, 2012 to April 30, 2012. The sample population was 1,169 registered nurses and licensed practical nurses. The sample size was 270 nurses. Seven surveys were not completed entirely and were not included in the data analysis. With 263 surveys completed, the response rate was 22.76%.

Data analysis for the study was guided by the research hypothesis *"Perceived formal power, perceived informal power, and perceived access to work empowerment structure have a positive impact on intent to stay"*. Frequencies were calculated from the demographic variables. Descriptive statistics were calculated for the CWEQ –II and intent to stay information. Relationships of the variables, including the demographic variables, were assessed using Pearson's product-moment correlation coefficients. Self-reported intent to leave was collected to compare to future turnover statistics.

Study findings were presented to the thesis committee, the organization's research committee, office of nursing practice, nurse leaders of the participating units, and the organizational retention committee. As part of the agreement to utilize the CWEQ-II, a copy of the data was also distributed to the author of the tool, Dr. Heather Spence Laschinger, University of Western Ontario.

Sample Demographics

The demographic variables indicated that 98.12% (n=258) were RNs and 1.88% (n=5) were LPNs. Comparison of demographic variables is illustrated in Table 1.

Table 1

Demographic variables indicating frequency and percent

Demographic Characteristics	Frequency	Percent
Gender		
Male	18	6.84
Female	245	93.16
Age		
20-29	120	45.63
30-39	45	17.11
40-49	37	14.07
50-59	57	21.6
60-69	4	1.52
Education		
LPN Associates Degree	3	1.14
LPN Diploma Degree	1	0.38
RN Associate's Degree	27	10.27
RN Diploma	24	9.13
RN Bachelor's Degree	196	74.52
RN Master's Degree	9	3.42
Other	3	1.14
Clinical Practice Area		
Medical –Surgical-Rehab	89	33.84
Critical Care - Adult	40	15.21
Pediatric/Pediatric ICU/NICU	21	7.98
Emergency Department-Observation	21	7.98
Obstetrics/Gynecology	16	6.08
Surgery/Recovery/Day Unit	21	7.98
Procedural Areas-	16	6.08
Psychiatric Areas	6	2.28
Other	29	11.03
Number of years Working in Nursing		
< 1	33	12.55
1 - 5	82	31.18
6- 10	37	14.07
11-15	20	7.06
>15	91	34.06
Number of Years in Current Hospital		
<1	44	16.73
1-5	87	33.08
6-10	47	17.87
11-15	22	8.37
>15	63	23.95
Employment Status		
Full-time	239	90.87
Part-time	19	7.22
PRN	5	1.90

The majority of respondents identified themselves as female (n=245) while only 6.84% identified themselves as male (n=18). The largest group identified themselves as ranging in age from 20-29 (n=120). The smallest group identified his or her age as 60-69 (n=4). The majority of the nurses responding were bachelor prepared registered nurses (BSN). Currently, BSN is the entry level standard for registered nurse hired in the organization. Thirty three percent of the nurses (n=87) had been with the organization for one to five years and nurses with greater the 15 years were the next highest demographic group at 23.95% (n=63). The largest number of nurses responding had greater than 15 years of experience representing 34.6% (n=91). Nurses with one to five years experience were the next largest group at 31.18% (n=82). Nurses working fulltime represented 90.87% (n=239). The primary shift worked by the majority of the nurses was days at 41.44% (n=109), rotating days and nights was the second highest group at 23.57% (n=62).

Results

The Cronbach's alpha reliability coefficient values where calculated for each of the six subscales of the CWEQ- II measuring the reliability of the organizational empowerment structures (opportunity, support, information, resources, formal power and informal power) in addition to the global empowerment scores. The Cronbach's alpha reliability coefficient scores were 0.801 to 0.849, which was significant for demonstrating reliability. These values compared to previous studies reporting values of 0.70 to 0.89 (Laschinger, Finegan, & Shamian, 2001). The Cronbach's alpha coefficient examines internal consistency of the instrument and the extent of which all items in the instrument consistently measure the construct. A score of 1.00 indicates perfect reliability. A score of 0.80 to 0.90 demonstrates an acceptable level of reliability of an instrument (Burns & Grove, 2009). The Cronbach's alpha reliability coefficient for each subscale scores are displayed in Table 2.

