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Relationship Between Nurses' Perception of Empowerment, Job Satisfaction, and Intent to Stay

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Abstract

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MS Nursing, Loma Linda University, 2009

BS Nursing, University of San Agustin (Philippines), 1999

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Retention of perioperative nurses who work in the operating room is critical to an organization's effectiveness and financial wellness. Factors that retain perioperative nurses are empowerment and job satisfaction. The purposes of this quantitative study, guided by Kanter's theory of structural empowerment, were to determine (a) the level of empowerment and job satisfaction among perioperative nurses and their intent to stay in the organization and (b) if age, gender, education, perioperative experience, and national nursing certification predict empowerment among perioperative nurses. Fifty-five perioperative nurses responded to the Conditions for Work Effectiveness Questionnaire-II, Nursing Workplace Satisfaction Questionnaire, and Intent to Stay Scale surveys via recruitment through the Association of PeriOperative Registered Nurses, Facebook, and LinkedIn. Using multiple regression analysis, results revealed that empowerment was not a statistically significant predictor of intent to stay. However, age and holding a national nursing certification predicted empowerment. Job satisfaction was a statistically significant predictor of a nurses' intent to stay in the organization. The results affect positive social change because increasing the job satisfaction of perioperative nurses will lead to their desire to remain within the organization and increase retention. Retaining experienced and competent perioperative nurses' results in attaining organizational goals, ultimately translating to quality patient care. Further research is needed to study the moderating effects and qualitatively investigate the meaning of empowerment.

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Dedication

I am dedicating this dissertation to my *tatay* Nelson Checa and *nanay* Rosemarie Checa, my first teachers and leaders in life.

To my beautiful daughter, Kyrst'n Lynn Hall, I hope this inspires you on your own academic journey. I love you from the bottom of my hypothalamus.

To my nursing faculty, mentors, and nurses that touched my life and practice – from the Philippines, Singapore, Chicago, Colorado Springs, Loma Linda, and San Diego – and to all perioperative nurses past, present, future – this study is for you.

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To Ryan, thank you for bearing with me and my tunnel vision when I need to write. You are an invaluable support.

To all of you, thank you. My heart is full.

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Chapter 1: Introduction to the Study

Introduction

Nurses account for nearly half of the healthcare workforce. The World Health Organization estimates the need for 9 million nurses and midwives by 2030 globally (Marć, et al., 2018; World Health Organization, 2018). Global demographic changes due to an aging population, expansion of a nurses' role such as specialization, along with economic drive brought by globalization and immigration are some of the reasons for this global challenge (Both-Nwabuwe et al., 2017; Marc et al., 2018). In the United States, the American Association of Colleges of Nursing (AACN, 2019) reported that the nursing shortage is impacted by the inability to meet the demand for nursing jobs, lack of nursing school faculty, the retirement of experienced nurses, and the needs of an aging population. As rewarding as the nursing profession is, it is also a highly stressful and demanding career. Currently, 23.7% of the hospitals report a Registered Nurse (RN) vacancy rate of greater than 10%, with 22.9% of all new RNs leaving within a year of employment and a national RN turnover rate averaging to 17.2% (Nursing Solutions Inc., 2019). The decrease in nursing staff and an increase in overtime is associated with declining patient safety, poor quality of care, and missed nursing care (Cho et al., 2016). Furthermore, patient mortality is increased by 3% for every day the experienced nursing staffing is below the unit mean at an institution (Griffiths et al., 2018). From an organization standpoint, nursing turnover is costly. Duffield et al. (2014) revealed that the nursing turnover costs ranges from $20,561 up to $48,790. It is, therefore, imperative that

organizations develop strategies to retain nurses and prevent them from leaving the organization and profession.

