

COMPARISON OF BURNOUT AND EMPOWERMENT BETWEEN NEW  
GRADUATE AND EXPERIENCED NURSES EMPLOYED IN ACUTE CARE

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**Title**

Comparison of Burnout and Empowerment Between New Graduate and Experienced  
Nurses Employed in Acute Care

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## **ABSTRACT**

The nursing profession is expected to experience massive staff shortages due to experienced nurses reaching retirement and new nurses leaving the profession related to feelings of burnout. This study describes quantitative and qualitative perceptions of new graduate and experienced nurses employed in acute care. Two measurement tools, the Maslach Burnout Inventory (MBI) and the Conditions for Work Effectiveness Questionnaire (CWEQ-II), were administered using an online survey. An overall moderate level of burnout and empowerment were identified. Unit clusters differed in both burnout and empowerment subscale responses. New graduates differed in some responses regarding burnout, specifically depersonalization.

Additionally, two open-ended questions provided insight about the participants' opinions regarding burnout and empowerment. Four burnout themes were identified: challenging work milieu, need for better compensation, desire for increased managerial support, and toll of professional demands. Four empowerment themes were also identified: feeling valued, positive communication, nurse retention, and wholesome relationships.

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## **CHAPTER I: THE RESEARCH PROBLEM**

### **Introduction**

Nursing shortages continue to plague healthcare systems across the globe. According to the American Association of Colleges of Nursing (AACN), the United States is projected to experience a shortage of registered nurses that will intensify as the Baby Boomers continue to age (Rosseter, 2014). The U.S. Bureau of Labor Statistics (BLS) reported that job growth in the healthcare sector was outpacing the growth realized in 2011, and registered nurse job openings are expected to increase by 26% by 2020. To compound the problem, there is a shortage of nursing educators and nursing schools are struggling to expand capacity to meet the rising demand. Increasing rates of burnout among the registered nurse population with intent to leave are causing vacancies to open faster than they are filled exacerbating the situation (Rosseter, 2014).

New graduates are the future of the nursing profession. Retention of core nursing staff and the addition of enthusiastic new nurses could be the answer to the worsening scarcity. However, new graduate nurses, or those having three or fewer years of professional experience, excited to begin their careers fall susceptible to negative staff attitudes or have unrealistic prior expectations and experience burnout unique to their population (Berry, Gillespie, Gates, & Schaefer, 2012; Lashinger, Grau, Finegan, & Wilk, 2010; Lashinger, Finegan, & Wilk, 2009; Smith, Andryszyn, & Lashinger, 2010). Negative experiences include heavy patient assignments, hostility and bullying from older nursing staff, and working day/night rotations (Beecroft, Dorey, & Wenten, 2008; Ilhan, Durukan, Taner, Maral, & Bumin, 2007; Laschinger, Finegan, & Wilk, 2009; Laschinger, Grau, Finegan, & Wilk, 2010). Burnout has been studied for

decades among nurses, but very few studies have sought to study the phenomenon in a new graduate population.

A theme emerged in a recent literature search performed on June 5, 2014 that supports the newness of the topic and a gap in knowledge. Using the key words “new graduate nurse” and “burnout”, a mere 1,421 articles surfaced in comparison to “nurse” and “burnout” that turned out more than 21,500 results using EBSCO, CINAHL, Academic Search Premier, Alt Health Watch, Healthsource: Nursing/Academic, and MEDLINE search engines. Similar findings surfaced when searching “nurse” AND “empowerment” (22,000 articles) compared to “new graduate nurse” AND “empowerment” (530 articles). Once the search was narrowed to include only acute care, the number of articles decreased by more than half. Although studied extensively in the general nurse population, little research has focused specifically on new graduate nurses and their experiences of burnout in the workplace.

### **Statement of the Problem**

A persistent gap in knowledge exists related to the lack of previous research and the emergence of unique needs related to retention and satisfaction of new graduate nurses. Despite efforts of individual organizations, the nursing scarcity will continue to escalate. An AACN factsheet shared that 13.3% of newly licensed nurses had changed jobs after one year and 37% of new nurses stated that they were ready to change jobs (Rosseter, 2012). This number is similar from a poll conducted in 2005 where the Bernard Hodes Group found that the average turnover rate was 13.9% (Rosseter, 2014). Multiple studies specific to new graduates have concluded that negative work environments, poor transitions, and little to no social support leads to high turnover rates (Ilhan, Durukan, Taner, Maral, & Bumin, 2007; Laschinger, Finegan, & Wilk,

2009; Lashinger & Grau, 2011), some as high as 60% within the first year of employment (Laschinger, Wong & Grau, 2012, p. 1267).

Rudman and Gustavsson (2011) examined burnout trajectories among new graduate nurses and found that during the first three years of practice, roughly every fifth nurse is “burned out” (p. 290). The term burnout can be defined as a syndrome comprising two core dimensions: exhaustion and cynicism or disengagement (Rudman and Gustavsson, 2011; Leiter & Maslach, 2009; Beckstead, 2002). Burnout develops due to prolonged, stressful situations in the workplace. Stressful events for a new nurse may differ greatly from what more experienced nurses describe as taxing. The latter precisely describes the reason new graduate nurse population desperately needs to be examined in a different light. With the complexity of care and unending change in healthcare, burnout will continue to increase if major interventions are not implemented. Experienced nurses who undergo burnout will undoubtedly contribute to the burnout of new graduate nurses, resulting in a negative continuum (Rudman & Gustavsson, 2011). However, a question arises about how to combat burnout. Is there a solution?

In much of the recent literature, the opposite of burnout is defined as empowerment (Gandi, Wai, Karick, & Dagona, 2011; O’Mahony, 2011; Lashinger & Grau, 2011; Leiter & Maslach, 2009). Empowerment was first studied by Elizabeth Kanter (1972) in the business realm and has slowly migrated to healthcare. A multitude of studies within nursing has shown that those who describe their work environments as empowering have fewer symptoms of burnout, give better patient care, and are more satisfied with their chosen profession. Empowerment may hold the key to reversing symptoms of burnout and assisting new graduates in the transition from school to the workforce and retaining experienced nurses through job satisfaction.

### **Purpose of the Study**

The purpose of this study was to determine nurses' perceptions of burnout and empowerment and to discover the relationship between burnout and empowerment subscales. Using the Maslach Burnout Inventory (MBI) and the Conditions for Work Effectiveness Questionnaire (CWEQ-II), correlations were identified between the subscale scores as well as the total scores as a whole. The Maslach Burnout Inventory measures burnout and is composed of emotional exhaustion, depersonalization, and personal accomplishment (Maslach, Jackson, & Leiter, 2010). The Conditions for Work Effectiveness Questionnaire measures empowerment and is composed of six subscales: opportunity, support, resources, information, as well as formal and informal power (Laschinger, 2012). These tools and concepts are discussed in the Literature Review.

The study also aimed to identify burnout and empowerment structures that may exist among specific age groups or units within the facility. The investigator hoped to contribute to and expand the limited body of knowledge surrounding burnout in new graduate nurses. Results of the study provided evidence to institutions with intent to help decrease burnout among the new graduate and general nurse populations via empowerment structures.

### **Significance for Nursing**

The study of burnout among new graduate nurses is extremely significant to the nursing profession. As previously discussed, the nursing shortage and burnout rates continue to skyrocket. Knowing that the nursing shortage is expected to reach 260,000 by 2025 (Rosseter, 2013), strategies must be found to retain new nurses in the workforce. Research studies have found that with positive, engaged nursing leadership, burnout rates and intent to leave decrease significantly (Glasberg, Norberg, & Soderberg, 2007; Laschinger, Wong & Grau, 2012).

Managers and nursing leadership need additional education about the specific needs of new graduate nurses. Additional research on burnout and empowerment structures may provide evidence to help new graduates develop coping skills or tools to combat a negative work environment. With a focus on interventions for novice nurses, the nation may see an increase in nursing retention, resulting in improved patient care, increased patient satisfaction, and improved health care financing. The culture of “nurses eating their young” will dissipate as positivity and teamwork will be fostered among all staff, novice and experienced alike, forging the future of nursing through empowerment.

Burnout and empowerment structures can impact the nursing profession on a global level. The United States is a leader in nurse turnover and burnout rates, however many other developed countries are experiencing the same issues (Poghosyan, Clarke, Finlayson, & Aiken, 2010). Despite different languages, culture, and technology, the core beliefs and values of nursing remain the same: to provide excellent patient centered care. Continued research can make a positive impact on the nursing profession around the world.

As the literature search revealed, burnout and empowerment among new graduate nurses remains an underdeveloped concept to researchers. The concepts are complex and many factors may influence the presence of burnout. The time when burnout actually begins in novice nurses is still unknown, but new literature suggests that it may start during the undergraduate years (Rudman & Gustavsson, 2012; Rella, Winwood, & Lushington, 2008). Additional knowledge gathered from surveying new graduates in relation to burnout may spark interest in future studies that continue to explore when burnout begins. Interventions to guard against burnout may someday be implemented into the classroom. The current study contributes to the nursing body of knowledge surrounding new graduate nurses, a population worthy of attention.

Finally, graduate level nurses will benefit from additional knowledge. As the new graduate nurse population continues to be studied, burnout patterns may develop that indicate when the burnout process actually begins, specific factors related to new graduate intent to stay, and ultimately allow managers, nurse leaders and educators to anticipate new graduate needs. Through anticipating new graduate nurse needs, nurse leaders will be able to customize specific work environments.



## CHAPTER II: LITERATURE REVIEW AND STUDY FRAMEWORK

### Review of Related Literature

#### Measurement Tools

Before the reader can understand literature reviews regarding burnout and empowerment, a thorough explanation and review of the selected measurement tools will first be discussed.

Burnout and empowerment can be measured in multiple ways. However, the researcher selected valid and reliable tools that have been shown to measure perceptions of burnout and empowerment among the nursing population.

**Maslach Burnout Inventory.** The Maslach Burnout Inventory (MBI) was developed to measure burnout as a specific source of occupational stress among human services professionals, particularly those working in healthcare. The MBI has since been adapted for use with educators and workers in other occupations. The MBI is recognized as the leading measure of burnout (Maslach, Jackson, & Leiter, 2010). In this particular study, the researcher used the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) because it is geared toward those in the helping professions, including nurses and other healthcare professionals.

The MBI-HSS is designed to assess the three components of the burnout syndrome: emotional exhaustion, depersonalization, and lack of personal accomplishment. Each component has a separate subscale (Maslach, Jackson, & Leiter, 2010). *Emotional exhaustion* (EE) describes nurses' feelings of psychological depletion due to work burden. Emotional exhaustion is known as the cornerstone of burnout and is a leading indicator or predictor of burnout.

*Depersonalization* is the process of being detached and having an unfeeling response to clients.

*Personal Accomplishment* describes feelings of competence and successful achievement at work (Maslach, Jackson, Leiter, Schaufeli & Schwab, 2013).

The frequency with which each respondent experienced perceptions related to each subscale is assessed using a six-point response format. Burnout is recognized as a continuous variable and scores can range from low to moderate to high degrees of experienced feelings (Maslach, Jackson, & Leiter, 2010). Emotional exhaustion is measured on a scale from 0-54; Depersonalization is measured on a scale from 0-30; Personal Accomplishment is measured on a scale from 0-48. The personal accomplishment scale is interpreted as the opposite of emotional exhaustion and depersonalization in that low scores of PA mean increased perceptions of exhaustion and depersonalization. Means and standard deviations for the MBI subscales related to those who work in healthcare are reported in Table 1. Maslach and colleagues provided this data for interpretation in the scoring manual (Maslach, Jackson, & Leiter, 2010).

Table 1

*MBI-HSS Reported Means and Standard Deviations for Medical Professionals*

	Emotional Exhaustion	Depersonalization	Personal Accomplishment
Mean	22.19	7.12	36.53
Standard Deviation	9.53	5.22	7.34

Multiple confirmatory factor analyses of the MBI-HSS have been conducted and replicated. Research shows that the Emotional Exhaustion and Depersonalization subscales are distinct but highly correlated and related to other measures of psychological and physiological strain, and Personal Accomplishment is more closely related to control-oriented coping. Twenty of the 22 questions load consistently and exclusively on each appropriate subscale (Maslach, Jackson, & Leiter, 2010).

The MBI-HSS is both reliable and valid. Internal consistencies reported by the tool developers were estimated by Cronbach's alpha in a population of 1,316 subjects. Coefficients

for each subscale were the following: 0.9 for Emotional Exhaustion, 0.79 for Depersonalization, and 0.71 for Personal Accomplishment. These consistencies were reported for five test-retest samples (Maslach, Jackson, & Leiter, 2010). Other studies have found similar consistencies. In a survey of people who work with clients who have intellectual disability and dementia, Cronbach's alphas were as follows: 0.91 for EE, 0.76 for PA, and 0.62 for DP (Chao, McCallioin, & Nickle, 2011). Overall Cronbach's alphas reported among nursing studies related to the MBI range from 0.89 to 0.91 (Lashinger, Grau, Finegan, & Wilk, 2010; Lashinger, Finegan, & Wilk, 2009; O'Mahony, 2011).

Maslach and colleagues confirmed validity through correlating scores with behavioral ratings made independently by a person who knew the individual well, such as a spouse or co-worker. MBI-HSS scores also correlated with the presence of certain job characteristics that were expected to contribute to experiencing burnout. Finally, the scores were correlated with measures of various outcomes that had been hypothesized to be related to perceptions of burnout. The authors also utilized a method of discriminant validity to verify findings (Maslach, Jackson, & Leiter, 2010).

The researcher chose the Maslach Burnout Inventory (MBI) because it is noted to be the leading measure of burnout (Maslach, Jackson, & Leiter, 2010). The MBI has been used to assess burnout among new graduate and experienced nurses, assess differences in subscale responses between specific units or areas of nursing, and has been applied internationally. The researcher did not note any limitations to using this tool.

**Conditions for Work Effectiveness Questionnaire.** Dr. Heather K. Spence Laschinger, a nurse researcher, developed the Conditions for Work Effectiveness Questionnaire (CWEQ-II). She utilized Kanter's Theory of Empowerment and its associated six structures: information,

support, resources, opportunity, formal power, and informal power (Laschinger, 2012).

*Information* can be defined as having access to or knowledge of the organization's policies, goals, and beliefs. *Support* involves constructive feedback and guidance from peers and managers as well as emotional support from colleagues. *Resources* are provided through access to supplies, materials, or equipment needed to carry out the work of the organization.

*Opportunity* includes future prospects and expectations for mobility and growth, including furthering education, participation on committees, and advancing careers (Kanter, 1972; Kanter, 1993).

Kanter derived that access to empowerment structures is facilitated by formal and informal power. *Formal power* is influenced by characteristics that increase autonomy and creativity, including participation in decision-making and access to organizational goals.

*Informal power* is a result of positive relationships and support from peers, managers, and other groups both internal and external to the organization (Kanter, 1972; Kanter, 1993).

The aforementioned structures are measured on a five point Likert scale. From the confirmatory factor analysis that validated this instrument and was conducted by Dr. Laschinger in 2001, a total empowerment score was created. To attain this score, the researcher sums the subscales of the CWEQ-II (score range: 6-30). Higher scores represent higher levels of perceived empowerment and correlates with scores from each subscale (Laschinger, 2012). Additionally, a two-item global empowerment scale was included for validation purposes. This score should also correlate with the total empowerment score and subscale interpretations. Previous studies produced Cronbach alphas ranging from 0.79 to 0.82 (Smith, Andrusyszyn, & Lashinger, 2010; Ning, Zhong, Libo, & Qiujie, 2009; Sarmiento, Laschinger & Iwasiw, 2004).

The researcher chose the Conditions for Work Effectiveness Questionnaire (CWEQ-II) because it was developed by a nurse researcher, Dr. Heather K. Spence Laschinger, to be used among the nursing population and there was not another easily accessible tool to measure empowerment. Multiple nursing studies showcase its applicability and accuracy in measuring perceptions of empowerment. Cronbach's alpha as well as the two-item validity tool within the survey provided reliability and validity. One limitation of the CWEQ-II is that the tool is relatively new and although shown to be valid and reliable, may still need additional research to increase the value of Cronbach's alpha.