Table 2

Cronbach's alpha reliability coefficient scores for the empowerment subscales

Variable (Empowerment Subscales)	Standardized variable correlation with total	Alpha
Opportunity Score	0.471	0.849
Information Score	0.563	0.836
Support Score	0.624	0.827
Resource Score	0.529	0.840
Formal Power Score	0.693	0.816
Informal Power Score	0.6011	0.830
Global Empowerment	0.7923	0.801

The Pearson correlation coefficient (r) measured the strength or linear relationship between the different variables (Burns & Grove, 2009). The Pearson correlation coefficient was calculated for all six subscales and the global empowerment score. Correlation is demonstrated with the possible value being -1.0 to 1.0. A positive correlation indicates all variables increase or decrease together. A value of -1.0 would indicate a perfect negative inverse relationship. In a negative linear relationship, high score on one variable is related to a low score on the other. A value of +1.0 would indicate a perfect positive correlation, indicating a linear relationship of a high score on one variable is associated with a high score on the other variable or a low score on one variable is associated with a low score on another variable. A score of zero indicates no linear relationship. A score of below 0.3 is considered a weak linear relationship, 0.3 to 0.5 as a moderate linear relationship, and scores above 0.5 as a strong linear relationship (Burns & Grove, 2009). The subscores demonstrated positive correlations among all empowerment structures. Table 3 demonstrates correlation for all the subscales

Table 3

Pearson correlation coefficients for the six subscales and global empowerment scores

Pearson correlation coefficients N = 263 Probably > [r] under HO: Rho = 0							
Pearson correlation Coefficient	Opportunity Score	Information Score	Support Score	Resource Score	Formal Score	Informal Score	Global Power Score
Opportunity Score	1.000	0.333 <.0001	0.334 <.0001	0.194 0.0015	0.376 <.0001	0.505 <.0001	.0.392 <.0001
Information Score	03.333 <.0001	1.000	0.430 <.0001	0.362 <.0001	0.443 <.0001	0.383 <.0001	0.550 <.0001
Support Score	0.334 <.0001	0.430 <.0001	1.000	0.400 <.0001	0.551 <.0001	0.447 <.0001	0.579 <.0001
Resource Score	0.194 <.0001	0.362 <.0001	0.400 <.0001	1.000	0.481 <.0001	0.276 <.0001	0.653 <.0001
Formal Power	0.376 <.0001	0.443 <.0001	0.551 <.0001	0.481 <.0001	1.000	0.499 <.0001	0.651 <.0001
Informal Power Score	0.505 <.0001	0.383 <.0001	0.447 <.0001	0.276 <.0001	0.499 <.0001	1.000	0.542 <.0001
Global Power Score	0.392 <.0001	0.550 <.0001	0.579 <.0001	0.653 <.0001	0.650 <.0001	0.542 <.0001	1.000

A simple frequency table was utilized to evaluate the response on the intent to stay or leave questions. The CWEQ-II is contained in Appendix D. The results demonstrated that 42 nurses (15.97%) responded yes, they would like to leave the organization. The largest age group expressing they would like to leave the organization was the 20-29 year old group. Twenty percent of this group indicated they would like to leave and 8.75% indicated they plan to leave their employer as soon as possible.

Two hundred twenty- one nurses (84%) responded they did not want to leave the organization. Two hundred forty nurses (91.25%) responded they did not plan to leave their employer as soon as possible. Ninety- four nurses (35.75%) responded that they agreed with the statement "Under no circumstances will I voluntary leave my present employer. One hundred sixty-nine nurses (64.26%) disagreed with the pervious statement. Nurses with one to five years

of nursing experience were the group that demonstrated the highest percent on the intent to leave question. Eleven nurses in this group (20%) responded they plan to leave the organization as soon as possible.

The mean score for each of the empowerment structure (opportunity, information support resources, formal power, and informal power) subscales and a global empowerment score were calculated by summing and averaging the items. The scores ranged between one and five. Higher scores represented more access to each empowerment structure. Opportunity represented the highest subscale score with a mean score of 4.24. The questions on the opportunity subscale included: how much of each kind of opportunity do you have in your present job; challenging work; the chance to gain new skill and knowledge on the job; and tasks that use all of your own skills and knowledge. The response for 'challenging work' was rated the highest by the nurses. The mean score was 4.35, with one hundred thirty-eight nurses (52.47%) rating it a five indicating 'a lot of challenge'. Two nurses (0.76%) indicated they perceive no challenge in their work. Informal power scored second highest with a mean score of 3.63. The questions asked to assess informal power were: how much opportunity do you have for these activities in your present job; collaborating on patient care with physicians; being sought out by peers for help with problems; being sought out by managers for help with problems; and seeking out ideas from professionals other than physicians, e.g., physiotherapists, occupational therapists, and Dieticians. Respondents rated formal power the lowest with a mean score of 3.10. The questions asked to assess formal power were: in my work setting/job, the rewards for innovation on the job are; the amount of flexibility in my job is; and the amount of visibility of my work-related activities with the institution is. Twenty-seven nurses indicated there were no rewards for innovation on the job and fifteen nurses indicated there was no visibility of his or her work-

related activities within the organization. With 263 participants, Table 4 shows the mean, standard deviation, and number of respondents for each subscale.