The perioperative environment is not invulnerable to the nursing shortage. The median percentage of vacant perioperative nurses' positions is increasing annually, and 63% of operating room (OR) managers reported having at least one open position in their organization (Bacon & Stewart, 2018). The average perioperative nurse in the US is 51-55 years old, higher than any nurses in other specialty areas, and exacerbating the perioperative nursing shortage not only due to staff turnover but retirement (Beitz, 2019; Sadler, 2019; Sherman et al., 2014). Since the OR is the economic engine of a facility, not only are there financial ramifications resulting from the perioperative nursing shortage, but also poor patient outcomes through diminishing patient care (Association of periOperative Registered Nurses [AORN], 2017; Björn et al., 2015a). The cause of the perioperative nursing shortage is complex and a system-wide perspective of the work environment when investing in human capital must not be overlooked. Termed *structural empowerment*, an organization's work environment is essential in setting up the work climate that can affect the performance of an individual and the cohesion of the unit (Fan et al., 2016). There is scarcity in the literature of how structural empowerment affects a perioperative nurse's decision to stay in the organization, but there is growing evidence that an empowered nursing environment, in general, attracts and retains qualified nurses (Fan et al., 2016; Goodare, 2017). If an organization creates empowering work structures, this then empowers staff through their contribution to task-related decisions, remedy quality-related problems, increased and sustained productivity, work quality, and

performance (Kuokkanen et al., 2014; Rapp et al., 2016). Ultimately, an empowered work environment revitalizes nurses through organizational support and opportunities, decreasing turnover (Goodare, 2017). Understanding how perioperative nurses perceive structural empowerment is key in achieving an optimal work environment that spurs organizational commitment and the intent to stay in the organization.

When nurses are empowered to make a difference in their work environment and do not leave their organizations, they can transform society. Empowered nurses transform society through the exemplar of professional growth, being a change agent in the work environment, and the commitment to practice the highest standards of patient care (Wei et al., 2018). Ultimately, structural empowerment provides a framework for a nurse's professional behavior, practices, and obligation to contribute positively to the lives of patients and, in turn, the community (Clavelle et al., 2016). All things considered, the ripple effects of an empowered work environment in nursing retention and preventing turnover while investing in human capital results in a positive social change and unequivocally transforms the society for the better.

In Chapter 1, a summary of the research literature as a background, the problem statement, and the purpose of the study is presented. Furthermore, the research questions, theoretical framework, and nature of the study is briefly discussed. Last, the variables, assumptions, scope, limitations, and significance of the study is presented.

Background

Nurses are essential in the health care environment as they are key to quality patient care. However, the crucial state of the nursing shortage is alarming as it globally

affects the sustainability of the health care workforce (Castro Lopes et al., 2017). Nursing workforce issues are a chronic problem that is complicated with the problem of attrition and retention (Castro Lopes et al., 2017). Attrition has been posited to be an indicator of work-related problems such as poor job satisfaction and lack of career opportunities (Castro Lopes et al., 2017). In addition, retention maintains workforce stability and is determined by job satisfaction, quality of work-life, or organizational commitment (Chang et al., 2015; Wong et al., 2015). The issue of the nursing shortage is a constant, complex, and global problem.

Specialized nursing environment is also vulnerable to the nursing shortage problem. Specifically, the perioperative environment is a highly specialized, technical, and stressful environment that is not immune to the staff shortages (Ball et al., 2015; Björn et al., 2015a; Eskola et al., 2016; Monahan, 2015; Myers, 2017; Sherman et al., 2014). The demand for perioperative nurses has been steadily increasing up to 2% yearly, but this is offset by the small percentage of current perioperative nurses practicing, with 20% of them retiring compounded with workforce pipeline issues due to the fact that perioperative nursing is not part of any nursing student's clinical rotation (Ball et al., 2015; Sherman et al., 2014). Additionally, the average perioperative nurse turnover rate was 13% in 2018, versus 10% in 2017 (Saver, 2018). In the perioperative environment, voluntary turnover is the result of a process that involves several factors in the work environment factors that can lead to the decision to resign (Lögde et al., 2018). Abuse of power by nurse managers, stressful working conditions, and lack of recognition and autonomy are factors that may cause a perioperative nurse to leave the organization

(Lögde et al., 2018). Studies had shown that social structures that result in access to information, support, resources, and opportunities shape an empowered work environment (García-Sierra & Fernández-Castro, 2018; Li et al., 2018). Empowerment, specifically, structural empowerment is a construct that encompasses organizational structure and management practice to utilize a nurse's wisdom, expertise, and self-determination in the achievement of organizational goals (García-Sierra & Fernández-Castro, 2018; Van Bogaert et al., 2014). Largely, organizational factors such as a positive work environment and culture, as well as individual factors such as job satisfaction, are posited to influence nursing retention and attrition (Björn et al., 2015a; Chang et al., 2015; De Almeida et al., 2017; Goodare, 2017; Graystone, 2018). The work environment, therefore, is crucial in understanding the reason why a perioperative nurse decides to stay or leave the organization.