### **Burnout**

Burnout has long been studied among the nursing population. Burnout has been defined as "sustained response to the chronic work stress comprised of three components: the experience of being emotionally exhausted, negative feelings and attitudes towards the recipients of the service (depersonalization), and feelings of low accomplishment and/or professional failure (lack of personal accomplishment). Burnout is a prolonged response to chronic emotional and interpersonal stressors that an employee encounters in the context of a job" (Gandi, Wai, Karick, and Dagona, 2011, p. 183). Globally, burnout is increasing in North America, Europe, and Asia. Poghosyan, Clarke, Finalyson, and Aiken (2010) examined six countries and found that burnout was on the rise and negatively affected patient care. Burnout continues to affect thousands of nurses internationally. Researchers have sought to examine the context in which burnout occurs and factors that may predispose nurses to experience burnout. The following paragraphs show commonalities discovered among multiple research studies, linking experiences to feelings of burnout.

Glasberg, Norberg, and Soderberg (2007) and Patrick and Lavery (2007) found that organization reform and restructuring led to negative feelings among staff. As a result, nurses questioned their own abilities and worth and felt less valued as people. Trust and morale ultimately decreased and workload increased due to staff loss. Feelings of cynicism and exhaustion prevailed among staff, leading to burnout. Pessimism breeds pessimism and burnout may be contagious: it is communicated from one person to another (Glasberg, Norberg, & Soderberg, 2007).

Social climate of the workplace may also lead to burnout. A mismatch between the employee's expectations and the extent to which the workplace is meeting them creates a disconnect and may initiate the burnout process. Examples of expectations include workload, control, reward, social support within the workplace, fairness, and values (Fearon & Nicol, 2011). Garrett and McDaniel (2001) sought to explain the correlation and discovered that the social climate affects a nurse's behavior, feelings, and growth. The social climate affects morale, well-being, aspirations, and achievement, self-understanding, and impulse control. The authors stated that coping can be negatively affected by perceptions about social climate, leading to emotional withdrawal and burnout. Once a nurse becomes withdrawn and dissatisfied with his or her work environment, one's intention to leave skyrockets and is directly related to cynicism, a component of burnout (Leiter & Maslach, 2009).

What can lead to dissatisfaction in the workplace? A focus on productivity, referred to as "efficiency savings" in one study, was found to increase the risk of burnout (Fearon & Nicol, 2011). Organizational change, including downsizing, a focus on the budget, and reorganization of healthcare services that results in reduced resources, has been found to impact perceptions of burnout (Glasberg, Norberg, & Soderberg, 2007; Patrick & Lavery, 2007). Watts and colleagues

(2013) found that bureaucratic cultures, found in many inpatient hospital settings, appeared hierarchical and more oriented toward power and driven by protocol and procedures. Staff working in this type of environment reported a decreased sense of satisfaction. In contrast, staff that perceived their work environment to be more dynamic and entrepreneurial had a greater sense of satisfaction in their roles (Watts, Robertson, Winter, & Leeson, 2013).

Multiple studies have discussed that heavy patient workloads lead to feelings of burnout (Chang, & Daly, 2001; Garrett & McDaniel, 2001; Gandi, Wai, Karick, & Dagona, 2011; O'Mahony, 2011). Aiken, Clarke, and Sloane (2002) found that when there was not enough staff to get the job done and resources were inadequate, nurses reportedly felt overburdened, ignored, and undervalued by administrators. The authors also found that each additional patient per nurse was associated with a 23% increase in the chance that burnout would occur. In contrast, Breen and Sweeny (2013) found that positive managerial support and high staff morale created high levels of job satisfaction even with reports of a high workload.

Ericson-Lidman and Strandberg (2007) studied co-workers' perceptions of signs preceding workmates' burnout. The authors found that burnout may be difficult to interpret, as signs of burnout were reported as qualities that, to some extent, were encouraged in the prevailing culture. For example, nurses are expected to be "drained" at the end of the day, and self-sacrifice is an honorable trait. Examples of self-sacrifice include pushing his or herself to more than can be expected (taking one five minute lunch break and one bathroom break in twelve hours, taking on a difficult patient load, performing co-workers' responsibilities) and placing themselves last by caring about the patient, the family, and co-workers first (p. 203).

Working in acute care is also linked to higher levels of burnout (Spooner-Lane & Patton, 2007). Gillespie and Melby (2003) and O'Mahony (2011) found that nurses working in acute and

emergency care units had intense interactions with people on a daily basis. The nature of patient care in these departments is also physically and emotionally demanding. Nurses are faced with heavy demands for empathy, sympathy, and compassion. Through survey results, chronic stress was found to lead to symptoms of burnout, especially emotional exhaustion.

A major cause of turnover is related to unsatisfying workplaces. Lashinger and colleagues (2009) found that emotional exhaustion, cynicism (depersonalization), and supervisor incivility most strongly predicted turnover intentions. Another study found that certain dimensions of the nurse practice environment predicted job outcome variables and nurse ratings of quality of care. Dimensions included the perceived workload, decision latitude (clinical autonomy) and social capital (Coleman, 1990). The amount of workload and perception of personal accomplishment directly impacted perceptions of burnout. Social capital, defined as aspects of the social structure that benefit its members including trust, reciprocity, and a basic set of shared values (Coleman, 1990), is potentially protective against feelings of emotional exhaustion. Workload was found to have potentially deleterious influences regarding the presence of burnout on quality of care and job outcomes (Van Bogaert, Kowalski, Weeks, Van Heusden, & Clark, 2013). Essentially, these studies provide evidence that the work environment can have a major influence on the presence of burnout and intent to stay.

Van Bogaert, Clarke, Roelant, Muelemans, and Van de Heyning (2010) found that the unit culture affected quality of care and nurse burnout. The presence of emotional exhaustion predicted the level of job satisfaction. In relation to previous findings, the presence of emotional exhaustion and a negative work environment created a culture of burnout that appeared to be widely accepted among the nursing profession (Van Bogaert et al., 2010). Depersonalization and nurse-physician relations are also predictors of burnout and turnover intentions. Emotional



exhaustion was found to be a predictor of quality of care and job satisfaction at the unit level (Van Bogaert, Clark, Wouters, Franck, Willems, & Mandelaers, 2013). A unit culture that does not actively attempt to prevent burnout can negatively affect patient care and nursing job satisfaction. If a negative culture prevails among the general nurse population, how does it affect new graduate nurses?

**New Graduates.** Regardless of place of employment, younger nurses suffered from a higher rate of burnout (Gillespie & Melby, 2003; Ilhan, Durukan, Taner, Maral, & Bumin, 2007). Younger nurses faced an initial shock when confronted with the realities of the job (Ilhan et al., 2007) and did not have adequate coping mechanisms due to their young age and little life experience (Lashinger, Wilk, Cho, & Greco, 2009), resulting in 66% of the new graduate population experiencing symptoms of burnout (Cho, Lashinger, & Wong, 2006). The transition from student to professional has been linked to low-self esteem and decreased confidence (Smith, Andrusyszyn, and Laschinger, 2010). Role stress also has been linked to burnout due to lack of clear and consistent information about the role and conflicting expectations (Chang, Hancock, Johnson, Daly, & Jackson, 2005; Rella, Winwood, & Lushington, 2008) along with lack of support and work overload (Chang, & Hancock, 2003). Due to differences in age and experience, one can anticipate that new graduate nurses experience increased burnout and have different needs than more experienced nurses.

Being unable to utilize knowledge gained during undergraduate education and experiencing incivility from co-workers led to higher levels of burnout (Laschinger, Finegan, & Wilk, 2009). A disconnect was found between expectations and actual experience of workload and fairness, leading to feelings of cynicism and burnout. These levels were found to be highest among nurses within their first year of practice (Lashinger & Grau, 2012).

Bullying from older nurses is not a new topic to this discussion. Almost all nurses are familiar with the phrase “Nurses eat their young”. In a particular study, almost one third of new nurses experienced bullying (Lashinger, Grau, Finegan, & Wilk, 2010). These negative experiences were strongly correlated to the presence of all three components of burnout and affected emotional exhaustion the most. A pattern was discovered that revealed emotional exhaustion quickly leads to cynicism, and cynicism in turn has an effect on efficacy (Lashinger, Grau, Finegan, & Wilk, 2010; Berry, Cillespie, Gates, & Schaefer, 2012). Bullying and burnout also posed a threat to successful transition into the workplace and may have caused increased absenteeism and nurses leaving the profession altogether (Lashinger, Wong, & Grau, 2012).

Leiter and colleagues (2009) found that a greater person/organizational mismatch existed for Generation X nurses than for Baby Boomers. They believe the mismatch was due to the fact that Baby Boomers essentially constructed the current workplace and thus projected their values into it. The research revealed that when a greater value mismatch occurs, there is a greater susceptibility for Generation X nurses to experience burnout and reveal a stronger intention to quit.

Because the topic of burnout among new graduate nurses has not gained interest until recently, researchers are unsure of all factors that may contribute to burnout. Rudman and Gustavsson (2012) examined correlations among nursing students through their first year of practice. The researchers found that burnout increased from 30% to 41% across three years. Emotional exhaustion was prevalent due to feeling unprepared when asked to utilize nursing skills and frustration due to the lack of research utilization (using evidence-based practices learned in school) during the first year of practice. These feelings continued throughout the first three years of practice and were most intense during the second year. Reported symptoms of

burnout increased by nearly 50% and led to increased intentions to leave the profession all together (Rudman & Gustavsson, 2011).

If the nursing shortage is expected to reach 260,000 by 2025 (Rosseter, 2013), strategies must be found to retain new nurses in the workforce. The concept of empowerment may provide solutions to the nursing shortage. The following paragraphs describe how empowerment has been utilized in research and how it directly affects new graduate nurses.

### **Empowerment**

Empowerment in the workplace directly affects nurse perceptions of professional growth and development (Kuokkanen, & Leino-Kilpi, 2000). Nurses who felt empowered were also positively affected to provide improved quality of patient care, including helping nurses to predict fewer falls and other risks (Purdy, Lachinger, Finegan, Kerr, & Olivera, 2010). Nurses also felt compelled to share empowerment structures with their patients, resulting in positive post-hospital stay outcomes and lower readmission rates (Lashinger, Gilbert, Smith, & Leslie, 2010).

The literature reveals that nurses felt respected with the presence of structural and psychological empowerment. Reported lack of respect, or paying attention to and taking seriously another person (Lashinger & Finegan, 2005), is associated with poor job performance and lower perceptions of the quality of patient care (Faulkner & Laschinger, 2008; Ning, Zhong, Libo, & Qiuji, 2009; Lashinger & Finegan, 2005). McDermott and colleagues (1996) found that access to empowerment structures shaped the employee behavior and attitudes toward challenges and situations in the work environment. Commitment toward the organization increased as feelings of empowerment grow. This phenomenon was almost contagious, as sharing power (empowerment) with others expanded one's own power (McDermott, Laschinger, & Shamian,

1996). Also true is the relationship between empowerment and intent to stay. The more empowered a nurse felt, the less likely he or she was to leave the organization (Nedd, 2006).

The presence of structural empowerment was negatively related to the presence of burnout and bullying exposure. Laschinger and colleagues (2010) found that bullying might occur less when work environments provide access to empowering work structures that in turn promote nurses' health and well-being. Feelings of emotional exhaustion and depersonalization are likely to be aggravated by bullying behaviors (Laschinger, Grau, Finegan, & Wilk, 2010). A high level of professional interaction, perceptions of empowerment, and involvement in decision-making has been found to reduce levels of burnout (Breen & Sweeny, 2013).

However, providing access to Kanter's empowerment structures does not solve all problems. Councils and committees, described as resources and opportunity for development, are not effective if nurses do not have the authority to influence day-to-day practice. Without the structures of formal power to make a difference, nurses often become cynical. Cynicism is a component of burnout (Laschinger & Wong, 1999). To ensure feelings of empowerment among staff, managers play a critical role. Nurses have reported that reduced access to the support and resources from managers limited their perceptions of empowerment, leading to reduced ability to provide high quality patient care (Lucas, Laschinger, & Wong, 2008). In contrast, nurses who felt valued and perceived that management was offering good support had lower feelings of burnout (Breen & Sweeney, 2013; Watts, Robertson, Winter, & Leeson, 2013).

**New Graduates.** Empowerment among the new graduate population is a relatively new topic for researchers. The early years of practice have been noted to be a significant confidence-building period for new graduates, however, many are exposed to dis-empowering situations and incivility in the workplace (Smith, Andrusyszyn, & Laschinger, 2010). Access to opportunity,

the prospect of advancing within an organization and a chance to develop knowledge and skills, was the most empowering factor reported by new graduate nurses (Smith, Andrusyszyn, & Laschinger, 2010). This supports previous statements in that the inability to utilize knowledge and evidence based practice learned in undergraduate studies is a leading contributor to burnout (Laschinger, Finegan, & Wilk, 2009).

Structural empowerment is vital to enable new graduate nurses to practice effectively (Laschinger, Wilk, Cho, & Greco, 2009). New nurses desperately need the structure of support to assist them in the transition from student to professional, which is perceived as a dramatic adjustment (Smith, Andrusyszyn, & Laschinger, 2010; Laschinger, Wilk, Cho, & Greco, 2009). Lack of support is also strongly related to turnover intentions (Smith, Andrusyszyn, & Laschinger, 2010; Beecroft, Dorey, & Wenten, 2008). New graduates also need formal orientation and open communication in order to feel empowered. Timely provision of constructive feedback, congruence of patient assignments, participative/democratic governance, and continuing staff development opportunities were shown to contribute to positive perceptions of the workplace (Greenwood, 2000).

As the researcher sought an anecdote to burnout, a common concept echoed throughout multiple study results: empowerment. Leiter and Maslach (2009) state that burnout is the opposite pole of engagement, a concept directly linked to empowerment. Through creating access to empowerment structures, nursing leaders are essentially safeguarding against the development of burnout. Not only is this information applicable to the study at hand, findings from further research studies may affect nurse educators and nurse leaders in managerial positions. The following section describes Kanter's Theory of Empowerment, the chosen theoretical framework for this study.

## **Theoretical Framework**

The theoretical framework for the proposed study is based on Rosabeth Kanter's Theory of Empowerment. In Kanter's model, access to empowerment structures is facilitated through formal and informal power. The following paragraphs evaluate the purpose, proposition, and assumptions related to Kanter's Theory of Empowerment.

The purpose of Kanter's Theory of Empowerment is to describe the relationship between employee's perceptions of empowerment in the workplace and job satisfaction (Kanter, 1972). Rosabeth Kanter developed this theory after studying 19<sup>th</sup> Century utopian communes for her doctoral degree and has carried the concept throughout her studies. Kanter explains the relationships between the structures of empowerment (information, support, resources, and opportunity), formal and informal power, and its application in any organization. The aforementioned relationships predict job satisfaction among employees, along with retention and overall work efficacy. Kanter's theory also prescribes solutions for poor work environments and provides suggestions to increase job satisfaction and employee attitudes in organizations (Kanter, 1972; Kanter, 1993). Kanter considers empowerment the polar opposite of burnout, or disempowerment. She believes that no matter the employees' age, acquisition of empowerment structures through formal and informal power significantly indicates job satisfaction and work effectiveness (Kanter, 1972; Kanter, 1993).

Summation of research findings derived from a literature review generated shared ideas and outcomes. A major theoretical proposition emerges when applying Kanter's Theory of Empowerment to the general nurse population:

Perceived access to empowerment structures (information, support, resources, opportunity) through formal and informal power results in high levels of empowerment,

job satisfaction, and increased quality of patient care as perceived by each individual nurse (McDermott, Laschinger, and Shamian, 1996; Nedd, 2006; Ning, Zhong, Libo, and Qiujie, 2009; Lashinger, Gilbert, Smith, and Leslie, 2010).

A thorough understanding of major theoretical propositions clearly illustrates a gap in knowledge related to new graduate nurses. The assumptions that a new graduate population would share similar experiences with their older counterparts seems illogical. Further research is needed to clarify the propositions related to Kanter's Theory of Empowerment among the new graduate nurse population.