Table 4

Empowerment subscale mean and standard deviation scores

Variable	Number	Mean	Standard Deviation
Opportunity	263	4.245	0.763
Information	263	3.165	0.934
Support	263	3.354	0.885
Resources	263	3.169	0.825
Formal Power	263	3.108	0.823
Informal Power	263	3.630	0.762
Global Power	263	3.471	0.913

The structural empowerment scores for all research participants were calculated with a mean of 20.972 indicating a moderate level of perceived structural empowerment. The relationship between total structural empowerment score and desire to leave the organization was also calculated. Forty-two nurses indicated they would like to leave the organization. The group who relied they would like to leave demonstrated a lower mean structural empowerment score of 16.935. The mean structural empowerment score of the nurses indicating they would like to stay with the organization was 21.379. The findings were similar comparing the structural empowerment scores in nurses who responded that they plan to leave the organization as soon as possible. Twenty-three nurses responded they plan to leave the organization. The structural empowerment score for this group was 16.442. The structural empowerment score of the group

that answered no they did not plan to leave was 21.075. The question stating: *Under no circumstances will I voluntarily leave my employer*, demonstrated a similar relationship. The respondents that indicated they would like to leave or plan to leave as soon as possible demonstrated a lower overall structural empowerment score compared to those who did not plan to leave. The group that answered "no" they would not leave the organization voluntarily demonstrated the highest structural empowerment score with a mean score of 22.095. Table 5 shows the mean structural empowerment score, standard deviation, maximum and minimum t scores in relationship to response on the intent to stay questions.

Table 5

Mean structural empowerment scores in relationship to intent to stay

T-Test Procedure						
Scoring Mean 6 – 13 = low empowerment, Mean 14-22 = Moderate empowerment, Mean 22 -30= Higher Empowerment						
Intent to Stay Question	N	Mean	Standard Deviation	Standard Error	Minimum score	Maximum score
Plan to Leave as soon as possible – **Yes**	23	16.442	4.821	1.005	6.000	22.667
Plan to leave as soon as possible – **No**	240	21.073	3.113	0.201	9.75	28.167
Like to leave- **Yes**	42	16.935	4.054	0.626	6.000	22.667
Like to leave- **No**	221	21.379	2.944	0.1980	9.7500	28.167
Under no circumstances will I voluntarily leave – **Disagree with statement**	169	19.877	3.685	0.2835	6.000	27.500
Under no circumstances will I voluntarily leave- **Agree with statement**	94	22.095	2.742	0.283	14.583	28.167

The t-test is used to test for significant differences statistical measures of two samples. T-test uses standard deviation to estimate standard of error of the sample distribution. T-test assumes sample means for the population are normally distributed (Burns & Grove, 2009). All questions demonstrated a positive correlation between structural empowerment scores and intent to stay. Refer to survey in Appendix F for intent to stay questions.

Combining educational levels of Bachelors and Masters preparation, nurses (n=205) indicated that 18.05 % would like to leave, 9.76% plan to leave as soon as possible and 65% would not leave voluntarily under any circumstances. The results of non-bachelor prepared registered nurses and licensed practice nurses (n=58) indicated that 8.62% would like to leave, 5.17% plan to leave as soon as possible and 60.34% said they would not leave voluntarily under any circumstances. Nurses in both groups had similar overall empowerment scores with both being lower in answering yes to the questions would like to leave and plan to leave.

In comparing demographic variables with intent to stay, in the 30 to 39 age group 22% would like to leave the organization and 6.67% plan to leave the organization. This group also demonstrated the highest number of nurses (68.89%) that would not leave voluntarily under any circumstances. The next highest age group indicating that they would like to leave (20%) was the 20 to 29 group. This age group also had the highest percent of nurses who plan to leave at 10%.