There is an enormous wealth of research studies on empowerment. However, empowerment is an abstract concept that is often ambiguous (Arslan Yürümezoğlu & Kocaman, 2019) and is described either through the lens of an individual's critical introspection, psychological perception towards work or in organizational behavior (Kuokkanen et al., 2014; Li et al., 2018). The focus of this research study is on structural empowerment which is a study of the workplace (Moore & Ward, 2017) and is hypothesized as the working environment (Meng et al., 2014). The perioperative setting is a high risk, fast-paced, stressful, diverse, and a specialized work environment (Brown et al., 2017; Charkhat Gorgich et al., 2016; Park & Chang, 2019). Nevertheless, there were very limited number of research studies on structural empowerment and the

perioperative environment. The gap in knowledge that this study addressed is a much-needed exploration of the relationship between structural empowerment and job satisfaction with a perioperative nurse's intent to stay. Job satisfaction and a healthy environment are attained when a perioperative nurse is involved in the decision making of their practice, change initiatives, and activities that decrease stress (Brunges & Foley-Brinza, 2014). This study also explored the predictors of structural empowerment in the perioperative setting. Understanding the predictors of structural empowerment facilitates a better understanding of the job-related structures of power to increase organizational trust, commitment, and efficacy (Fragkos et al., 2020; Gholami et al., 2019; Li et al., 2018). Understanding the achievement of an optimal work setting that attracts and retains nurses is paramount (Fan et al., 2016). The depth of the perioperative nursing shortage is complicated and multifactorial but can be bridged by addressing the gap of how it is affected by the macrocosm of the perioperative environment.

As such, this study is needed to equip perioperative nurses and leaders the additional insight and strategies on how the work environment contributes to the perioperative nursing shortage. Recognizing the value and relationship of structural empowerment with job satisfaction and the intent to stay in the organization, allows nursing leaders to design workplace strategies that improve the nursing practice, increase organizational commitment, and promotes safe quality care (Gholami et al., 2019). Structural empowerment and its theoretical propositions are a template for supportive job conditions and an intent to stay culture that is essential in addressing nursing retention

and turnover (Meng et al., 2014). Knowledge and retention strategies addressed in this research study are essential in tackling the issue of the perioperative nursing shortage.

Problem Statement

The perioperative nursing shortage needs assessment. The OR is denoted as the economic engine of an organization because it can generate more than 60% of a hospital's revenue (Ball et al., 2015). Surgical care consists of a third of the overall health care spending in the US, with the OR comprising one of its most expensive expense (Childers & Maggard-Gibbons, 2018). The average cost of OR time is $36-$37 per minute, and two-thirds goes towards wages and benefits of OR staff, not to include the amount in turnover and perioperative nursing orientation (Childers & Maggard-Gibbons, 2018). The problem in the retention and attrition of perioperative nurses can cause huge financial, safety, and access consequences (Sherman et al., 2014). While the full time vacant perioperative nursing positions is low at 7.1% (Bacon & Stewart, 2018), and the perioperative nursing turnover rate is 1.9% below the national average of 17.2% (Nursing Solutions Inc., 2019), the shortage of perioperative nurses is steadily increasing, affecting more organizations annually, and are the most difficult to fill (Bacon & Stewart, 2018; Nursing Solutions, 2019; Sherman et al., 2014). Furthermore, orientation to the perioperative environment takes at least 6 months to a year (Bacon & Stewart, 2018; Monahan, 2015). Orientation costs of a perioperative nurse are estimated at $59,000 (Ball et al., 2015) and do not include the replacement cost of turnover which is about $132,000 to $228,000 or can be as high as 150% of a nurses' annual salary (Monahan, 2015; Sherman et al., 2014). Downtime in an OR due to inadequate staffing and lack of

qualified perioperative nurses is not only costly due to delayed or canceled surgery cases but can ultimately cause poor patient outcomes (Monahan, 2015; Sherman et al., 2014). Perioperative nursing staff turnovers are expensive and have enormous economic and patient safety implications.