Gaining a thorough understanding of the concepts related to empowerment is essential to truly understanding the relationship between empowerment and burnout among new graduate nurses. The following are major concepts derived from Kanter's Theory: information, support, resources, opportunity, formal power, and informal power. These concepts were discussed in the Literature Review and further descriptions are included in the section entitled "Conceptual and Operational Definitions".

The concept of power, both formal and informal, was most critical to the development of this study. Because burnout is often thought of as deprivation of power or control over a situation, implementing empowerment structures may be the antidote. Access to power and feeling empowered provides the novice nurse with a positive outlook on his or her personal work situation. The opposite, or antithesis, of burnout has been described as empowerment (Gandi, Wai, Karick, & Dagona, 2011; O'Mahony, 2011; Lashinger & Grau, 2011; Leiter & Maslach, 2009) and provides the researcher with a solid foundation for further studies.

A critical appraisal of Kanter's theory reveals that the model is comprehensive in content, is highly abstract, and has conceptual stability throughout definitions and applicability to the

nursing profession. In current literature, the concept of empowerment is used frequently with successful outcomes. The researcher believes that this theory contributes to the nursing profession through congruence to nursing standards and provides structure and direction in the evolution of empowering workplaces.

### **Research Questions**

By understanding the background and significance of the study, coupled with a review of the literature and an explanation of the theoretical framework, provides a foundation for the proposed research. For the purpose of this study, the research questions are as follows:

1. Does age and amount of time worked influence the presence of burnout?
2. Do specific units foster feelings of burnout or empowerment more than other units?
3. Do new graduate nurses experience burnout more frequently than experienced nurses?
4. Is there a difference in responses between new graduate and experienced nurses on the Maslach Burnout Inventory (MBI) subscales?
5. Is there a difference in responses between new graduate and experienced nurses on the Conditions for Work Effectiveness Questionnaire (CWEQ) subscales?

### **Conceptual and Operational Definitions**

#### **Conceptual Definitions**

The researcher notes that a conceptual definition provides a variable or concept with connotative meaning and is established through concept analysis. Conceptual definitions are often developed from the study framework and serves as a link between the study framework and the operational definition of the variable (Grove, Burns, and Gray, 2013). *Burnout* is described by nursing researchers as a psychological syndrome that involves a prolonged response to chronic interpersonal stressors on the job (Rudman and Gustavsson, 2011; Leiter & Maslach,



2009; Beckstead, 2002). Burnout includes three distinct parts: emotional exhaustion, depersonalization, and personal accomplishment. These concepts are measured on three distinct subscales.

*Emotional exhaustion* (EE) describes nurses' feelings of psychological depletion due to work burden. Emotional exhaustion is known as the cornerstone of burnout and is a leading indicator or predictor of burnout. *Depersonalization* is the process of being detached and having an unfeeling response to clients. *Personal Accomplishment* describes feelings of competence and successful achievement at work (Maslach, Jackson, Leiter, Schaufeli & Schwab, 2013).

Kanter (1972;1993) believed that *empowerment* is theoretically defined as the notion of individuals having the power to accomplish their work in a meaningful way. Laschinger and colleagues recently defined empowerment in healthcare as “ensuring that individuals, both nurses and patients, have the resources necessary for maintaining their health and well-being” (Laschinger, Gilbert, Smith, and Leslie, 2010, p. 5). Applying Kanter's concept of empowerment to healthcare provides a unique perspective that is applicable to this study.

Kanter describes empowerment as being composed of the following structures: information, support, resources, and opportunity. The following are definitions of empowerment structures (i.e. information, support, and opportunity) found in Kanter's literature. For this study, the theoretical definition of empowerment was the “ability to mobilize human and material resources to accomplish work” (Kanter, 1972). *Information* was defined as having access to or knowledge of the organization's policies, goals, and beliefs. *Support* involves constructive feedback and guidance from peers and managers as well as emotional support from colleagues. *Resources* are provided through access to supplies, materials, or equipment needed to carry out the work of the organization. *Opportunity* includes future prospects and expectations for mobility

and growth, including furthering education, participation on committees, and advancing careers (Kanter, 1972; Kanter, 1993).

Kanter derived that access to empowerment structures is facilitated by formal and informal power. *Formal power* is influenced by characteristics that increase autonomy and creativity, including participation in decision-making and access to organizational goals. *Informal power* is a result of positive relationships and support from peers, managers, and other groups both internal and external to the organization (Kanter, 1972; Kanter, 1993).

### **Operational Definitions**

In contrast to conceptual definitions, an operational definition is a description of how variables or concepts will be measured in a study (Grove, Burns, & Gray, 2013). In this study, burnout was measured by the Maslach Burnout Inventory (MBI) (Maslach, Jackson, Leiter, Schaufeli & Schwab, 2013). The MBI consists of 22 items on a seven-point Likert scale, where the numbers 0 to 6 represent never to daily. The three components of burnout are included via three distinct subscales: emotional exhaustion (EE), depersonalization, and personal accomplishment (PA). As discussed in the literature review, high scores on the burnout subscales are indicative of burnout.

Empowerment was measured by the Conditions for Work Effectiveness Questionnaire (CWEQ-II). This tool measured perceptions of job-related empowerment, including the concepts of resources, support, information, and opportunity (Lashinger, 2012). Items are derived from Kanter's description of characteristics of powerful and powerless job settings (McDermott, Laschinger, and Shamian, 1996).

Nineteen items on a five-point Likert scale (1-5) measure the six components of Kanter's structural empowerment: opportunity, information, support, resources, formal and informal

power. Each has its own distinct subscale. Items for each subscale are summed to give a total empowerment score that can range between 6 and 30. Higher scores represent higher perceptions of the empowerment construct. A two-item measure of global empowerment is included as a construct validity check. Such questions allow for the exploration and development of the operational definitions of support, information, resources, and opportunity that are crucial to the employees' perception of an empowering work environment (Lashinger, 2012).

### **Assumptions**

The following study assumptions were derived from a number of nursing research articles (McDermott, Lashinger, & Shamian, 1996; Nedd, 2006; Ning, Zhong, Libo, & Qiuji, 2009; Lashinger, Gilbert, Smith, & Leslie, 2010) and coincide with assumptions stated in Kanter's Theory of Empowerment.

1. The organization has a significant effect on an employee's life.
2. Empowerment is the opposite of burnout.
3. Employees have free will despite the restrictions of their positions.
4. Employees' ability to demonstrate their clinical skills is not the same in all positions.

## **CHAPTER III: METHODOLOGY**

The study originated from the author's own reflections regarding burnout and empowerment in nursing, as well as a review of literature that indicated a gap in knowledge. Throughout the following chapter the research design is explained, the population and sample are described, the protection of human subjects is ensured, and the plan for data collection and analysis is provided.

### **Research Design**

The research design for the study sought to answer the aforementioned research questions listed on page 22. The design involved a quantitative method that is descriptive and exploratory. The researcher sought to understand the relationship between burnout and empowerment among new graduate nurses as compared to more experienced nurses. Kanter's Theory of Empowerment contributed to the study through provision of a comprehensive theoretical framework that has been used in multiple nursing studies involving burnout and empowerment.

The framework provided a concept specific to the researcher's study and has influenced the present study in many ways. Power and empowerment have been defined as the opposite of burnout based on the literature review. The provision of this definition and the connection to the entire theoretical framework contributes consistency and meaning to the research design.

The researcher explored the relationship between burnout and empowerment among new graduate nurses. The researcher also sought to discover if years of experience or unit of employment provided any additional indicators or predictors of burnout. Utilizing a structured survey and two validated measurement tools (MBI and CWEQ-II) allowed the researcher to concretely analyze the experiences and perceptions of burnout and empowerment among new graduate nurses in a 400-bed, acute care hospital located in the Midwest. By the use of validated,

accurate tools, the findings have the possibility to contribute to the body of nursing knowledge on burnout and empowerment. The two open-ended questions included at the end of the survey allowed the researcher to further analyze staff perceptions regarding factors that staff believed contribute to burnout and empowerment. These qualitative responses added rich data to supplement the quantitative findings and gave a unique view of perceptions in the organization.

### **Population and Sample**

First and foremost, the population under examination was composed of all nurses who spend greater than 50% of their work time at the patients' bedside and currently work on an acute care unit in a 400-bed, mid-western hospital. The units have been clustered per National Database of Nursing Quality Indicators (NDNQI) definitions (American Nurses Association, 2013) to provide congruity and protect identities of nurses from very small or specialized units. The classifications are as follows: Medical/Surgical, Critical Care, Women/Children, and Specialty/Other. The sample was comprised of the nurses who responded to the survey.

The participants were selected based on convenience. Sampling criteria included being a nurse (LPN or RN), 50% or greater direct patient care responsibilities, full-time, part-time, PRN, or per-diem status and must work on an acute care unit. To clarify, direct patient care responsibilities. As stated by the American Nurses Association's National Center for Nursing Quality, these responsibilities include: medication administration, nursing treatments and nursing rounds, admission, discharge, and transfer activities, patient teaching and communication, coordination of patient care, documentation time and treatment planning (National Database of Nursing Quality Indicators Staff, 2012).

Exclusion criteria were: 1) registered nurses in management, 2) supervisor or 3) nurse educators with less than 50% of job responsibilities in direct patient care, 4) agency or traveler

nurses, 5) new hires or internal transfers employed in current unit or work group less than three months, and 6) nurses on a leave of absence. The aforementioned information was gathered from nursing administration with proper consent and approval. A power analysis was performed to ensure validity and strength of the study.

### **Institutional Review Board Approval**

The protection of human subjects was submitted to the University and Medical Center's respective Institutional Review Boards. The individual participant's identity was protected through the removal of personal identifiers from the survey. The researcher sent the survey link to each unit manager with instructions to forward it on to their staff nurses, protecting the identity of participants, as individual e-mail addresses were not seen. The researcher was unable to see individual responses, further protecting the participants' identity. The survey was distributed electronically; therefore consent was obtained from every subject when accessing the survey link. The researcher explained that the subject could withdraw from the study at any time during the consent process or the survey itself. The computer and data files are encrypted and password protected. Finally, the data and password protected flash drive are kept in a locked file in the researcher's private office.

### **Data Collection**

The following paragraphs depict the process of data collection that includes the procedure for collection, instrumentation, and the plan for analyzing the data. The researcher has achieved understanding of the process that includes gathering supporting information and formulating an accurate plan for the distribution and analysis of results. Due to advancements in technology, additional attention was given to ensure quality and protection of electronic survey responses.

## **Procedure**

The researcher approached unit managers post IRB approval, explained the intent of the study and discussed speaking at unit meetings. However, no unit meetings were hosted during the month of data collection due to budget cuts and time constraints. Instead, the nurse researcher posted fliers on the units and was available for questions during that time. The researcher also created a video that was sent out in an e-mail link that described the purpose of the study, the structure of the survey link, the informed consent process, and assured protection of subjects. Both institutional review boards approved these modifications. The researcher also sent reminders to unit managers to include “Huddle Tips” on the charge nurse boards that would be read as updates and reminders to participate in the survey during shift change. Although this plan was an adaptation of what was originally planned, the researcher believes that consistency and continuity of the recruitment process was guaranteed because the entire study population received the same information in the exact same way.

The researcher distributed surveys via an online survey, a collaborative effort between the researcher, the hospital’s IT department, and the University Group Decision Center. The electronic survey was sent the first Monday in November (November 4, 2013), with reminder e-mails that followed each Monday thereafter for the following three weeks (November 11, 18, and 25, 2013). Responses were collected electronically. Initial and reminder e-mails were sent in the early morning to increase the return rate of the survey (Dillman, Smyth, & Christman, 2009). By conducting the survey during the month of November, the researcher prevented survey fatigue from negatively affecting response rates. The researcher worked with the institution to ensure that other research studies or staff surveys were not being sent out during the months of October

to December 2013. The researcher also made rounds on each unit to encourage staff to take the survey.

### **Instrumentation**

The researcher utilized two validated tools to measure burnout and empowerment. A demographics section was added to quantify additional information that could detect relationships among age, experience, unit, and burnout or empowerment characteristics. The following items were included in the demographic inventory: age, gender, race, highest degree completed (LPN or RN), total years as a nurse, unit, years worked on unit, status (full time, part time, per diem), and an open question addressing involvement at the hospital (unit based council, committees, nursing senate, etc). Two-open ended questions that asked for personal opinions regarding factors that contribute to burnout and empowerment were also included.

The Maslach Burnout Inventory-Human Services Survey (Maslach, Jackson, Leiter, Schaufeli & Schwab, 2013) was utilized to measure the components of burnout: emotional exhaustion (EE), depersonalization, and personal accomplishment (PA). Twenty-two items on a seven-point Likert scale (0-6) (never-daily) represented the three components of burnout on three distinct subscales. A high score on each burnout subscale was indicative of burnout.

The Conditions for Work Effectiveness Questionnaire (CWEQ-II) (Lashinger, 2012), developed by nurse researcher Dr. Heather K. Spence-Laschinger, measured empowerment. Nineteen items on a five-point Likert scale (1-5) measured the six components of Kanter's structural empowerment: opportunity, information, support, resources, formal and informal power. A two-item global empowerment scale was used for construct validation purposes. Items for each subscale are summed to give a total empowerment score that can range between 6 and 30. Higher scores represent higher perceptions of that particular empowerment construct.



## **Data Analysis**

The researcher utilized descriptive statistics to analyze study data. Assistance was sought from the University Statistical Counseling Center at to ensure proper use of statistical procedures and to ensure the quality of data. Multiple statistical tests were used to answer the research questions and are further discussed in Chapter IV. Correlations were noted between subscale responses, age, and unit cluster. For the qualitative portion of the study, the researcher chose to utilize a Heideggerian approach for data analysis. Individual responses to the two open-ended questions were studied and placed into corresponding themes. The researcher became immersed in the data by reading and re-reading content and assuring accuracy of themes. The co-investigator also participated in this activity and validated the four burnout and four empowerment themes. This technique is further discussed in Chapter IV.

### **Data Validity**

The quantitative results were validated by each corresponding statistical test. Qualitative themes were validated because a large number of similar responses fell neatly into themes and sub-themes. The subtheme concepts that had correlating concepts were clustered together and the researcher created and named overarching, corresponding themes. Because this study had a 40.2% response rate (421 responses), enough data to conduct the statistical analysis and achieve meaningful results, the data is thus validated.

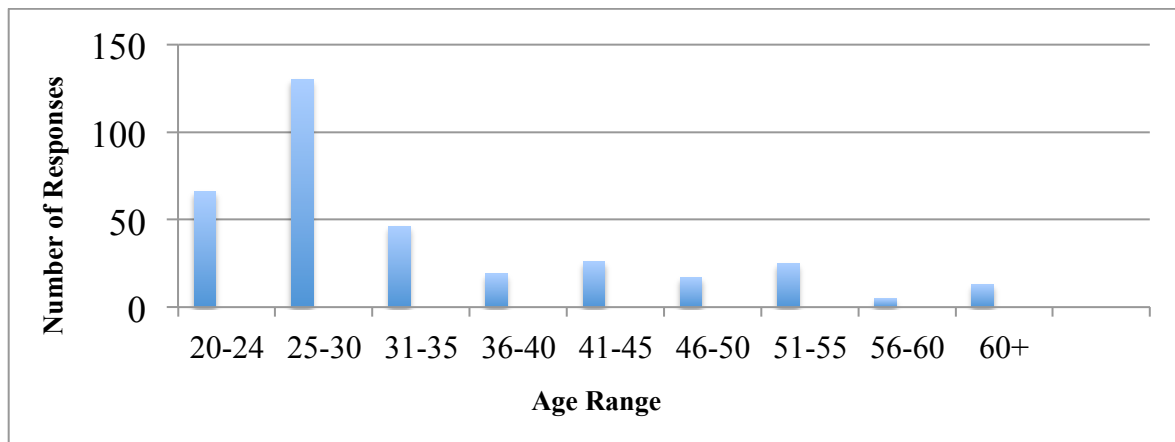
The following chapters present the quantitative and qualitative results of the study, as well as interpretation of the findings and implications for nursing practice. Quotations from the open-ended questions will be included within the discussion. Because the participants were willing to openly share thoughts and personal feelings regarding burnout and empowerment, the researcher believes the collected data to be true and valid.