The statistical analysis demonstrated that the nurses being employed in the organization for one to five years reported the highest percent responding they would like to leave and plan to leave respectively at 24.39% and 13.41%. Nurses with one to five years experience and those working one to five years on a particular unit reported the highest percent of responding they would like to leave and are planning to leave. Based on these statistics, the highest number of

nurses who plan to leave the organization was in the 20 - 29 age group having one to five years nursing experience. Table 6 shows the breakdown of nurses by years in nursing, years in the organization, years on a unit, and responses to the intent to intent to stay questions expressed in percent of respondents for each group.

Table 6

Relationship of Intent to Stay and years of service and years in nursing

	Would like to leave %	Plan to leave %	Under no circumstances will voluntarily leave %
Years in nursing			
• < 1 n= 33	6.06	3.01	60.1
• 1-5 n= 82	24.39	13.41	69.51
• 6-15 n=57	21.05	7.02	63.16
• > 15 n=91	8.79	7.63	61.54
Years in Organization			
• < 1 n=44	6.82	4.55	63.64
• 1 -5 n=87	22.99	12.64	66.67
• 6 -15 n=69	20.29	8.7	68.12
• <15 n=64	7.94	6.35	57.14
Years on Unit			
• <1 n=65	10.7	6.15	63.08
• 1-5 n=91	24.18	12.09	68.13
• 6 -15 n=56	16.07	5.36	64.29
• >15 n=51	7.84	9.8	58.82

Units that demonstrated the highest intent to leave were short-term stay units including the emergency department, procedural departments, observation unit, and day unit. Would like to leave was indicated by 19.10% of the respondents from these units and 10.11% indicated that they plan to leave. The adult critical care units came in second with 17.5% indicating they would like to leave and 10% indicating they plan to leave. The women's and children's units

scored the lowest on both would like to leave and plan to leave at 5.4% each. The general medical surgical units scored highest with intent to stay with 68.04% indicating that they would not leave voluntarily under any circumstances.

CHAPTER FIVE. DISCUSSION AND RECOMMENDATIONS FOR FUTURE RESEARCH

Discussion

The study provided the opportunity to test Kanter's Structural Theory of Organizational Empowerment (1997) in a hospital based nursing population. The results support the hypothesis that *perceived formal power, perceived informal power, and perceived access to work empowerment structures have a positive relationship with intent to stay*. Consistent with the theoretical expectation and prior studies (Sourdif, 2004; Neb, 2006; Hill, 2010; Lacey, et al, 2007), this study demonstrated that empowerment structures defined in Kanter's theory were significantly related to intent to stay. Nurses who perceived access to opportunity, information, support, and resources existed within the organization, all rated higher on measures of intent to stay. The statistics also demonstrated that low empowerment scores correlated with higher self-reported intent to leave. The results are consistent with previous studies and the Conditions of Work Effectiveness Questionnaire-II was an effective way to assess perceived power in an organization (Hill, 2011; Nebb, 2006)

Nurses in the study perceived themselves to be only moderately empowered with an overall mean structural empowerment score of 20.972. As with previous studies, results did not show any significant difference of structural empowerment scores related to age, gender, years in nursing, years in the organization or unit (Nebb, 2006; Laschinger & Havens, 1996). The findings are consistent with the theoretical perspective that work behavior and attitudes are not necessarily related to personal characteristics, but are related to empowerment structures being available or not available within the organization. The study did show some variation in intent stay scores based on demographic variables. Nurses who had worked in the organization one to five years were the largest group and reported the highest response of wanting to leave the

organization. Nurses ranging in age from 30 to 39 indicated the highest response of wanted to leave the organization at 22%. These statistics indicate that efforts used to prevent turnover in new hires within the first year have been successful. Mangers of the organization should now focus more efforts on retention strategies of nurses with one to five years in the organization to maintain the level of expertise at the beside and to support patient safety.

Nurses in the study rated *Opportunity* as the highest empowerment structure. The results indicate that nurses perceived autonomy in their role, a sense of challenge, and the chance to learn and grow in the organization to be incentives to stay. Perceived *formal power* received the lowest score of all empowerment structures. Despite having a job that is considered challenging and offers opportunity to learn and grow, the low formal power score indicated that respondents did not perceive their job offered the flexibility and visibility they desired. Participants did not perceive their nursing position as relevant and having an impact on key initiatives within the organization. Nurses indicated they were not recognized for the job they do and their contribution to the organization.