The Perioperative Nurse's Intent to Stay in the Organization

A perioperative nurse's intent to stay in the organization is multifactorial in nature and understanding the factors that influence retention is necessary. In general, nurses are the organization's surveillance system tasked to provide continuous patient care, prevent adverse events, detection of patient problems, and deliver timely interventions (Cho et al., 2016). Perioperative nursing, however, involves care that is nontraditional, described as technical rather than traditional, making it unique (Björn et al., 2017; Eskola et al., 2016). The stressful and challenging environment of the perioperative arena is unique in its entirety due to the multifaceted role of the perioperative nurse as a circulator or scrub RN in addition of being the room manager, equipment handler, and patient's advocate (Eskola et al., 2016; Myers, 2017). The OR multidisciplinary team comprising of surgeons, anesthesiologists, nurses, and scrub personnel presents an extra challenge of working harmoniously in a stressful and dynamic environment (Wakeman & Langham, 2018). The complexity and demands of the perioperative environment are exacerbated by the hierarchy of roles and knowledge within the team (Eskola et al., 2016; Pupkiewicz et al., 2015). In some instances, the perioperative environment may also be reclusive, where nurses do not want to speak out and share information, and novice nurses and scrub personnel feels intimidated and lack support (Pupkiewicz et al., 2015). The

compounding effects of hierarchy, the reclusiveness, and status guarding to a complex, surgical environment can negatively impact teamwork and distrust in the organization (Eskola et al., 2016; Pupkiewicz et al., 2015). In the 2018 AORN annual salary and compensation survey, 28% of the respondents indicated that they are likely to quit, citing reasons of wanting to change employers (67%), changing careers (15%), retiring (8%), or personal reasons (10%; Bacon & Stewart, 2018). For perioperative nurses that are satisfied with their jobs, 73% cited that their satisfaction is due to the job itself and on effective management or organization structure (Bacon & Stewart, 2018). On the other hand, 70% of the perioperative nurses that are dissatisfied with their job attributed this dissatisfaction also to management and, additionally, the work environment or culture (Bacon & Stewart, 2018). Leadership and work practices that are characterized by shared decision making, presence of autonomy, and career development opportunities are linked to nursing retention (Cowden & Cummings, 2015). In addition, attitudinal antecedents that influence a nurse to stay in the organization include job satisfaction and the perception of structural empowerment within the work environment (Cowden & Cummings, 2015; Laschinger et al., 2014b). The work environment is a critical factor that can influence a nurse to stay in the organization, and in turn, a nurse's intention to stay is a crucial predictor of retention (Chen et al, 2014). It is eminent how integral the role of the organization and nursing leaders are in providing a work environment that is conducive for staff retention.

Structural Empowerment

In response to the challenges brought by the nursing shortage and healthcare climate, organizations have evolved into a completely new paradigm in the use of organizational power. The focus becomes sharing this power with employees and creating a culture of shared decision making (Graystone, 2018; Iliman Puskulluoglu & Altinkurt, 2017). This sharing of power, a construct known as empowerment, not only creates a culture that empowers the perioperative nurses but wisely using human resources to achieve organizational effectiveness (Graystone, 2018; Iliman Puskulluoglu & Altinkurt, 2017; Orgambídez-Ramos, & Borrego-Alés, 2014). Specifically, structural empowerment is based on Kanter's theory of structural empowerment that conceptualized the ability of an organization to get things done through access to information, resources, opportunity, and support (DiNapoli et al., 2016; Kanter, 1979; Meng et al., 2014). Structural empowerment is not determined by a nurse's personal predisposition but is based on an empowered social structure that is present in the work environment resulting in the improvement of work performance (Goedhart et al., 2017; Li et al., 2018). As a management practice, structural empowerment is vital in the personal control of the work environment and professional growth of nurses (García-Sierra & Fernández-Castro, 2018; Goedhart et al., 2017). Structural empowerment is postulated to affect job satisfaction and, in turn, decrease nursing turnover (Cicolini et al., 2014; Dahinten et al., 2016). Generally, empowerment can impact the perioperative nurse's organizational commitment (Cowden & Cummings, 2015). A positive organizational commitment is a product and an indication of an organization's success in creating connections and