## CHAPTER IV: RESULTS

In this chapter, the investigator presents the demographics, sample characteristics and relevant descriptors of the respondents while maintaining participant anonymity. The research questions will be answered in numerical order. Lastly, the qualitative themes will be presented.

### Demographic Information

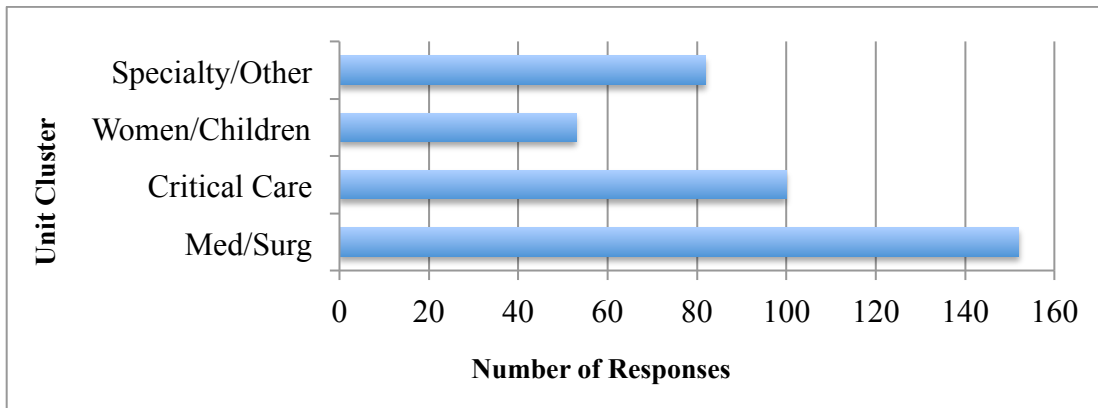
For this study, a total of 421 nurses responded to the survey forming an initial 40.2% response rate. Of that sample, 389 were eligible to complete the survey because they had worked independently (off of orientation) for more than three months, resulting in an adjusted 39% response rate. Ninety-two percent of respondents were female, 97% were Caucasian, and 97% were Registered Nurses. The participants were asked to identify with an age range with 34% identifying with the 25-30 year old age range, and 17% with the 20-24 year-old age range. This information is illustrated in Figure 1.



**Figure 1:** Age Range of Participants

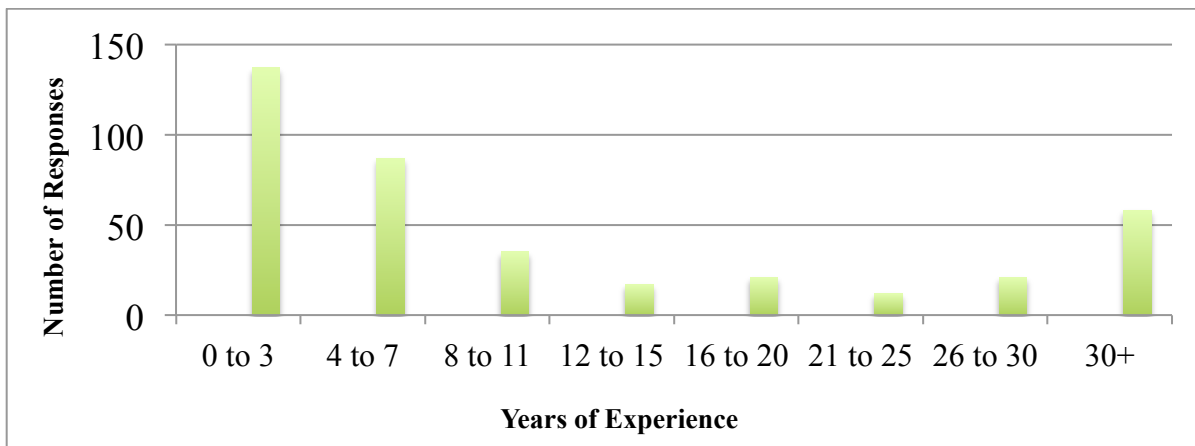
Eighty-six percent of the participants had a full-time employment status, with 10% as part time and 4% per diem. The participants were asked to identify with a unit cluster, established by utilizing the National Database of Nursing Quality Indicators (NDNQI) survey classification. Thirty-nine percent of respondents identified with the Med/Surg unit cluster, 26% with Critical

Care, 14% with Women/Children, and 21% with Specialty/Other. The unit cluster responses are illustrated in Figure 2.

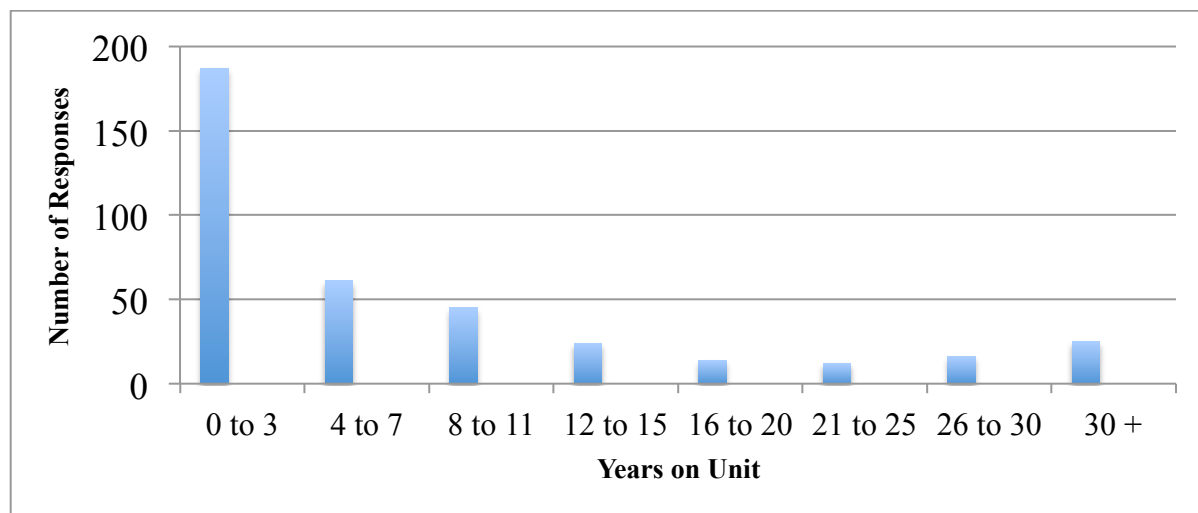


**Figure 2:** Unit Cluster Responses

Thirty-five percent of respondents had 0-3 years of nursing experience, 22% had 4-7 years, and 15% had over 30 years. Years of nursing experience reported by study respondents are illustrated in Figure 3. A similar trend was noted with the total years on their respective units. Forty-nine percent had been on their unit for three years or less, 16% had been there 4-7 years, 12% had been there 8-12 years, and 7% had spent over 30 years on their unit. Total years spent on the respondents' respective units are illustrated in Figure 4.



**Figure 3:** Years of Nursing Experience



**Figure 4:** Total Years on Unit

### Quantitative Results

Overall, a moderate level of burnout (EE  $M = 24.7087$ ,  $SD = 11.5792$ ) (see Table A1) and empowerment (Total Structural Empowerment = 19.14) were noted. Emotional Exhaustion (EE) is the cornerstone for predicting burnout (Maslach, Jackson, & Leiter, 2010) and the Total Structural Empowerment gives a summarized view of empowerment in the workplace. The Total Structural Empowerment value is created by summing the subscales of the CWEQ-II (scores range from 6-30). Higher scores represent greater perceptions of empowerment (Laschinger, 2012). The following paragraphs will describe the statistical tests performed and results for each research question. The researcher's analysis was confirmed by the Statistical Counseling Center. Because no prior information suggested that differences existed across any group means, the researcher operated under a null hypothesis that no mean differences existed between groups. In all tests, a significance level of 0.05 was used.

1. Does age and amount of time worked influence the presence of burnout?

A regression approach was utilized to answer this question. In prediction, regression analysis uses the method of least squares (Kim & Mallory, 2014). The independent (predictor) variable or variables influence change in the value of the dependent variable in regression analysis. The goal is to determine how accurately one can predict the value of an outcome (or dependent) variable based on the value or values of one or more predictor (or independent) variables (Burns, Grove, & Gray, 2013).

Burnout is the dependent variable ( $M=69.1045$ ) with independent variables “age” and “amount of time worked”. The analysis of variance concluded that the overall model p-value was 0.0064, indicating a difference among the means. In predicting with parameter estimates, the p-value for “age” was 0.0648 and is deemed not significant for predicting burnout. The p-value for “amount of time worked” (experience) is 0.4754 and is also not statistically significant in predicting burnout. Therefore, age and the amount of time worked did not significantly influence the presence of burnout in this study. Table 2 showcases statistical detail in regard to this research question.

Table 2

*Comparison Data of Age and Experience Regarding Burnout*

Variable	DF	Parameter Estimates			
		Parameter Estimate	Standard Error	t Value	Pr >  t
<b>Intercept</b>	<b>1</b>	72.92140	1.44626	50.42	<0.0001
<b>Experience</b>	<b>1</b>	0.58411	0.81754	0.71	0.4754
<b>Age</b>	<b>1</b>	-1.55460	0.83924	-1.85	0.0648

2. Do specific units foster feelings of empowerment or burnout more than other units?

A General Linear Model (GLM) procedure was used to answer this question. The GLM procedure uses a regression approach and the method of least squares to fit general linear models (SAS Institute, 2014). The method of least squares helps to develop the line of best fit, or to develop the line that allows the highest degree of prediction possible (Grove, Burns, & Gray, 2013).

The dependent variable (burnout and empowerment) is assumed to be continuous because it is a constructed scale, and the responses are averaged rather than clustered at respective endpoints of the scale. The two scales used were the Maslach Burnout Inventory (MBI) that measures burnout, and the Conditions for Work Effectiveness Questionnaire-II (CWEQ-II) that measures empowerment. The MBI is a combination of three subscales: emotional exhaustion, depersonalization, and personal accomplishment. The emotional exhaustion subscale is composed of nine questions, the depersonalization subscale is composed of five questions, and the personal accomplishment is composed of eight questions. All MBI subscales are measured on a seven point Likert scale (0-6) (Maslach, Jackson, & Leiter, 2010).

The CWEQ-II is a combination of six subscales: opportunity, resources, information, support, formal power, and informal power. Opportunity, resources, information, support, and informal power are each composed of three questions. Formal power is composed of four questions. All CWEQ-II subscales are measured on a five point Likert scale (1-5) (Laschinger, 2012).

**Burnout.** The Maslach Burnout Inventory was averaged for each unit cluster: Medical/Surgical, Critical Care, Women/Children, and Specialty/Other. Overall, the p-value for burnout was 0.0008. Therefore, the researcher initially concluded that the differences of unit

cluster means were statistically significant. The differences in unit means can be seen in Table 3. Using the method of least squares, a comparison of the units was conducted. Critical Care, Med/Surg, and Specialty/Other unit clusters reported no significant difference in regard to perceptions of burnout. In contrast, Women/Children reported statistically significant differences in means in regard to perceptions of burnout. The related p-values can be noted in Table 4.

Table 3

*Comparison of Unit Cluster Overall Means (Burnout)*

	<b>Mean</b>	<b>SD</b>
<b>Med/Surg (1)</b>	71.9858156	14.9479983
<b>Critical Care (2)</b>	68.6195652	15.2133851
<b>Women/Children (3)</b>	61.5208333	15.3622771
<b>Specialty/Other (4)</b>	69.1621622	15.4627498

Table 4

*Pairwise Comparison of Unit Cluster P-Values (Burnout)*

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>1</b>		0.0989	<.0001	0.1959
<b>2</b>			0.0090	0.8191
<b>3</b>				0.0069
<b>4</b>				

A further analysis using the method of least squares was performed to compare the means of each subscale among the four unit clusters. The researcher utilized a pairwise comparison table to illustrate reported p-values among all unit clusters.

**Emotional Exhaustion.** Differences in means were found when comparing Med/Surg with the other three unit clusters, as shown in Table 5. Specialty/Other, when compared with Critical Care and Women/Children, did not have statistically significant differences in means. Differences in means were inconclusive between Critical Care and Women/Children unit clusters (p-value = 0.0526). These p-value comparisons are listed in Table 6.

Table 5

*Emotional Exhaustion Subscale Means*

	<b>Mean</b>	<b>SD</b>
<b>Med/Surg (1)</b>	28.0496454	10.9663943
<b>Critical Care (2)</b>	24.3152174	11.5110356
<b>Women/Children (3)</b>	20.4375000	10.9114546
<b>Specialty/Other (4)</b>	21.2567568	11.4246319

Table 6

*Pairwise Comparison of Emotional Exhaustion Subscale P-Values*

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>1</b>		0.0133	<.0001	<.0001
<b>2</b>			0.0526	0.0812
<b>3</b>				0.6933
<b>4</b>				

**Depersonalization.** Med/Surg, Critical Care, and Specialty/Other responses did not show statistically significant differences in means. Women/Children experienced depersonalization differently than Med/Surg, Critical Care, and Specialty/Other. Table 7 and Table 8 illustrate these differences



Table 7

*Depersonalization Subscale Means*

	<b>Mean</b>	<b>SD</b>
<b>Med/Surg (1)</b>	8.12765957	5.83444337
<b>Critical Care (2)</b>	7.82608696	6.29251901
<b>Women/Children (3)</b>	5.27083333	4.94540226
<b>Specialty/Other (4)</b>	9.20270270	7.09230671

Table 8

*Pairwise Comparison of Depersonalization Subscale P-Values*

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>1</b>		0.7138	0.0056	0.2226
<b>2</b>			0.0198	0.1513
<b>3</b>				0.0006
<b>4</b>				

**Personal Accomplishment.** Med/Surg, Critical Care, and Women/Children did not have statistically significant differences in means. Specialty/Other experienced personal accomplishment differently than Med/Surg, Critical Care, and Women/Children. Means and comparison of p-values are noted in Table 9 and Table 10.

Table 9

*Personal Accomplishment Subscale Means*

	<b>Mean</b>	<b>SD</b>
<b>Med/Surg (1)</b>	35.8085106	7.09216358
<b>Critical Care (2)</b>	36.4782609	6.45607008
<b>Women/Children (3)</b>	35.8125000	7.29516380
<b>Specialty/Other (4)</b>	38.7027027	6.37144686

Table 10

*Pairwise Comparison of Personal Accomplishment Subscale P-Values*

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>1</b>		0.4638	0.9972	0.0033
<b>2</b>			0.5836	0.0373
<b>3</b>				0.0227
<b>4</b>				

**Empowerment.** The Conditions for Work Effectiveness Questionnaire (CWEQ-II) was also averaged among the four unit clusters. Overall, the p-value was 0.0132 and again the researcher concluded that the differences in means among all unit clusters were statistically significant. Using the method of least squares, a comparison of the units was conducted. Differences in means are illustrated in Table 11 and Table 12. Again, a further analysis was performed to compare means for each subscale among the four unit clusters.

Table 11

*Comparison of Unit Cluster Overall Means (Empowerment)*

	<b>Mean</b>	<b>SD</b>
<b>Med/Surg (1)</b>	69.5985401	10.7767860
<b>Critical Care (2)</b>	67.2584270	12.7916238
<b>Women/Children (3)</b>	64.8297872	12.2993799
<b>Specialty/Other (4)</b>	71.4459459	12.7226924

Table 12

*Pairwise Comparison of Unit Cluster P-Values (Burnout)*

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>1</b>		0.1512	0.0188	0.2846
<b>2</b>			0.2604	0.0265
<b>3</b>				0.0032
<b>4</b>				

**Opportunity.** The overall p-value was 0.0501. For the purposes of this study, the researcher concluded that some units did have statistically significant differences in means. As shown in Table 13 and Table 14, Critical Care significantly differed in means when compared to Med/Surg and Women/Children. Otherwise, other unit comparisons did not differ significantly.