Focusing on only one empowerment structure in an organization is not enough, all empowerment structures need to be intact for an effective team and organization. High scores need to be evaluated in terms of what is being done to influence the scores and continued efforts must be made to maintain and increase those scores. A low score can be seen as a problem or an opportunity to enhance the work environment, improve nurse satisfaction, and ultimately affect intent to stay. Nurse leaders in the organization need to consider establishing initiatives to improve each empowerment structure score. Establishing a formal recognition program including a clinical ladder could be one initiative that would raise the nurses' low formal power score.

Self- reported planning to leave or wanting to leave the organization needs to be scrutinized not only in relationship to empowerment scores, but also in relationship to turnover. The findings of the study are both relevant and timely as the organization involved in the study is faced with increasing turnover rates and challenged to preserve the elements of professional nursing practice. Nurse leaders in the organization should utilize the results as a starting point to assess the nurses' perceptions of workplace empowerment. Results also provide insight into potential turnover risks based on intent to stay or leave scores. The organization involved in the study had a turnover rate of 14.5% year to date at the time of the study. The previous mentioned turnover statistic compares to 15.97% of the nurses surveyed responding that they would like to leave the organization. All nurses responding they would like to leave the organization should be considered an additional risk for turnover. According to Thomas (2009), one sign of a culturally and financially healthy organization is low turnover. High turnover is associated with employee dissatisfaction with the organization. Scrutinizing the data could provide insight for developing action plans and strategies to decrease turnover and enhance perceived empowerment structures for nurses in the organization. Efforts focusing on the empowerment structures should be included in retention plans. As previous stated 51.8% of the hospitals surveyed in 2013 lacked a formal retention plan (Nursing Solutions, 2013).

Recommendations for Future Research

Kanter's Structural Theory of Organizational Empowerment should continue to be used by organizations to assess relationship of empowerment structures with intent to stay and turnover. Many organizations have established nurse residency programs for new graduate nurses. Research should be done assessing the difference in perception of empowerment structures by new graduate nurses participating in nurse residency programs compared to new graduate nurses

who did not have the opportunity. Another area for future study is to analyze patient outcomes or satisfactions scores and to see if there is a positive correlation among nursing empowerment scores, patient outcomes, and patient satisfactions survey. These findings are relevant as the hospital in the study is being reimbursed based on performance and patient satisfaction, and as they are moving forward as a Magnet-aspiring organization. Most research using Kanter's theory has been conducted with nursing. Future studies could evaluate the impact of empowerment on other healthcare professionals. The CWEQ-II could be used to evaluate and compare the perception of empowerment across the disciplines in an organization.

Limitations

Limitations to the study were identified. The present study was conducted at one organization. The findings of the study are to be utilized only within the context of the environment and characteristics of the organization and the respondents. Low response rates may not guarantee the sample was representative of the nursing population of the organization. Caution must also be taken in attempting to generalize the results to other organizations and the nursing workforce.

Additional limitations identified were related to the measurement of empowerment structures. Only participant self-reported perception of access to empowerment structures were measured with no direct measurement of these structures. It also should be noted that the organization involved in the study and the community in which the organization was located experienced several high-stress events within the year that may have influenced nurses' perception of power and intent to stay. These events included restructuring of leadership within the organization, the implementation of an electronic medical record which required restriction

of vacations throughout spring and into summer, understaffing with a plan for use of agency nurses, rapid growth of the organization, and the potential for flooding in the community.

Conclusion

The study supports Kanter's theory that empowerment structures have an impact on retention of employees in the organization. It is important for the organization to focus on improving these empowerment structures rather than focusing on attributes of individuals. Providing nurses with opportunity, resources, support, and information is not enough. It is only when nurses view these structures as accessible and obtainable that there will be a direct impact on nursing intent to stay and commitment to the organization.

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APPENDIX A. IRB APPROVAL

NDSU NORTH DAKOTA STATE UNIVERSITY

Institutional Review Board
Office of the Vice President for Research, Creative Activities and Technology Transfer
NDSU Dept. 4000
1735 NDSU Research Park Drive
Research 1, P.O. Box 6050
Fargo, ND 58108-6050

701.231.8995
Fax 701.231.8098

Federalwide Assurance #FWA00002439

Monday, November 21, 2011

Dr. Norma Kiser-Larson
Nursing
136 Sudro

Re: IRB Certification of Human Research Project:

"Nursing Empowerment and Intent to Stay"
Protocol **#PH12071**

Co-investigator(s) and research team: **Loretta Heuer, Joyce Schmaltz**

Study site(s): **Sanford Health** Funding: **n/a**

It has been determined that this human subjects research project qualifies for exempt status (category # 2) in accordance with federal regulations (Code of Federal Regulations, Title 45, Part 46, *Protection of Human Subjects*). This determination is based on the protocol form received 10/20/2011, consent/information sheet received 10/24/2011 and training documentation received 11/21/2011.