opportunities for employees resulting in an unequivocal reason to stay in the organization (Ke & Hung, 2017). The exploration of structural empowerment in the perioperative setting will give organizations a powerful insight into perioperative nursing turnover and retention.

Part of the exploration of empowerment is to examine perioperative nurse characteristics that can contribute and predict the attainment and perception of structural empowerment. Demographic variables such as age, gender, education level, length of perioperative nursing experience, and any specialty nursing certification of perioperative nurses was investigated as predictors of structural empowerment. It is essential that these demographic variables are studied because nursing turnover is contributed by a decrease in the perception of empowerment and job satisfaction (Cramer et al., 2014). For instance, Generation X nurses are moderately satisfied with their work environment, especially on their access to empowering structures of opportunity and informal power (Christopher et al., 2018). Informal power through an established interpersonal relationship with peers is vital in instilling trust and respect, thus decreasing nursing turnover (Christopher et al., 2018). As for gender, a study by Fitzpatrick et al. (2014) established that female nurses perceived structural empowerment higher than men through their access to opportunity, but researchers found no difference in the intention to leave the profession or organization. Also, a nurse with a higher educational level is perceived to be more familiar with the construct of structural empowerment and is thus more engaged in change initiatives and shared decision-making processes within the organization (Van Bogaert et al., 2016). With respect to work experience, a study by

Gholami et al. (2019) determined that nurses that are in the profession for less than 5 years have a minimal perception of structural empowerment in organizational structures and managerial behaviors. Last, in a systematic literature review conducted by Whitehead et al. (2019), the relationship between nursing certification and structural empowerment showed consistent and significant findings that certified nurses have a higher perception of structural empowerment. Overall, studies indicated that nurses with a higher perception of empowerment are less likely to leave either the position or the profession (Arslan Yürümezoğlu, & Kocaman, 2019; Fitzpatrick et al., 2010; Khan et al., 2018; Meng et al., 2014). Structural empowerment is a powerful construct in nursing retention literature that has a great application potential to a specialized perioperative environment.

Gap in the Literature

There is a vast amount of nursing literature on empowerment that aims to explore its significance in increasing nursing retention and decreasing turnover. Access to empowering structures in the work environment is posited to be the best predictor in a nurse's intention to stay in the organization (Meng et al., 2014). There is also a growing literature on structural empowerment among specific population nursing population such as nursing students (Moore & Ward, 2017), nurses in academic settings (Kretzschmer et al., 2017; Orgambídez-Ramos & Borrego-Alés, 2014), clinical nurses (Dahinten et al., 2016), and hemodialysis nurses and technicians (Hayes et al., 2015). However, despite the abundance of literature on the concept of empowerment, there is still a paucity in the number of empowerment studies conducted in the perioperative arena. Most structural empowerment studies are conducted in clinical areas but are lacking the perspective of