Table 13

*Opportunity Subscale Means*

	<b>Mean</b>	<b>SD</b>
<b>Med/Surg (1)</b>	12.2116788	2.39616930
<b>Critical Care (2)</b>	12.7977528	2.29713149
<b>Women/Children (3)</b>	11.6382979	2.50586731
<b>Specialty/Other (4)</b>	12.4729730	2.45073639

Table 14

*Pairwise Comparison of Opportunity Subscale P-Values*

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>1</b>		0.0735	0.1581	0.4506
<b>2</b>			0.0077	0.3899
<b>3</b>				0.0629
<b>4</b>				

**Information.** Table 15 and Table 16 illustrate differences in means regarding perceptions of access to information. Critical Care again differed significantly in means when compared to Med/Surg and Specialty/Other. All other unit comparisons were not significantly different.

Table 15

*Information Subscale Means*

	<b>Mean</b>	<b>SD</b>
<b>Med/Surg (1)</b>	9.06569343	2.87791893
<b>Critical Care (2)</b>	7.95505618	2.58891919
<b>Women/Children (3)</b>	8.34042553	2.91380967
<b>Specialty/Other (4)</b>	8.95945946	2.44074539

Table 16

*Pairwise Comparison of Information Subscale P-Values*

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>1</b>		0.0029	0.1159	0.7869
<b>2</b>			0.4329	0.0196
<b>3</b>				0.2236
<b>4</b>				

**Resources.** Specialty/Other significantly differed in means when compared to Med/Surg and Critical Care. Otherwise, all other unit comparisons did not significantly differ in means.

Data regarding this subscale is shown in Table 17 and Table 18.

Table 17

*Resources Subscale Means*

	<b>Mean</b>	<b>SD</b>
<b>Med/Surg (1)</b>	8.37956204	2.20671231
<b>Critical Care (2)</b>	8.47191011	2.60283887
<b>Women/Children (3)</b>	8.89361702	2.28638734
<b>Specialty/Other (4)</b>	9.39189189	2.51471052

Table 18

*Pairwise Comparison of Resource Subscale P-Values*

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>1</b>		0.7768	0.2043	0.0036
<b>2</b>			0.3286	0.0149
<b>3</b>				0.2646
<b>4</b>				

**Support.** Med/Surg significantly differed in means when compared to Critical Care and Women/Children. All other unit comparisons did not significantly differ in means. Table 19 and Table 20 illustrate these conclusions.

Table 19

*Support Subscale Means*

	<b>Mean</b>	<b>SD</b>
<b>Med/Surg (1)</b>	9.46323529	2.49416530
<b>Critical Care (2)</b>	8.64044944	2.92810515
<b>Women/Children (3)</b>	8.53191489	2.53541064
<b>Specialty/Other (4)</b>	9.05405405	2.72427893

Table 20

*Pairwise Comparison of Support Subscale P-Values*

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>1</b>		0.0243	0.0398	0.2889
<b>2</b>			0.8215	0.3249
<b>3</b>				0.2945
<b>4</b>				

**Formal Power.** Interestingly, Women/Children significantly differed in means from each of the other units. The significant difference in means is noted in Table 21 and Table 22.

Table 21

*Formal Power Subscale Means*

	<b>Mean</b>	<b>SD</b>
<b>Med/Surg (1)</b>	14.0656934	2.79496496
<b>Critical Care (2)</b>	14.0561798	2.63438604
<b>Women/Children (3)</b>	12.5531915	2.78043249
<b>Specialty/Other (4)</b>	14.1351351	3.09362723

Table 22

*Pairwise Comparison of Formal Power Subscale P-Values*

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>1</b>		0.9802	0.0016	0.8646
<b>2</b>			0.0033	0.8588
<b>3</b>				0.0028
<b>4</b>				

**Informal Power.** Critical Care and Women/Children significantly differed in means when compared to Med/Surg and Specialty/Other. Critical Care and Women/Children did not significantly differ from each other. Data supporting these conclusions is shown in Table 23 and Table 24.

Table 23

*Informal Power Subscale Means*

	<b>Mean</b>	<b>SD</b>
<b>Med/Surg (1)</b>	8.56934307	2.39728897
<b>Critical Care (2)</b>	7.60674157	2.65269150
<b>Women/Children (3)</b>	7.53191489	2.21507742
<b>Specialty/Other (4)</b>	9.19178082	2.66488239

Table 24

*Pairwise Comparison of Informal Power Subscale P-Values*

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>1</b>		0.0050	0.0146	0.0867
<b>2</b>			0.8683	<.0001
<b>3</b>				0.0004
<b>4</b>				

3. Do new graduate nurses experience burnout more frequently than experienced nurses?

A T-Test was utilized to answer the third research question. A T-Test assesses whether the means of two groups are statistically different from each other (Grove, Burns, & Gray, 2013). Equal variances were analyzed using the Pooled method, and unequal variances were analyzed using the Satterthwaite method.

The two groups in question were experienced nurses ( $M = 66.4628$ ,  $SD = 15.5879$ ) defined as those with four or greater years of nursing experience, and new graduate nurses ( $M = 70.5636$ ,  $SD = 15.2430$ ), those with three or fewer years of nursing experience. By analyzing the equality of variances (Folded F-test p-value = 0.7646, Pooled p-value = 0.0175), the researcher determined that there was a statistically significant difference in perceptions of burnout between new graduate and experienced nurses.

4. Is there a difference in responses between new graduate and experienced nurses on the Maslach Burnout Inventory (MBI) subscales?

Again, a T-Test and F-Test were utilized to compare the responses of new graduate and experienced nurses. A comparison of group means is listed in Table 25. The researcher concluded that new graduate nurses do not have a significantly higher mean response of Emotional Exhaustion ( $p=0.1353$ ) or Personal Accomplishment ( $p=0.1408$ ). However, there was evidence to conclude that there was a statistically significant difference in means between new graduate and experienced nurses in regard to the Depersonalization subscale ( $p<0.001$ ), as noted in Table 26.

Table 25

*Comparison of Means Among MBI Subscales*

	<b>Emotional Exhaustion</b>	<b>Depersonalization</b>	<b>Personal Accomplishment</b>
<b>New</b>	25.3644	9.0551	36.1441
<b>Experienced</b>	23.4298	5.7521	37.2810



Table 26

*Comparison of P-Values Among MBI Subscales*

	<b>Emotional Exhaustion</b>	<b>Depersonalization</b>	<b>Personal Accomplishment</b>
<b>F-Test</b>	0.2554	0.3728	0.2514
<b>Pooled</b>	0.1353	<.0001	0.1408

5. Is there a difference in responses between new graduate and experienced nurses on the Conditions for Work Effectiveness Questionnaire (CWEQ) subscales?

Again, a T-Test was utilized to compare the responses of two groups: new graduate and experience nurses. The F-test assisted in comparing the variances of two random samples from a normal distribution (Kim & Mallory, 2014). No statistically significant difference in means was found among all six empowerment subscales. See Table 27 and Table 28 for a detailed comparison of means and p-values between new and experienced nurses. Therefore, the researcher concluded that there were no major differences in mean responses between new graduate nurses and experienced nurses.

Table 27

*Comparison of Means Among CWEQ-II Subscales*

	<b>Opportunity</b>	<b>Information</b>	<b>Resources</b>	<b>Support</b>	<b>Formal Power</b>	<b>Informal Power</b>
<b>New</b>	12.4378	8.5622	8.7339	8.9526	13.6867	8.2155
<b>Experienced</b>	12.1379	8.8448	8.5517	9.2328	14.2672	8.4655

Table 28

*Comparison of P-Values Among CWEQ-II Subscales*

	<b>Opportunity</b>	<b>Information</b>	<b>Resources</b>	<b>Support</b>	<b>Formal Power</b>	<b>Informal Power</b>
<b>F-Test</b>	0.0241	0.2263	0.0529	0.2086	0.6158	0.0403
<b>Pooled</b>		0.3663		0.3586	0.0738	
<b>Satterthwaite</b>	0.3031		0.5301			0.4183

### **Qualitative Results**

The researcher utilized a Heideggerian approach to analyze the qualitative data.

Heideggerian phenomenology is different from the work of Edmund Husserl in that Husserl looked at the description of lived experience, whereas Heidegger sought to utilize the interpretation of lived experiences. Heidegger's belief is that the world is knowable only through the subjectivity of being in the world (Grove, Burns, & Gray, 2013).

Heideggerian phenomenologists state that the person is situated in a specific context and time that shapes his or her experiences, paradoxically freeing and constraining the person's ability to establish meanings through language, culture, history, purposes and values. The body, the world, and the concerns unique to each person are the context within which that person can be understood. Heideggerians believe that the person experiences being within the framework of time. Each person only has situated freedom, not total freedom (Grove, Burns, & Gray, 2013; Reiners, 2012).

This philosophy suggests that the researcher is as much a part of the research as the participant, and that their ability to interpret the data is reliant on previous knowledge. According

to Heideggerians, interpretive research free of judgment or influence of the researcher does not exist. The researcher is viewed as “being in the world” of the participant and research question. The researcher must be open and upfront with this viewpoint and accept that he or she cannot understand anything from a purely objective position (McConnell-Henry, Chapman, & Francis, 2009).

The researcher developed two open-ended questions at the end of the survey for participants to express personal ideas regarding factors they believed contributed to burnout and empowerment. Responses to the questions provided rich data that supplemented the quantitative results. The following paragraphs describe the themes that emerged upon analysis of the data.

### **Burnout Factors**

Upon analysis of 257 responses regarding burnout, four themes emerged. Multiple subthemes comprised each of the four themes. A handful of responses were categorized under “other” and were deemed to be non-significant findings in relation to the purpose of this study.

**Negative Work Milieu.** Five subthemes comprised the concept of a negative work milieu. First, subjects reported that the presence of a heavy workload contributed to feelings of burnout. Many nurses explained that higher patient acuity along with higher nurse to patient ratios would lead to negativity. High census of the unit (meaning that all of the beds were full), coupled with a focus on productivity of the unit, rather than the acuity of patients, could contribute to feelings of burnout.

Heavy, difficult, or inconsistent patient assignments led to feelings of burnout. Patient flow on the unit, including admissions at shift change and the quick turnover of patients, and working with unfamiliar patients (ex: cardiac patient on a neurological unit) led to perceptions of

negativity. Finally, added nursing roles and responsibilities with less time and resources, along with additional required documentation resulted in feelings of negativity among respondents.

The second subtheme involved staffing. The respondents perceived a lack of staff on the units, including support staff (nursing assistants), inflexible staffing guidelines (referring back to the focus on productivity versus patient acuity) resulted in negativity. Mandatory stays, feeling pressured to pick up extra shifts because the unit was short or working extra shifts in order to prevent mandatory stays led to increased feelings of burnout.

The third subtheme spoke to a lack of resources on the unit. Older, outdated equipment or equipment that was in need of repair and supplies that were not available when needed was a reported factor that resulted in feelings of burnout. A lack of education among staff regarding changes happening on the unit, having “less time to do more” including extra charting, no breaks, and extended hours led to negativity. One respondent stated that it was disheartening when more items were added to the nursing “to-do” list because extra tasks took away from time getting to know the patient at the bedside.

Environment was the fourth subtheme to emerge. A fast-paced environment (referring to the high turnover of patients and increasing patient acuity) as well as disorganization led to the overall sense of a negative atmosphere among co-workers. A lack of teamwork, poor attitudes and low morale, and a lack of respect among staff contributed to perceptions of burnout. Negativity can lead to increasing turnover rates, which is the final subtheme. Many respondents discussed that seeing high rates of turnover was disheartening and precepting so many new staff was exhausting. A number of nurses also expressed that a perceived lack of professionalism among new nurses also led to negativity in the workplace.

**Need for Just Compensation.** The discussion of pay and finances was a major subtheme in regard to the need for just compensation. Nurses reported minimal pay increases at the facility and the perceived potential to get paid more elsewhere. A lack of benefits, including no pension and perceived minimal compensation for extra hours (lack of pre-commit pay) along with a perceived lack of loyalty to long-term employees contributed to perceptions of burnout. Respondents also reported that the institution only used incentive when management was desperate for staff to fill shifts. Constant focus on the budget was reported as stressful and tiring, and led to a perceived focus on money instead of the patient. Finally, budget cuts that involved removing resources, like a circulating nurse, in addition to “chipping away at [current] benefits” resulted in a negative response.

Inflexible scheduling, a lack of vacation time, and too many shifts in a row led to dissatisfaction among respondents. Rotating shifts (nights to days, every other weekend), long hours and feeling overworked increased negative feelings. Finally, being pulled or floated to other units, coupled with poor orientation to those units, contributed to feelings of burnout.

**Lack of Support by Management.** Respondents revealed that a lack of support from management contributed to feelings of burnout. A deficiency of physician accountability was a major concept in the data. One respondent explained that when “physicians fail to be upfront with patients and family members about the reality of a patient’s diagnosis, which leaves the nurse in a difficult position” they felt burned out. Poor nurse-physician relationships, negativity, and a lack of teamwork also played into negativity of the workplace. Other subthemes included a lack of change where “change is needed”, as well as the managers “not owning [their] work”.

The concept of poor communication also came through loud and clear in the data analysis. Many respondents discussed that they felt like “everything goes through the grapevine”

and a lack of transparency with what information managers relayed to the staff existed. Aside from the need for improved communication, other subthemes included the perception that nurses continued to “eat their young”.

A major subtheme that emerged was a perceived need for improved leadership skills. A lack of involvement of the staff was perceived as a lack of control, and respondents stated they had little participation in decision-making in regard to unit changes. Respondents also felt that no encouragement was provided to increase involvement in unit activities regarding change.

Micromanagement and a lack of transparency also cultivated negativity. Staff felt that they were “kept in the dark” regarding who was making the decisions and why the decisions were being made. Multiple changes occurring too quickly or the perception that the system was in a constant state of change also led to perceptions of burnout. Respondents also perceived disconnect between staff and management, as well as a lack of responsiveness to staff concerns.

Nurses perceived that they were not being heard by management and also “had no say in what happens”. Respondents reported a lack of feeling valued in statements such as “I am just a number” or “I am just a warm body in scrubs”. A lack of recognition or no praise for a job well done was also perceived. One respondent stated that nurses felt like they were “only being told how to do [my] job better with no acknowledgement of how [I] do [my] job well”.

**Toll of Professional Demands.** The final theme encompassed three subthemes: physical, emotional, and mental demands. Many respondents discussed the aspect of hard physical work, including heaving lifting, transferring patients, and being on their feet for over 12 hours. Emotional demands of the profession included the fact that nursing is indeed stressful. Nurses spoke to encountering challenging situations on a daily basis and a few mentioned that a lack of personal positive coping mechanisms would lead to feelings of burnout.

Finally, mental demands included failure or feeling defeated if unable to care for each patient to the nurse's personal expectations or not seeing improvement in patients despite all efforts being made. Many respondents addressed fears of making errors and associated increasing liability due to increasing patient acuity or questioning if documentation was thorough enough. Working with demanding or combative patients, patients with high needs or who are highly anxious, and patients who abuse alcohol, narcotics, or other drugs would lead to feelings of burnout. Caring for patients and families who may have unrealistic expectations, including those that may be ungrateful or who do not realize the hard work that nurses do also contributed to feelings of burnout.

### **Empowerment Factors**

Upon analysis of 200 responses regarding burnout, four themes emerged. Upon analyzing the results, many respondent statements revealed that if they had a particular resource, then they would experience empowerment. Some respondents reported what empowerment was not, and these responses correlated with the burnout themes. Again, a handful of responses were categorized under "other" and were deemed to be not significant findings in relation to the purpose of this study.

**Feeling Valued.** The first theme encompassed what nurses need to feel empowered. Respondents discussed the need for encouragement and positive feedback, acknowledgement and praise for what they do well, and validation of feelings and ideas. Voicing opinions and feeling they were being listened to was extremely important to the respondents. One respondent stated, "In my opinion, nurses just want to know we are appreciated and the easiest way to do that is to tell us". Other respondents explained that something as little as a smile and

compliments from patients and co-workers was enough to feel valued. Others desired to be recognized as an integral profession from other members of the interdisciplinary team.