Please also note the following:

- This determination of exemption expires 3 years from this date. If you wish to continue the research after 11/20/2014, the IRB must re-certify the protocol prior to this date.
- The project must be conducted as described in the approved protocol. If you wish to make changes, pre-approval is to be obtained from the IRB, unless the changes are necessary to eliminate an apparent immediate hazard to subjects. A *Protocol Amendment Request Form* is available on the IRB website.
- Prompt, written notification must be made to the IRB of any adverse events, complaints, or unanticipated problems involving risks to subjects or others related to this project.
- Any significant new findings that may affect the risks and benefits to participation will be reported in writing to the participants and the IRB.
- Research records may be subject to a random or directed audit at any time to verify compliance with IRB policies.

Thank you for complying with NDSU IRB procedures; best wishes for success with your project.

Sincerely,

Kristy Shirley

Kristy Shirley, CIP, Research Compliance Administrator

APPENDIX B. ORGANIZATIONAL LETTER OF SUPPORT

Sanford
801 Broadway N
PO Box 2010
Fargo, ND 58122
(701) 234-2000
sanfordhealth.org

SANFORD
HEALTH

June 6, 2011

Sanford Medical Center Fargo
Institution Review Board

Dear Committee Members,

This letter is in support of the medical center nursing staff participation in the research project titled "Nursing Empowerment and Intent to Stay in the Organization", to be completed by Joyce Schmaltz, RN, BSN, as a component of her education requirements for completion of a Master's Degree in Nursing at North Dakota State University.

The study will utilize two instruments with data collected voluntarily from staff nurses in the organization in an electronic format. Agreement to participate will be received from patient care unit manager/directors.

The study findings will be aggregated to assure confidentiality and findings presented to the organization and may add additional knowledge for the development of retention strategies for nursing.

Please contact me if any further information is desired.

Sincerely,

Carla Hansen, MS, RN
Chief Nursing Executive
Sanford Medical Center Fargo

Our Mission:
Dedicated to the work of
health and healing

APPENDIX C. INTRODUCTORY LETTER

NDSU NORTH DAKOTA STATE UNIVERSITY 701.231.7395

Department of Nursing

College of Pharmacy, Nursing, and Allied Sciences
NDSU Dept. 2670
136 Sudro Hall, P.O. Box 6050
Fargo, ND 58108-6050

Nursing Research Study

The healthcare industry continues to have significant problems in recruitment and retention in the nursing sectors. Several national studies have demonstrated that empowerment is a major factor that influences retention of nurses.

You are being asked to participate in an online survey that will help to identify key factors that are connected to empowerment of nursing staff in the organization. These factors include opportunity, resources, information, support, informal power, and formal power.

The survey consists of the Conditions of Work Effectiveness Questionnaire II, a 21 question Likert scale instrument. In addition, there is a section of demographic questions that will help identify characteristics of the survey participants. As you complete the survey, think about your work environment in the past six months. Read each question and mark one answer that best describes your work. If will take approximately 5-10 minutes to complete the survey. Your responses will be kept confidential. Individual data will be accessible only to Joyce Schmaltz, NDSU graduate student.

Participation is voluntary. You may choose not to participate or quit participating at any time without penalty or loss of benefits to which you are already entitled. You will not be able to be identified by youe response. All data will be reported in group findings and in no way will individual responses be revealed.

Your completion of the survey indicates your informed consent to participate in this research study.

Please contact Joyce Schmaltz at joyce.schmaltz@ndsu.edu or Dr. Norma Kiser-Larson at norma.kiser-larson@ndsu.edu if you have questions about the research. For questions about your rights as a research participant, or to file a complaint regarding the research, contact NDSU Human Research Protection Office, 701.231.8908, or ndsu.irb@ndsu.edu.

Thank your time and consideration.