nurses in specialty areas like the intensive care or OR (Van Bogaert et al., 2016). The perioperative environment suffers greatly from the lack of qualified OR nurses lost in voluntary turnover (Lögde et al., 2018). Likewise, there is limited information on what makes a high demand, high flexibility, and high-technological environment of the OR attractive for perioperative nurses to stay (Björn et al., 2015a). There remains a significant gap in the literature regarding the factors that predict structural empowerment and how significant the relationship of structural empowerment, job satisfaction, and intent to stay are among perioperative nurses. Essentially, research studies posited that positive and empowered work environment increases job satisfaction (Cicolini et al., 2014) and attracts and retains highly qualified nurses (Fan et al., 2016; Goodare, 2017), thereby impacting the sustainability of the nursing workforce (Cicolini et al., 2014). With the current perioperative nursing shortage, it is important to bridge the gap in discovering the factors that predict a perioperative nurse's intent to stay in the light of an empowered work environment. Nursing is often called a vocation as individuals often cite that the professional desire to make a difference in the lives of others is the primary reason for entering the profession (Goodare, 2017). A perioperative work culture that thrives on shared decision making and access to resources is instrumental in creating a positive nursing work environment that can result in an empowered and satisfied perioperative nurse workforce (Graystone, 2018; Laschinger et al., 2014b). An understanding of empowerment structures will assist the organization and nursing leaders to develop and implement effective retention strategies and increasing the perioperative workforce.

Purpose of the Study

The purpose of this study was to determine the level of empowerment and job satisfaction among perioperative nurses and their relationship to intent to stay in the organization. In addition, this study was also to determine if age, gender, education, perioperative experience, and national nursing certification can predict empowerment. To address this gap in the literature, the approach used a quantitative, correlational survey design.

The independent variables in this study were empowerment and job satisfaction, while the dependent variable was intent to stay. Background/demographic variables gathered in this study were explored and used as independent variables and empowerment as the dependent variable.

Research Questions and Hypotheses

Research Question (RQ) 1: Which of the demographic factors (age, gender, education, perioperative experience, and certification) can reliably predict empowerment among perioperative nurses?

$H_0$1: There is no relationship among age, gender, education, perioperative experience, certification, and empowerment among perioperative nurses.

H_A1: There is a relationship among age, gender, education, perioperative experience, certification, and empowerment among perioperative nurses.

RQ 2: Do empowerment, and job satisfaction predict intent to stay in the organization for perioperative nurses?

$H_0$2: There is no relationship between empowerment, job satisfaction, and intent to stay in the organization for perioperative nurses.

H_A2: There is a relationship between empowerment, job satisfaction, and intent to stay in the organization for perioperative nurses.

Theoretical and/or Conceptual Framework of the Study

The foundation of this study is Kanter's theory of structural empowerment, which has evolved and was derived from Kanter's 1977 seminal work. The major theoretical propositions of this theory include the use of power which can be formal and informal. *Formal power* is created by the position of the job while *informal power* is created through network and connections within and outside of the organization (Cicolini, 2014; Dahinten et al., 2016; De Almeida et al., 2017; Kretzschmer et al., 2017; Iliman Puskulluoglu & Altinkurt, 2017; Laschinger et al., 2014; Orgambídez-Ramos et al., 2017; Orgambídez-Ramos & Borrego-Alés, 2014; Thuss et al., 2016). Through this power, access to four empowerment structure occurs: (a) *access to opportunities* for professional growth and development, (b) *access to information* such as organizational policies and goals (c) *access to support* such as feedback and guidance, and (d) *access to resources* to enable an individual to do their job (Cicolini, 2014; Dahinten et al., 2016; De Almeida et al., 2017; Kretzschmer et al., 2017; Iliman Puskulluoglu & Altinkurt, 2017; Laschinger et al., 2014; Orgambídez-Ramos et al., 2017; Orgambídez-Ramos & Borrego-Alés, 2014; Thuss et al., 2016). A more detailed explanation of this theory is presented in Chapter 2.

As mentioned, the concept of a healthy and positive work environment is extensively studied in nursing literature. One of the major themes from the systematic

review conducted by Wei et al. (2018) is on the significant and positive impact of a healthy work environment on nurse's job satisfaction and retention. A positive work environment is highlighted by empowerment, transformation, and a culture where nurses are included in the attainment of an organization's goals (Wei et al., 2018). Kanter's theory of structural empowerment emphasizes the importance of social structures in the work environment (Horwitz & Horwitz, 2017). If these social structures are present, then this presents a situational condition wherein a nurse has the access and power to be productive and effective, ultimately providing them the motivation to align their personal goals with the organization, giving them an incentive to stay (Horwitz & Horwitz, 2017). The theory of structural empowerment and its constructs will provide a framework for this study in discovering what social structures are important for a perioperative nurse to perceive the presence of an empowering work environment. Kanter's theory of structural empowerment will also expound on the association and characteristics of the work environment that makes a perioperative nurse decide to stay or leave the organization. Ultimately, an organization's empowering culture determines its success or failure (Horwitz & Horwitz, 2017). Kanter's theory of structural empowerment is an excellent theoretical foundation that delves exclusively into the work environment, thereby providing this research study an excellent lens in the examination of the specialized world of the perioperative environment.