Perceptions of autonomy, as well as opportunities for growth and involvement in unit governance were evident as proponents of empowerment. Many respondents discussed that being involved in committees, unit activities, and shared decision-making in changes occurring throughout the hospital contributed to positive perceptions. Some explained that currently being involved in the nursing senate or serving as a preceptor also resulted in feelings of empowerment. In relation to problem solving, one response revealed that once a problem was noticed, if staff could come up with solutions and actually see management take staff suggestions to solve the problem was extremely rewarding and empowering. Also, seeing changes that were being made to improve the work environment or “visible action” from management was related to positive feelings.

Being asked for opinions and ideas regarding unit changes was also important contributors in regard to empowerment. One respondent explained, “Being able to make some of our own decisions about staffing and all decisions not coming from people that do not work directly with patients” was key in promoting staff empowerment. Another stated that he/she felt empowered because “our managers truly value and seek out input and keep us in the loop”. Perceptions of respect, support, and “management that believes in you” also contributed to a positive attitude.

**Positive Communication.** The second theme addressed qualities of leadership that were needed in order for staff to feel empowered. Leadership that was involved in the unit, took a “hands-on” approach, and demonstrated open and honest communication allowed staff to know the reason behind the action. Transparency was important to the respondents. When knowing the



reason behind the action, empowerment increased. “Having a common direction of the organization and its goals and [having] all members on board” was valued. One respondent stated, “Management has the ability to be a great resource in terms of flexibility and supporting you as a nurse”. A good example of managerial support came from another respondent that explained how his/her manager encouraged their advancement and knowledge and pushed them to get more involved both inside and outside the hospital setting.

Multiple other responses addressed the need for managers who care about their staff and who “walks the talk” would also contribute to feelings of empowerment. The data supported the need for staff to feel like someone “has their back”. One respondent explained that “having management and/or clinical coordinators not tolerating inappropriate behavior from patients or visitors” was extremely important. Another explained that in their opinion, “having a hands on, hit the floor running manager that is aware of what is happening on the floor is vital. If your leader is unaware and out of touch with the reality of nursing, the whole unit as a whole is going to suffer”.

A majority of respondents also spoke to the simple idea of encouragement from leadership and co-workers, as well as the need for positive, constructive feedback in order to better themselves. One stated that they desired “positive feedback for a job well done. This doesn’t have to be done publicly but to be verbally told, one on one, would be nice”. In general, respondents discussed that conveying a positive attitude to others, “lifting one another up” and being encouraging would lead to feelings of empowerment.

**Nurse Retention.** Building confidence during orientation, continuing education and adequate resources including equipment, supplies, and staff were reported to lead to perceptions of empowerment. “Giving employees the tools needed to perform [their] job with excellence”

was important to the respondents, and as one person further explained that “having the things I need to do my best at my job every day (supplies, equipment, and other people to help)”.

Realistic patient assignments and an appropriate workload were related to increased nurse retention. “Adequate staff and nurse to patient ratio that will allow us to give the great care that is expected of us” and “feeling like I can ‘be a nurse’ with the current [patient] load instead of just doing crisis management and giving pills” contributed to empowerment. Having enough time to complete tasks was also important, especially being able to take breaks and leaving on time, “feeling like you have enough time to look out for patients’ best interests and anticipate interventions”, and being able to take time to know patients were all related to feelings of empowerment.

Educational offerings, gaining new skills and knowledge, access to information and training, and becoming certified led to positive feelings. Opportunities for growth within the unit and organization, in addition to having an opportunity to serve in a leadership position, were also discussed multiple times by the respondents. Improving skills, like IV starts and sufficient training for computerized charting, was also important.

Finally, rewards for length of service, scheduling flexibility, and realistic wages (competitive with other facilities) were reported as contributors to empowerment. Utilizing incentives like pre-commit pay was reported as key to promoting empowerment. Pre-commit pay is utilized at the institution as an extra ten dollars per hour when picking up a shift. For example, the nurse would get a forty-dollar bonus for picking up a four-hour pre-commit shift. Thoughtful scheduling and staff participation in scheduling were important to the respondents.

**Wholesome Relationships.** Support from peers and managers and the perception that managers were advocating for their nursing staff were contributors to empowerment. Again, staff

involvement in unit decisions (manager-nurse teamwork) was related to empowerment. Many respondents discussed the importance of having a “healthy” or “positive” work environment. One nurse even noted that the importance of having a “culture that views mistakes as learning opportunities for growth” in order to feel empowered. Another stated, “You need an environment that fosters empowerment and a feeling of being valued by the institution”.

In order to foster a healthy work environment, some respondents mentioned the need for a positive personal attitude. This concept included “believing that you make a difference”, self-confidence, competence, and self-worth. “Other people demonstrating positive attitudes” and the concept of mutual respect among all members of the interdisciplinary team was also related to an empowering workplace.

Finally, the respondents discussed the importance of teamwork in relation to perceptions of empowerment. Teamwork between physicians and nurses was a popular subtheme, in addition to interdisciplinary collaboration and strong co-worker bonds. Accountability and ownership of one’s own work was also important. One nurse stated that, “I feel as though it is very empowering that most of the physicians work hand in hand with nurses. We are all working as a team and it is nice to be thought of as such and not as inferior”.

## **CHAPTER V: DISCUSSION AND CONCLUSIONS**

The purpose of this study was to determine nurses' perceptions of burnout and empowerment and to discover if a correlation existed between burnout and empowerment structures. The researcher utilized a Heideggerian approach to identify common themes that extended throughout the responses. Once identified, the qualitative themes supplemented quantitative results to capture a thorough understanding of perceptions of burnout and empowerment. In this chapter, the findings from Chapter IV will be discussed and conclusions will be drawn through Discussion of Results. Limitations of the Study, Implications for Nursing Practice, and Recommendations for Further Research will also be presented.

### **Discussion of Quantitative Results**

In order to be thorough and organized in the discussion of results, the researcher will begin by discussing the demographic data. Each research question will then be discussed in numerical order. Once the quantitative results have been discussed in relation to literature, the researcher will discuss the qualitative results.

In regard to demographic data, the researcher noted an overwhelming majority of the registered nurses were Caucasian and female. One research study revealed that across occupations, females have reported higher levels of burnout than males, particularly when they were relatively young or had little work experience (Bakker, Demerouti, & Schaufeli, 2002). This correlates with the current study's findings in that a majority of respondents were female and new graduates, thus contributing to the moderately high level of burnout.

An interesting bimodal effect was noted when looking at the demographic data regarding the total number of years worked as a nurse (Figure 3) and the total years on the respondents' respective unit (Figure 4). Participation from those who had 12-25 years of experience or who

had been on their respective units from 12-30 years significantly decreased in number compared to other group responses.

The researcher notes that bimodal distributions typically have two peaks and a valley. The peaks include two modes, or frequently occurring scores (Grove, Burns, & Gray, 2013). In both Figure 3 and Figure 4, two peaks in data were noted: young nurses and experienced nurses. The valley on the graphs represents a lack in participation from or a lack of nurses who are in the middle of their careers. The bimodal effect shows how burnout may have affected the middle sector of experienced nurses. Another possibility could be that nurses in this age range or point in their profession where they are taking on more management duties and spend less time at the bedside. Other possible explanations could include the fact that they were too busy to participate in the survey, or perhaps the survey did not intrigue them because they may not experience feelings of burnout at this point in their career.

As the qualitative data revealed, frequent orientation of new nurses coupled with inexperience and lack of professionalism of new nurses may lead to feelings of burnout among more experienced nurses. Patrick and Lavery (2007) found that increasing age and working fewer hours was associated with lower levels of emotional exhaustion and depersonalization. This finding fits the current study's bimodal findings in regard to years of experience and years of service on the unit.

#### 1. Does age and amount of time worked influence the presence of burnout?

Interestingly, age and amount of time worked (experience) were not significant factors that influenced the presence of burnout. This is a relatively unique finding as much of the literature states that younger nurses indeed experience burnout more frequently than experienced nurses (Gillespie & Melby, 2003; Ilhan, Durukan, Taner, Maral, & Bumin, 2007). Considering

the demographic data, a majority of participants were new graduate nurses ( $n = 137$ ), those with three or fewer years of nursing experience (Berry, Gillespie, Gates, & Schaefer, 2012; Lashinger, Grau, Finegan, & Wilk, 2010; Lashinger, Finegan, & Wilk, 2009; Smith, Andrysyszyn, & Lashinger, 2010). The researcher reasons that because a majority of new graduate nurses participated in the study, the results of this research question may be skewed.

The bimodal effect of the amount of time worked, noted in Figure 3, could also have an effect on the lack of relationship between age, time worked, and burnout as many of the more experienced nurses did not partake in this study. One study found that age, education, experience, and tenure were not significantly related to empowerment or intent to stay (Nedd, 2006). Therefore, the results found in this study do correlate with previous research. However, it would be beneficial to survey the population again and attempt to gain more participation from nurses who have between eight and thirty years of experience to confirm these findings.

## 2. Do specific units foster feelings of empowerment or burnout more than other units?

The researcher sought to understand how each unit cluster differed in responses on the Maslach Burnout Inventory subscales. Means did differ among the unit clusters. In order to fully understand how each unit cluster perceived components of burnout and empowerment, the researcher examined and compared responses on each subscale.

**Burnout.** By looking at the raw breakdown, the Women/Children cluster had the lowest level of emotional exhaustion ( $M = 20.4375$ ,  $SD = 10.9114546$ ), which is the cornerstone of predicting burnout (Maslach, Jackson, & Leiter, 2010). The Women/Children cluster also experienced the lowest level of depersonalization ( $M = 5.27083333$ ,  $SD = 4.94540226$ ). Therefore, the researcher concluded that the Women/Children unit cluster experienced the least amount of burnout. This finding was consistent with other research that has examined burnout

among nursing staff in birthing units (Kalicinska, Chylinska, & Wilczek-Royczka, 2012). The researcher hypothesized that nurses who work in labor and delivery experience lower levels of emotional exhaustion because they frequently experience moments of joy when babies are born. Laboring mothers are typically not critical and the workload may not be consistently as heavy as those in a typical medical unit. These nurses may also experience low levels of depersonalization due to the fact that assisting a mother through the laboring process involves a great amount of time spent at the bedside one on one, coaching and educating for hours. This type of interaction would allow for connecting with the patient and creating a bond.

Respondents who work in the Med/Surg unit cluster experienced the highest level of emotional exhaustion ( $M = 28.0496454$ ,  $SD = 10.9663943$ ). Their score was considered “high” because it was greater than 27 (Maslach, Jackson, & Leiter, 2010). This finding could be related to the increased acuity and complexity of adult medical patients. Healthcare continues to evolve and nurses are experiencing more demands, including pressure to ensure positive HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey results. HCAHPS was created by the Centers for Medicare and Medicaid Services (CMS) and it utilized for reimbursement (Agency for Healthcare Research and Quality, 2012). Qualitative responses spoke to increasing demands with access to fewer resources and working with difficult patients and families. If more prevalent on Med/Surg unit clusters, emotional exhaustion could be related to many of these factors. The researcher also noted that this cluster had the highest number of responses at 39%, depicted in Figure 2.

Those who identified with the Specialty/Other unit experienced the highest level of depersonalization ( $M = 9.20270270$ ,  $SD = 7.09230671$ ) and the lowest level of personal accomplishment ( $M = 38.7027027$ ,  $SD = 6.37144686$ ). Upon analysis of the units that comprise

Specialty/Other, the researcher noted that both the Adult and Pediatric Resource Team identified with this overarching cluster. According to a job description from the organization, the Resource Team does not have a primary unit and the nurses are trained to work on and float to multiple floors. Because they rarely have the same patients two shifts in a row, these nurses may feel disconnected or detached to the patient, resulting in high levels of depersonalization or being detached and having an unfeeling response to patients (Maslach, Jackson, & Leiter, 2010). The Emergency Department (ED) is also included in the Specialty/Other cluster. Patient turnover happens quickly in the ED, leaving staff little time to connect with patients. On the contrary, emergency department nurses may become burned out or detached from patients who frequent the facility seeking narcotics or a warm place to stay.

Personal Accomplishment describes the feelings of competence and successful achievement while at work (Maslach, Jackson, & Leiter, 2010). Because resource nurses are expected to be familiar with policies and procedures for over eleven units for Adult Resource and three units for Children's Resource, nurses may feel that they struggle through the shift if they are unfamiliar with a particular patient situation or policy. The researcher hypothesized that Resource Nurses may also feel unsuccessful because a great amount of time is needed to become proficient and confident in so many diverse and specialized areas of nursing. Emergency Department nurses may also experience low levels of personal accomplishment or failure when treating critical patients who may not survive, despite all efforts made. Qualitative responses alluded to fearing failure and feelings of helplessness when patients die. This concept appears closely linked to low personal accomplishment.

**Empowerment.** The CWEQ-II was averaged for each unit. Following the CWEQ-II interpretation guidelines, each mean was divided by the number of questions that correlated to



each specific subscale (Laschinger, 2012). Below is Table 29 with the corrected means. An interpretation of findings will follow.

Table 29

*CWEQ-II Corrected Subscale Means for Interpretation*

<b>Unit Cluster</b>	<b>Opportunity</b>	<b>Information</b>	<b>Resources</b>	<b>Support</b>	<b>Formal Power</b>	<b>Informal Power</b>
<b>Med/Surg</b>	4.0705596	3.02189781	2.79318735	3.15441176	3.51642335	2.85644769
<b>Critical Care</b>	4.2659176	2.65168539	2.82397004	2.88014981	3.51404473	2.53558052
<b>Women/Children</b>	3.87943263	2.78014184	2.96453901	2.84397163	3.13829788	2.5106383
<b>Specialty/Other</b>	4.15765767	2.98648649	3.13063063	3.01801802	3.53378378	3.06392694

In regard to empowerment, those who worked in Critical Care were found to have the highest perception of opportunity, which is defined as future prospects and expectations for mobility and growth, including furthering education, participation on committees, and advancing careers (Laschinger, 2012). Critical Care had the lowest access to information, which is defined as having access to or knowledge of the organization’s policies, goals, and beliefs (Laschinger, 2012). The field of nursing is extremely diverse, and multiple job opportunities arise if one has critical care experience. These include returning to school to become a nurse anesthetist, working in post anesthesia recovery or cardiac catheterization labs, or becoming a flight nurse (American Association of Critical-Care Nurses, 2013). In regard to perceptions of access to information, Critical Care nurses place all focus on the patient during their shift and may not have time to learn more about organizational goals or beliefs. Another possibility is that the manager may not share access to organizational information with staff.

Respondents from Specialty/Other experienced the highest access to resources, which includes access to supplies, materials, or equipment needed to carry out the work of the

organization (Laschinger, 2012) and informal power, which is a result of positive relationships and support from peers, managers, and other groups both internal and external to the organization (Laschinger, 2012). Informal power and support were factors found as most strongly related to nurses' feelings of being respected (Faulkner, 2007). Qualitative results explained that when nurses feel respected, they are more likely to feel empowered. Because some of the respondents from Specialty/Other work on multiple units, they may perceive a greater access to resources as they have great knowledge of many disease and treatment modalities. Inpatient psychiatry is another unit that falls under the Specialty/Other cluster. Psychiatric nurses have been found to have lower levels of burnout due to positive environmental factors (Van Bogaert, Clarke, Wouters, Franck, Willems, & Mondelaers, 2013). An increased perception of informal power has been validated in Breen and Sweeny's study. Psychiatric nurses reported a high level of professional interaction and empowerment, as well as good support and high staff morale (Breen & Sweeny, 2013). Perceived access to informal power and resources may buffer negative feelings of depersonalization and personal accomplishment among the Specialty/Other unit cluster, resulting in an overall moderate level of burnout.

Med/Surg nurses experienced the highest access to support, or constructive feedback and guidance from peers and managers as well as emotional support from colleagues (Laschinger, 2012). The perception of support could be influenced by strong relationships with unit managers, positive co-worker bonds, as well as open and honest communication shown by qualitative statements. High support in medical/surgical nurses is new to the body of research surrounding empowerment. Previous studies have confirmed other areas of nursing to have highest access to support, including psychiatric (Van Bogaert, Clarke, Wouters, Franck, Willems, & Mondelaers, 2013), pediatric (Beecroft, 2007), and birthing units (Kalicinska, Chylinska, & Wilczek-

Royzcza, 2012). Because the current study is unique in that it compares multiple areas of nursing, Med/Surg nurses experiencing support is unique and contributes additional knowledge to this field of study.