Joyce Schmaltz RN, NDSU Graduate Student

APPENDIX D. CONDITIONS OF WORK EFFECTIVENESS- II QUESTIONNAIRE

CONDITIONS OF WORK EFFECTIVENESS QUESTIONNAIRE - II

HOW MUCH OF EACH KIND OF OPPORTUNITY DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Lot
1. Challenging work	1	2	3	4	5
2. The chance to gain new skills and knowledge on the job.	1	2	3	4	5
3. Tasks that use all of your own skills and knowledge.	1	2	3	4	5

HOW MUCH ACCESS TO INFORMATION DO YOU HAVE IN YOUR PRESENT JOB?

	No Knowledge		Some Knowledge		Know A Lot
1. The current state of the hospital.	1	2	3	4	5
2. The values of top management.	1	2	3	4	5
3. The goals of top management.	1	2	3	4	5

HOW MUCH ACCESS TO SUPPORT DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Lot
1. Specific information about things you do well.	1	2	3	4	5
2. Specific comments about things you could improve.	1	2	3	4	5
3. Helpful hints or problem solving advice.	1	2	3	4	5

HOW MUCH ACCESS TO RESOURCES DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Lot
1. Time available to do necessary paperwork.	1	2	3	4	5
2. Time available to accomplish job requirements.	1	2	3	4	5
3. Acquiring temporary help when needed.	1	2	3	4	5

IN MY WORK SETTING/JOB:	None				A Lot
1. The rewards for innovation on the job are	1	2	3	4	5
2. The amount of flexibility in my job is	1	2	3	4	5
3. The amount of visibility of my work-related activities within the institution is	1	2	3	4	5

HOW MUCH OPPORTUNITY DO YOU HAVE FOR THESE ACTIVITIES IN YOUR PRESENT JOB?

		None				A Lot
1.	Collaborating on patient care with physicians.	1	2	3	4	5
2.	Being sought out by peers for help with problems	1	2	3	4	5
3.	Being sought out by managers for help with problems	1	2	3	4	5
4.	Seeking out ideas from professionals other than physicians, e.g., Physiotherapists, Occupational Therapists, Dieticians.	1	2	3	4	5

		Strongly Disagree				Strongly Agree
1.	Overall, my current work environment empowers me to accomplish my work in an effective manner.	1	2	3	4	5
2.	Overall, I consider my workplace to be an empowering environment.	1	2	3	4	5

Laschinger/2001

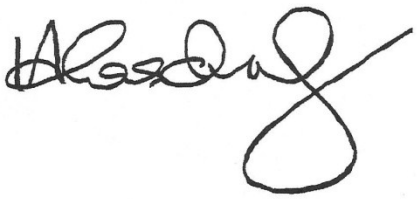
APPENDIX E. PERMISSION FOR USE OF CWEQ-II QUESTIONNAIRE

NURSING WORK EMPOWERMENT SCALE
Request Form

I request permission to copy the Nursing Work Empowerment Scale as developed by Dr. G. Chandler and Dr. Heather K. Spence Laschinger. Upon completion of the research, I will provide Dr. Laschinger with a brief summary of the results, including information related to the use of the Nursing Work Empowerment Scale used in my study.

Questionnaires Requested:
Conditions of Work Effectiveness-I (includes JAS and ORS):
Conditions of Work Effectiveness-II: yes
Job Activity Scale only:
Organizational Relationship Scale only:
Organizational Development Opinionnaire
or Manager Activity Scale:
Other Instruments:

Please complete the following information:
Date: 04/09/2009
Name: Joyce Schmaltz
Title: RN, BSN,CCRN-CSC Nurse Educator Cardiac Progressive Care
Cardiac Intensive Care Graduate Student
University/Organization: MeritCare Health System
North Dakota State University
Address: MeritCare Health System
801 N Broadway
Fargo, ND 58104
Phone: 701-234-6762
E-mail: joyce.schmaltz@meritcare.com
Description of Study: Our hospital is a 450 bed hospital that is looking at seeking magnet designation. I would like to use to tool as part of my graduate research to examine the relationship between empowerment, work relationships, and expertise of our nurses both in critical care setting and acute medical surgical settings.
Permission is hereby granted to copy and use the Conditions of Work Effectiveness Questionnaire
Date: April 13, 2009 Signature:



Dr. Heather K. Spence Laschinger, Professor
School of Nursing, University of Western Ontario
London, Ontario, Canada N6A 5C1

APPENDIX F. DEMOGRAPHIC AND INTENT TO STAY QUESTIONNAIRE

Sanford Health

Please circle your answers.