Interestingly, the Women/Children cluster that had scored moderately on the rest of the empowerment subscales and perceived the lowest formal power on their respective units. Formal power is influenced by characteristics that increase autonomy and creativity, including participation in decision-making and access to organizational goals (Laschinger, 2012). Although respondents from Women/Children reported the lowest perception of burnout, they reported only moderate perceptions of access to empowerment structures (reported in Table 28). The researcher found no existing literature to support this finding. Perhaps the responses from the Women/Children unit were due to the unit culture or a recent change that altered the staffs' perceptions at the time of the survey.

The researcher noted that this study was extremely unique and these results could be the first of its kind. Many studies have explored the comparison of burnout and empowerment between two units. Because this study explored the perceptions of both burnout and empowerment among four unit clusters that are composed of over 22 units, the results provide the perceptions and insights from a large group of nurses in the organization.

### 3. Do new graduate nurses experience burnout more frequently than experienced nurses?

By examining the T-Test results and comparing means, new graduate nurses ( $M = 70.5636$ ,  $SD = 15.2430$ ) did indeed experience a higher level of burnout when compared to experienced nurses ( $M = 66.4628$ ,  $SD = 15.5879$ ) in this study. A high level of burnout among new graduate nurses correlated with previous research findings. Younger nurses and nurses working full time are particularly vulnerable to burnout, and was complicated by the broad

demands of nursing in general (Spooner-Lane & Patton, 2007). Eighty-six percent of nurses in the current study reported full-time status and a large number of nurses were new graduates (n = 137). The researcher hypothesizes that inexperience coupled with full time status and reported demands of the profession (revealed in the qualitative data) led to new graduate nurses experiencing a higher level of burnout.

Although the results from this question confirmed that new graduate nurses experienced burnout more frequently than experienced nurses, the researcher noted that both groups of nurses perceived moderately high levels of burnout. The first research question revealed that age and the amount of time worked (experience) did not influence the presence of burnout. This finding is again unique when compared to the body of research regarding burnout among the new graduate population. This finding also adds a different perspective that all age groups of nurses experience burnout, and that research should instead focus on frequency of burnout instead of its general presence.

4. Is there a difference in responses between new graduate and experienced nurses on the Maslach Burnout Inventory (MBI) subscales?

Again, the researcher noted differences in responses on the MBI subscales among the unit clusters in the second research question. One difference was noted when comparing new graduate and experienced nurse responses on the MBI subscales. By looking at the means, the researcher concluded that new graduate nurses experienced a higher level of depersonalization ( $M = 9.0551$ ,  $SD = 6.1879$ ). New graduate nurses may experience a higher level of depersonalization because they may not have enough time to connect with their patients as they are focused on “learning the ropes” and are more task oriented. The researcher hypothesizes that new graduates may experience disconnect between their expectations of nursing that are formed

during undergraduate education and the reality they are confronted with upon entering the profession. Young nurses may lack confidence or coping skills when faced with difficult patient and family situations. As stated in the qualitative data, “nurses continue to eat their young”. Hostility from experienced nurses and an unbalanced skill mix where young nurses are taking on higher responsibility coupled with perceived lack of support from managers and lack of time for group reflection may contribute to feelings of depersonalization.

When the workplace fails to provide nurses with sufficient time to engage in clinical supervision, emotional exhaustion and depersonalization increase. This creates a disparity between nurses’ needs and the extent to which the workplace is meeting those needs (Fearon & Nicol, 2011). Interestingly, a study performed by Patrick and Lavery (2007) found that increasing age and working fewer hours was associated with lower levels of emotional exhaustion and depersonalization. This supports the finding that new graduate nurses do experience higher levels of depersonalization as explained in the third research question.

5. Is there a difference in responses between new graduate and experienced nurses on the Conditions for Work Effectiveness Questionnaire (CWEQ) subscales?

The researcher had noted differences in responses on the CWEQ-II subscales among the unit clusters in the second research question. However, there was not a statistically significant difference in means between new graduate and experienced nurse responses. Therefore, the researcher concluded that new graduate and experienced nurses did not differ in the ways in which they perceive empowerment, shown in Table 27 and Table 28.

Previous literature regarding empowerment did not support these findings. Most research studies examined differences in perceptions between two groups: new graduate versus experienced nurses or one particular area of nursing versus another. These results may be due to

the fact that a majority of participants were new graduates ( $n = 137$ ) and that a number of more experienced nurses did not participate (see Figure 3). Qualitative responses may answer this question more thoroughly. The researcher hypothesized that it is possible that all nurses, regardless of age or amount of experience, seek the same structures in order to feel empowered. Additionally, the qualitative results provide insight to the organizational culture and supplement findings from the five research questions.

### **Discussion of Qualitative Results**

Upon analysis of the results, the researcher noted that an inconsistency of scores occurred when comparing the qualitative statements to the quantitative scores. Overall, the scores for the Maslach Burnout Inventory and the Conditions for Work Effectiveness Questionnaire revealed moderated levels of burnout (EE  $M = 24.7087$ ,  $SD = 11.5792$ ) and moderate levels of empowerment (Total Structural Empowerment = 19.14). The qualitative statements portrayed more frustration and negativity than would be expected with a moderate level of burnout. The researcher hypothesized explanations for the obvious disconnect, including that many of the respondents may have used the open-ended questions as a venting mechanism. Participants may have been distracted by interruptions such as phone calls, patient call lights, and co-workers while taking the survey, resulting in the participant not thoroughly reading each quantitative question and answering it appropriately. Also, the tools may have been too generalized to measure the respondents' personal feelings regarding burnout or empowerment. The researcher also noted that the qualitative answers could have reflected frustrations that a neighboring state has a nursing union where benefits and pay are substantially higher.

Despite the differences in responses, many of the qualitative responses reflected what previous research studies have found when investigating the presence of burnout and

empowerment in acute care nurses. These findings are further discussed in the following paragraphs.

## **Burnout**

The social climate of the workplace can be negatively associated with burnout (Fearon & Nicol, 2011; Garrett & McDaniel, 2001; Leiter & Maslach, 2009). The concept of the social climate reported by the study respondents has been described as a negative work milieu. Components of a negative work milieu include a heavy workload, inadequate staffing, a lack of resources, the overall negative environment, and increasing staff turnover. Garrett and McDaniel (2001) studied the impact of environmental uncertainty that included the overall unit uncertainty. These concepts describe that when nurses experience uncertainty regarding the number of patient admissions, discharges, and transfers, their perceptions of stress, along with emotional exhaustion, increase. The study results found that the presence of environmental uncertainty affected all three components of burnout: high emotional exhaustion and depersonalization, coupled with low perceptions of personal accomplishment (Garrett & McDaniel, 2001).

The theme of a negative work milieu encompassed many subthemes, including the presence of a heavy workload. A heavy workload has been shown to influence the presence of burnout. Increased workload demands, such as many patients with varying needs per nurse, were associated with emotional exhaustion (Gandi, Wai, Karick, & Dagona, 2011). As previously discussed, Aiken, Clarke, and Sloane (2002) found that each additional patient per nurse was associated with a 23% increase in the chance that burnout will occur. For example, the authors found that nurses who had an 8:1 patient to nurse ratio would be around twice as likely to experience emotional exhaustion than a nurse who works with a 4:1 patient to nurse ratio (Aiken, Clarke, & Sloane, 2002). Because a large number of responses described frustrations regarding

heavy patient workloads, the researcher noted this as an important finding. An appropriate patient load is also necessary for new graduates to gain positive reinforcement from their work by seeing the results of their input. By doing so, new graduates may experience lower levels of burnout and retention rates could subsequently increase (Chang & Daly, 2001). Workload has also been found to have potentially deleterious influences on the perceived level of staff burnout, thus effecting quality of care and job outcomes (Van Bogaert, Clarke, Wouters, Franck, Willems, & Mondelaers, 2013).

The nurses who responded to this study made it very clear that a lack of teamwork, low morale, and incivility led to feelings of burnout. Nurses' perceived that concerns were not being heard by management and "having no say in what happens", speaking to a lack of validation. Other responses included negative feedback from management that overshadowed what was being done correctly and a perceived lack of appreciation. Other important concepts, including the need for managerial support, feeling valued and validated, have also been reflected in other studies. Aiken and colleagues' (2002) study found that nurses felt overburdened, ignored, and undervalued by administrators and thus experienced higher levels of dissatisfaction with their work environment. A lack of involvement in decision-making can lead to cynicism. Laschinger and Wong (1999) found that most "shared governance" efforts were seen by staff as chiefly structural with staff nurses on councils and committees but were without the authority to have significant control over professional practice.

Support continued to be a prevailing theme among the qualitative responses. Nurse managers are expected to be visible in the clinical setting by talking to nurses, asking questions and listening to the worldview from the staff nurse perspective. This can give nurse managers a fresh perspective of the current reality of nursing practice (McDermott, Laschinger, & Shamian,



1996). One study found that when nurses were continually seeking support, turnover intent and burnout were present (Beecroft, Dorey, & Wenten, 2008). A poor relationship with managers may lead to perceptions of supervisor incivility, increasing feelings of emotional exhaustion and cynicism. These factors have strongly predicted job dissatisfaction and low levels of organizational commitment (Lashinger, Wilk, Cho, & Greco, 2009). Support is needed in order to combat feelings of burnout (Kalicinska, Chylinska, & Wilczek-Royzcza, 2012).

In the current study, one respondent stated he or she felt like “nurses continue to eat their young”. Work place bullying can negatively impact productivity (Berry, Gillespie, Gates, & Schaefer, 2012). Bullying has been found to occur in negative workplaces where emotional exhaustion and depersonalization (cynicism) are high (Lashinger, Grau, Finegan, & Wilk, 2010; Lashinger, Wong, & Grau, 2012). Bullying can affect the cognitive demands of new graduate nurses and their ability to handle or manager their workload (Berry et. al, 2012).

While much of the research deems bullying to be a result of burnout, other causes may stem from generational differences. The current study’s demographics illustrated a wide span between age (Figure 1) and years of experience (Figure 3). The researcher hypothesizes that generational differences may exist and could create a hostile work environment. Fearon and Nicol (2011) found that skill mix may increase the risk of burnout. Leiter, Jackson, and Shaughnessy (2009) revealed that a greater person/organizational value mismatch occurred for Generation X nurses than for Baby Boomers. The authors believe that this happens because the Baby Boomers have essentially constructed the current workplace and have therefore imprinted their values. A greater value mismatch is related to a greater susceptibility to burnout and a stronger intention to quit for Generation X nurses (Leiter, Jackson, and Shaughnessy, 2009). Negativity of the workplace and a low morale can result in increased perceptions of co-worker

incivility that, in one study, was believed to be related to generational differences (Smith, Andrusyszyn, & Laschinger, 2010).

Another theme had emerged during data analysis that spoke to the need for just compensation. Many respondents were unhappy with current benefits, coupled with long shifts and pressure to pick up additional shifts on their days off. Feeling pressured to pick up extra shifts occurs due to increasing staff turnover and a higher patient census resulting in increased staffing needs. Patrick and Lavery (2007) studied the effects of age and hours worked. Working overtime (not voluntarily) was associated with increased levels of emotional exhaustion. The authors also found that when staff felt pressured and/or expected to work overtime, levels of emotional exhaustion and depersonalization increased.

The toll of professional demands was a final burnout theme that described how difficult the profession can be on a nurse's physical, mental, and emotional health. Respondents described situations where they were on their feet all day, lifting heavy patients, coping with the death of patients as well as dealing with difficult or demanding patients and families. New nurses may experience a high level of psychological distress or "culture shock" when entering the profession. One study found that new graduate nurses were more likely to perceive an imbalance between effort expended on the job and rewards received, coupled with low decisional latitude, high psychological demands, high job strain, and low support from colleagues and superiors (Lavoie-Tremblay, Wright, Desforges, Gelinas, Marchionni, & Drevniok, 2008).

Gillespie and Melby's (2003) study correlated well with the qualitative burnout results. The authors found that acute care nurses experienced high levels of emotional exhaustion. Reasons included staff shortages, skill mix, increased workload, a focus on cost-effectiveness instead of safe patient care, unrealistic expectations of patients and their families, a perceived

lack of support from managers, poor communication, a lack of time for group reflection, and junior staff with high needs. These concepts reflect much of the qualitative data presented in the current study, as well as quantitative results. In the current study, some respondents explained that they felt burned out because they were precepting too many new staff. Length of shifts that are both physically and mentally draining and shift rotations were also indicated to play into perceptions of burnout (Gillespie & Melby, 2003). Again, these findings reaffirm that acute care nurses, those surveyed in the present study, experienced frustrations that are not new to the profession.

### **Empowerment**

The researcher previously noted that the opposite of burnout is defined as empowerment (Gandi, Wai, Karick, & Dagona, 2011; O'Mahony, 2011; Lashinger & Grau, 2011; Leiter & Maslach, 2009). Empowering work environments are predictive of nurses feeling more autonomous and that their work is meaningful. These perceptions contribute to job satisfaction (Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010). Autonomy, along with receiving acknowledgement, was a large part of what study participants related to feeling valued in the workplace. Faulkner and Laschinger (2008) surmised that respect is closely aligned with leadership practices that empower nurses to practice autonomously within interdisciplinary teams. According to nurses in the current study, constructive feedback from supportive managers was also indicative of respect and promoted feelings of being valued. Nurses who participated in the current study also expressed the need for their efforts and concerns be brought to the forefront and to be recognized for their participation in organizational activities.

Some studies have focused their attention on what new graduates perceive as empowering. Smith, Andrusyszyn, and Laschinger (2010) found that access to opportunity was

the most empowering for new graduates. New graduate nurses felt that goal achievement was also important. In order to practice within professional standards, new graduates must have access to an adequate amount of resources to feel empowered (Lashinger, Wilk, Cho, & Greco, 2009). Many responses of the current study spoke to the need for resources and revealed that when nurses had adequate human and material resources, they perceived feelings of empowerment. Access to opportunity within the organizational, positive and open communication, recognition, and constructive feedback were also vital to perceive empowerment.

Nurse retention was also an important concept to study participants. Responses suggested that building confidence during orientation, availability of resources, appropriate workload, and rewards for length of service would contribute to feelings of empowerment. Participant suggestions were validated by previous research. Beecroft, Dorey, and Wenten (2007) found that if nurses were satisfied with their jobs, their pay, and if they felt committed to the organization, feelings of turnover decreased.

Finally, qualitative responses spoke to a need for wholesome relationships. This theme included support from peers and managers, involvement in unit decisions, teamwork, and an overall positive unit environment. Van Bogaert and colleagues (2010) found that with teamwork, staff was more able to cope with the complex tasks of patient care. Supportive environments were less likely to fuel emotional exhaustion and feelings of cynicism (depersonalization) (Lashinger & Grau, 2012). Workplace structures are foundational in shaping and enhancing work experiences and employee work life. Nurses in the current study expressed immense need for a positive relationship with management and to be validated in personal feelings and

concerns. The researcher hypothesizes that when needs are not met, depersonalization and burnout occur.

Tourangeau, Cummings, Cranley, Ferron, & Harvey (2009) sought to understand factors that influenced nurse retention. The findings of their study correlated significantly with the current study's results. The concepts listed below validate what this study's participants reported in the qualitative findings. As revealed in Tourangeau and colleagues research, nurses reported needing the following in order to remain empowered:

- Positive relationships with co-workers;
- Adequacy of both human and material resources for providing patient care;
- Visibility of and support from one's manager, including direct praise and recognition;
- Work rewards including pay, benefits, vacation time, flexible scheduling, and formal recognition for knowledge, experience, and effort;
- Access to funded educational opportunities, adequate orientation and ongoing formal support for new hires;
- Opportunity to participate in decision-making;
- Finding a balance between personal and professional life, not being called to come in and work on scheduled days off;
- Positive connections with patients and families;
- Manageable workload, including having the time to provide adequate care;
- External factors including competitive pay in relation to other local institutions.

The qualitative data from the current burnout study correlated well with previous research. The qualitative responses of this study are unique to the nursing profession. Multiple studies have found similar results when examining factors that contribute to burnout and empowerment. Therefore, the researcher concludes that the current study results are generalizable and relatable to a broad nursing population. Regardless of age or time spent in the profession, nurses need to perceive access to empowerment structures in order to combat burnout and remain positive about the nursing profession.

### **Limitations of the Study**

A number of limitations were identified in this study. The response rate was only 40%, therefore, roughly 600 nurses did not reply to the study. Those participants could have swayed the results one way or another as only a moderate level of burnout and empowerment was discovered. The majority of respondents were registered nurses, Caucasian, and female. This limits generalizability to other populations. Finally, the study was conducted at only two campuses of one institution in one city.

### **Implications for Nursing Practice**

Many implications for nursing practice have surfaced related to the study findings. The following paragraphs will describe research-based implications for nursing management in regard to promoting empowering environments. In accordance with the present study, support, general nurse needs, and potential interventions will be discussed. These categories were chosen due to the overwhelming qualitative responses and associated themes.

#### **Support**

A resounding concept from the qualitative data was the need for support. Institutions, especially managers, must increase their awareness of staff burnout. They must develop an ability to recognize signs of unhappiness in order to facilitate the possibilities for providing support in order to prevent burnout (Ericson-Lindman & Strandberg, 2007). Supportive workplaces, especially in times of change, can be protective against burnout. Emotional exhaustion can be reduced if nurse leaders promote work environments that increase perceptions of supervisor support and work involvement (Garrett & McDaniel, 2001). Many managers may be unaware of the untapped potential they possess to create a positive work environment. Performing periodic assessments of staff perceptions regarding unit uncertainty, encouraging

staff feedback on decisions, and articulating expectations regarding job performance is important (Garrett & McDaniel, 2001). Nurses need support and the opportunity to participate in decision-making. They will then realize their power and use it to improve the work environment.

Essentially, managers must help staff to secure power in order to breed empowerment (Glasberg, Norberg, & Soderberg, 2007). In relation to the present study, more staff involvement regarding patient flow, unit decisions, and scheduling may enhance perceptions of supervisor support and decrease the potential for burnout.

Supervisor support is an important coping resource (Schaufeli, 1999; Breen & Sweeney, 2013). Managers must strive toward improving work environments so that new nurses choose to stay in the profession (Lavoie-Tremblay, Wright, Desforges, Gelinas, Marchionni, & Drevniok, 2008). As new graduate nurses accumulate more experiences in a supportive environment, they may develop greater optimism, resilience, and a sense of hopefulness about their career (Laschinger & Grau, 2012). Nurses who view their work environments as empowering are more likely to provide high quality care. Enhancing empowerment in a supportive environment would allow nurses to experience satisfaction with their jobs (Ning, Zhong, Libo, & Qiujie, 2009). Interventions like recognition programs, teamwork, and specific timely feedback are not used nearly enough. These will help increase feelings of empowerment and worth, thus increasing commitment to organizational goals (McDermott, Laschinger, & Shamian, 1996). The present study revealed the importance of nurse managers working side by side with their staff. Respondents stated that increasing involvement and transparency, along with encouraging team building would help increase feelings of empowerment.

Finally, managers need to avoid labeling staff as unable to cope. Staff must feel comfortable about seeking support, as this should be considered normal and routine. By keeping

staff involved in changes happening on the unit, feelings of burnout may be reduced (Watts, Robertson, Winter, & Leeson, 2013). By promoting a supportive unit culture, perceptions of empowerment increase as feelings of negativity decrease. Many participants in the current study greatly valued support, yet many other needs were revealed and will be discussed in the following section.

### **Nurse Needs**

Engagement and involvement in the workplace was important to the current study's participants. Decreasing nurse participation in hospital affairs can lead to increasing feelings of emotional exhaustion due to a perceived lack of control (O'Mahoney, 2011). Involving nurses in decision-making and to have managers involved at the unit level is imperative (Van Bogaert, Kowalski, Weeks, Van heusden, & Clarke, 2013; Nedd, 2006; Chang, Hancock, Johnson, Daly, & Jackson, 2005). In order to promote engagement at work, strong leadership is vital. New graduate nurses, along with their experienced colleagues, desire to practice according to professional standards and value working in collegial settings (Lashinger, Finegan, & Wilk, 2009).

Nurses need to experience positive relationships with colleagues and supervisors. A positive relationship with colleagues and physicians has been found to decrease perceptions of emotional exhaustion and depersonalization (O'Mahoney, 2011). Empowered workplaces can improve teamwork that supports higher quality of care and more satisfied nurses (Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010). Recognition of nursing practice councils and the act of shared governance is also important to provide feelings of empowerment (Bogue, Joseph, & Sieloff, 2009).



Respondents also discussed the need for positive, strong managers that advocate and support their nursing staff. An example of this leadership style is authentic leadership. Authentic leadership creates supportive work environments and may reduce the probability of a negative culture developing. Authentic leadership contributes to a workforce that is less burned out, more satisfied with their jobs, and less likely to leave (Laschinger, Wong, & Grau, 2012). Managers indeed have the influence and resources to facilitate empowering work conditions that can increase nurses' feelings of being respected. Managers can also promote collaborative inter-professional and intra-professional relationships, along with providing continuous support to staff nurses. These concepts have been found as strategies for building respect and a positive environment (Faulkner & Laschinger, 2008).

Qualitative results discussed the importance for a positive relationship with management. In previous research, the concept of span of control was deemed a significant moderator of the relationship between nurses' perceptions of their manager's emotionally intelligent behavior and feelings of workplace empowerment. Span of control is described as the number of people who are supervised by a manager, alluding to the idea that a maximum number of employees can be effectively supervised and supported. Even managers may not be able to empower their staff if their span of control is large and if they are unable to focus enough attention on each employee. Due to this fact, each manager must develop their own leadership skills in order to empower staff and overcome large spans of control (Lucas, Laschinger, & Wong, 2008). Managers must also look beyond nurse to patient ratios and examine how the workplace is structured and organized to support nurse wellbeing, team performance, and the quality of patient care (Van Bogaert, Kowalski, Weeks, Van heusden, & Clarke, 2013).

Managers should find strategies that empower nurses for professional practice. This may be helpful in preventing workplace incivility, and therefore burnout (Laschinger, Finegan, & Wilk, 2009). Management influenced by the idea of empowering their staff can serve to strengthen staff nurses' professional self-esteem, which in turn will contribute to professional growth and development. Staff, however, cannot feel empowered merely by delegation (Kuokkanen & Leino-Kilpi, 2000).

Management must assure employees access to the information, support, and resources necessary to accomplish work and provide ongoing opportunities for employee development within the work setting. By doing so, leadership is actively combating burnout and depersonalization (Laschinger & Wong, 1999). The use of stress education and management strategies to decrease negative effects of stress also has been effective. By promoting team-building strategies, balancing priorities, enhancing social support through engaging in activities and peer support, managers provide access to empowerment structures. Flexibility of work hours, protocols to deal with violence, strategies to build commitment, and providing timely feedback as well as opportunities for staff to build autonomy can also provide a positive, supportive work environment (Chang, Hancock, Johnson, Daly, & Jackson, 2005).

Manageable workloads and enhancing workplace health will promote a nursing model of care that increases the perceived fairness of professional and organizational values in the organization (Maslach and Leiter, 2009). Implementing a system of recognition and acknowledgement, along with good co-worker relationships may also increase feelings of empowerment. Additionally, managers must have strategies in place to combat incivility and disempowerment in the workplace to prevent further attrition (Smith, Andrusyszyn, & Laschinger, 2010).

Resources are an important piece to feeling empowered. When nurses felt overburdened, ignored, and felt that resources were inadequate (including staff help), the chances of burnout increased (Aiken, Clarke, & Sloane, 2002). One study found that although job demands were high, an increased perception of job resources essentially buffered the negative role of an increased workload. Essentially, when staff had adequate resources to provide patient care, the presence of emotional exhaustion decreased (Gandi, Wai, Karick, & Dagona, 2011). An organizational intervention is needed to decrease workload placed on nurses (Schaufeli, 1999) in order to reduce the presence of burnout.

Participants in this study also discussed the toll of professional demands. Managers need to recognize the importance of working reasonable hours, as well as to understand the potential detrimental effect that having to work pressured or unexpected overtime has on staff (Patrick & Lavery, 2007). Nursing is indeed a stressful profession. Creating positive learning experiences, providing effective role modeling, and offering encouraging verbal support will result in a feelings of empowerment (Laschinger & Grau, 2012). Collaborating with other novice professionals will also help to reduce the stressful impact on new nurses' health and ability to provide care (Rudman & Gustavsson, 2011).

Managers must be aware that new nurses may already be suffering from a significant amount of stress and fatigue (Rella, Winwood, & Lushington, 2008). Burnout may start to develop during higher education (Rudman & Gustavsson, 2012) and when coupled with role stress experienced when entering the profession (Chang & Hancock, 2003; Chang, Hancock, Johnson, Daly, & Jackson, 2005), new graduate nurses have special needs in order to remain empowered. Adequate mentoring and guidance, as well as effective stress management may be essential to best support new nurses (Rella, Winwood, & Lushington, 2008).

## **Interventions**

Specific interventions have been studied among the nursing population. One example is Problem-Based Learning. This method increases perceptions of structural and psychological empowerment. It includes a collaborative approach to education and allows for each participant to take accountability for his or her own learning. Through PBL, participants find increased access to support by forming networks, opportunity, resources, and information (Siu, Laschinger, & Vingilis, 2005). Although PBL was implemented in undergraduate nursing education, it can easily be implemented into staff education. When nurses take ownership of their own education, they feel empowered and thus have increased perceived access to empowerment structures. Problem-Based Learning is applicable to the current study's nursing population because they seek independence, positive co-worker relationships, and access to resources, opportunity, and information.

Luthans, Avey, and Patera (2008) demonstrated success of an online, cost effective intervention strategy aimed at developing the four core components of psychological capital. As previously mentioned, psychological capital is a personal resource factor that is comprised of self-efficacy, hope, optimism, and resilience. Psychological capital has been shown to influence employees' responses to their work. For example, with increased psychological capital, new nurses' perceived a greater sense of fit between their job expectations and actual working conditions, thus increasing empowerment and decreasing negative perceptions such as bullying. Developing psychological capital among the current study's participants is applicable due to the reports of negative unit culture, bullying, and overall perceptions of feeling burned out. Encouraging the individual to foster feelings of hope, optimism, and resiliency could assist in changing the overall organizational culture.

Regardless of unit or level of burnout and empowerment, managers must understand value differences between generations to become more responsive in the workplace (Leiter, Jackson, & Shaughnessy, 2009). Although it may be difficult, leaders should focus retention efforts on variables that are changeable, such as the health of the work environment and opportunity for advancement, rather than on individual variables that cannot be changed (Nedd, 2006). Management must understand the factors that influence nurse retention at their specific organization. A focus on modifying the work environment and organizational characteristics rather than modifying nurse behaviors is important (Tourangeau, Cummings, Cranley, Ferron, & Harvey, 2009). Burnout is a very complex issue and more than one single cause or influencing factor exists, thus eliminating a simple solution. In the event that all other methods fail, management can help nurses cope by allowing them to respond constructively to their own needs. Self-reflection, along with autonomy, can help to develop assertiveness and decrease perceptions of burnout (Fearon & Nicol, 2011). If nothing else, the simple act of involving nurses in unit decisions, providing adequate resources, and rewarding them for a job well done will begin cultivating an empowering work environment (Nedd, 2006).

### **Recommendations for Further Research**

Because of a lack of comparative studies, burnout and empowerment must continue to be studied among new graduate and experienced nurses. Studying burnout and empowerment structures across multiple hospitals in a similar geographic location may broaden researchers' understanding of the unique organizational context in which burnout and empowerment may occur. Because participation from nurses with 12-25 years of experience or who have been on their respective units for 12-30 years was low in the current study, attempting to increase their response rate would be vital if the study was conducted again.

Due to evidence of a moderate overall perception of burnout and empowerment in the workplace, further exploration of the qualitative responses regarding contributing factors would be beneficial. Leiter and Maslach (2004) developed the Six Areas of Worklife Model. These six areas consistently have been shown to be organizational antecedents of work engagement and burnout across a wide variety of studies. The Six Areas of Worklife include: manageable workload, control, reward, community, fairness, and values (Leiter & Maslach, 2004). Looking at the themes that emerged from analysis of qualitative responses, the researcher noted that many themes overlapped with the Six Areas of Worklife concepts. Utilizing this survey tool would be beneficial to fully understand what are the perceived causes of burnout and empowerment among staff and quantify written responses.

Work engagement, in several studies, was found to significantly mediate the empowerment/effectiveness relationship. The impact of work engagement on work effectiveness was significantly stronger for experienced nurses (Laschinger, Wilk, Cho, & Greco, 2009). The researcher believes that studying work engagement among the participants may be beneficial. Perhaps the missing concept of work engagement is where the differences lie in regard to reports of burnout and empowerment on a quantitative and qualitative scale.

Due to the effectiveness of Problem-Based Learning (PBL) in undergraduate education, implementing PBL for continuing staff education may be appropriate. PBL promotes ownership of education, as well as provides access to empowerment structures (Siu, Laschinger, & Vingilis, 2005). Re-surveying the nurse population after PBL had been implemented to see if they perceived higher levels of empowerment would be interesting.

Many qualitative responses spoke to the need for managerial support in order to feel empowered. Perhaps burnout and empowerment need to be studied among the managers of an

institution in order to identify potential causes for perceptions of decreased support. Although not participating directly in patient care, managers may experience burnout unique to their position. Some researchers claim that burnout is contagious and pessimism breeds pessimism (Glasberg, Norberg, & Soderberg, 2007). The managerial population is worthy of examination and appropriate interventions in order to promote a positive work environment. Dr. Heather K. Spence Laschinger at Western University, the creator of the Conditions for Work-Effectiveness Questionnaire (CWEQ-II) used in the present study, has studied empowerment thoroughly amongst the nursing population. She has also created a survey tool called the Manager's Activity Scale (MAS) that measures manager's access to empowerment (Laschinger, 2012). Because a tool is already developed and is readily available, surveying the managerial population would be simple and efficient.

Other studies question if burnout begins in undergraduate nursing education (Rudman & Gustavsson, 2012; Rudman & Gustavsson, 2011). Further research should be conducted to examine presence of burnout throughout undergraduate nursing education and continue monitoring throughout the new graduate period (within first three years post graduation). The key to preventing burnout in the workplace may lie in the hands of nurse educators. If burnout does indeed begin during undergraduate studies, educators must equip nursing students with resources to combat burnout. Adequately preparing future nurses for success upon entering the profession is vital.

## **Conclusion**

Healthcare continues to be an ever-changing profession. Nurses are on the front lines providing excellent care to patients across the globe. Focusing on factors that contribute to burnout and empowerment structures within individual organizations is important to retain the current workforce and prevent a worsening nursing shortage. Through this study, a unique perspective of burnout and empowerment at one organization was revealed through quantitative and qualitative data. Giving nurses a voice to express needs and concerns is critical to providing access to empowerment structures. Teamwork, support, communication, and acknowledgement are vital to ensuring a positive work environment.



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## APPENDIX

Table A1

*MBI Results Across Entire Sample*

<b>Subscale</b>	<b>Scoring</b>	<b>Survey Result</b>	<b>SD</b>
<b>Emotional Exhaustion (EE)</b>	<b>High &gt; 27</b> <b>Moderate 17-26</b> <b>Low 0-16</b>	24.7086835	11.5791976
<b>Depersonalization (DP)</b>	<b>High &gt;13</b> <b>Moderate 7-12</b> <b>Low 0-6</b>	7.9355742	6.2358870
<b>Personal Accomplishment (PA)</b>	<b>High 0-31</b> <b>Moderate 32-38</b> <b>Low 39 and over</b>	36.5294118	6.9007696

(Maslach, Jackson, & Leiter, 2010)