1. Age
1= 60 -69
2 =50-59
3= 40-49
4= 30-39
4= 20-29

2. Preparation:
1= LPN Associates Degree
2= LPN Diploma
3= RN Associate's Degree
4= RN Diploma
4= RN Bachelor's Degree
5= RN Master's Degree
6= Other (specify) _____

3. Job Classification:
1= LPN
2= RN

4. Years in your current department/unit:
1= 1-5
2= 6-10
3= 11-15
4= >15
5= <1

5. Years in your current hospital:
1= 1-5
2= 6-10
3= 11-15
4= greater then15
5= less then1

6. Number of Years working in nursing?
1= 1-5
2= 6-10
3= 11-15
4= greater then15
5= less then1

7. Employment Status:
1= Full-time
2= Part-time
3= PRN

1

8. The shift I work is primarily:
1= Days
2= Nights
3= Day/night rotating
4= Evenings
5= Weekend status
6= Other (specify)_____

9. In what department/unit do you primarily work:

1. 1W Observation
2. 2S
3. 2E CIC
4. 3S med/surg
5. 3E CCS
6. 4E Peds
7. 4W FBS
8. 4N NICU
9. 4E PICU
10. 5S/5E Surg.
11. 6S Med/Special
12. 7S Onc.
13. 2W Neuro
14. OR
15. IR
16. PAC
17. EC
18. CCl
19. Day Unit
20. Eating Disorders
21. Psych
22. Other _____

10. Gender:
1= Male 2= Female

11. My manager/director is responsible for the following number of nursing units.
1=1 3= 3 or greater
2=2 4= don't know

12. Do you currently work at more than one institution?
1= Yes 2= No

13. I would like to leave my present employer
1= Yes 2= No

14. I plan to leave my present employer as soon as possible

1= Yes 2= No

15. I plan to stay with my present employer as long as possible

1= Yes 2= No

16. Under no circumstances will I voluntarily leave my present employer

1= Yes 2= No

17. In what year do you plan to retire? _____

APPENDIX G. PERMISSION FOR USE FIGURE 1

From: Heather Laschinger [mailto:hkl@uwo.ca]
Sent: Wednesday, September 19, 2012 3:44 PM
To: Schmaltz,Joyce
Subject: RE: Theoretical Framework

Hi Joyce,,,no problem…you have my permission!

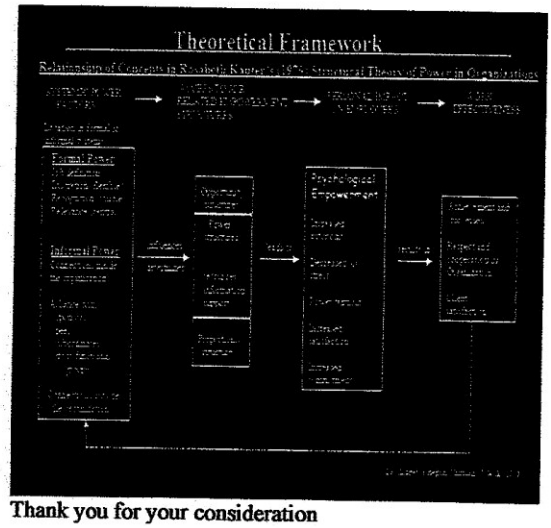
Western
Arthur Labatt Family
School of Nursing
Heather K. Spence Laschinger, RN, PhD, FAAN, FCAHS
Distinguished University Professor and
Arthur Labatt Family Nursing Research Chair in Health Human Resource Optimization

Arthur Labatt Family School of Nursing, Faculty of Health Sciences
Health Sciences Addition Room HSA41
University of Western Ontario, London, Ontario N6A 5C1
Telephone: 519-661-2111, Extension 86567
Fax: 519-661-3410

From: Schmaltz,Joyce [mailto:Joyce.Schmaltz@sanfordhealth.org]
Sent: September-19-12 3:01 PM
To: 'hkl@uwo.ca'
Subject: Theoretical Framework

Dr. Heather K. Spence Laschinger

My name is Joyce Schmaltz. I am a graduate student at North Dakota State University in Fargo ND. I am completing my thesis working on nursing empowerment and have utilized much of your previous research for the background for my research project. I would like to request permission to utilize the following diagram in my thesis.



Thank you for your consideration

Joyce Schmaltz
Joyce Schmaltz, RN,BSN, CCRN-CSC-CMC
(NDSU Graduate Student)
Sanford Medical Center
Cardiac Intensive Care/Cardiac Progressive Care
Clinical Care Supervisor/Nurse Educator