Nature of the Study

This was a quantitative, descriptive, correlational study. Quantitative research allows testing of theories through the examination of the relationship between variables

(Creswell, 2014). Quantitative research was integral in the core of this study and to elucidate the relationship between empowerment, job satisfaction, and intent to stay.

In RQ 1, background variables of respondent's age, gender, education, perioperative experience, and specialty nursing certification were the independent variables and empowerment, the dependent variable, and was analyzed using multiple regression. Empowerment was measured using the Conditions for Work Effectiveness Questionnaire II (CWEQ II). In RQ 2, the independent variables were empowerment and job satisfaction, while the dependent variable was intent to stay and analyzed using multiple regression. Job satisfaction was measured using the Nursing Workplace Satisfaction Questionnaire (NWSQ) and intent to stay by the Intent to Stay scale developed by Kosmoski and Calkin (1986). Regression analysis allows the researcher to analyze the variation and strength of the relationship of the dependent variable basing from one or more independent variables (Verma, 2016; Warner, 2013). Furthermore, regression analysis is used to identify variables that influences and predicts the dependent variable (Trotta, 2003). An online survey tool using the CWEQ II, NWSQ, and intent to stay scale questionnaire was deployed among perioperative nurses in the United States. I used the Statistical Package for the Social Sciences v. 25 (SPSS) to collate, store, and analyze data.

Definitions

The following terms were defined in this study:

Empowerment was defined as "to give power to" (Iliman Puskulluoglu & Altinkurt, 2017, p. 119). Empowerment is an evolving concept that was dependent on the

context it is applied (Appelbaum et al., 2014; Cicolini et al., 2014; Iliman Puskulluoglu & Altinkurt, 2017).

Intent to stay was defined as the behavioral intention leading to retention or continuous affiliation in the organization (Derby-Davis, 2014; Ke & Hung, 2017).

Job satisfaction was defined as the way an individual feel about their overall work life *(*Hayes et al., 2015) and response to work conditions that met their needs and value of the work experience (De Almeida et al., 2017; Liu et al., 2015).

Perioperative RN was defined as RN staff that circulated and/or scrubbed in surgery. These were nurses that normally staffed traditional ORs, ambulatory surgery centers, physicians' offices, labor and delivery suites, and other areas where surgical procedures are performed (Sherman et al., 2014).

Structural empowerment. Structural empowerment is creating organizational conditions that are necessary for growth and access (De Almeida et al., 2017) to power individual participation in shared decision making (Graystone, 2018; Iliman Puskulluoglu & Altinkurt, 2017). In this study, empowerment pertained to structural empowerment.

Assumptions

There were multiple assumptions for this research study. As a quantitative study, this provided an objective depiction and not my subjective opinion of empowerment in the perioperative setting through the use of published, reliable tools and statistical analysis. I assumed that the inclusion criteria set for this study was appropriate and that the respondents had experienced the phenomenon of empowerment or its structures. Generalizability of the results to the population of perioperative nurses as defined in this

study was also assumed. Nurses are ranked the highest in honesty and ethics and is lauded the most trusted profession for 18 years in a row (Reinhart, 2020). In turn, the prime assumption for this study was for respondents to answer the survey questionnaire honestly and truthfully. To give respondents a safe environment where they can answer honestly, anonymity was preserved and the choice to withdraw from the study was made available.

Scope and Delimitations

Empowerment is a complex concept dependent on the context to which it is used. This research study addressed structural empowerment and not psychological empowerment. Psychological empowerment is a motivational construct that includes the dimensions of meaning, competence, self-determination, and impact specific to the work environment (Spreitzer, 2008; Thuss et al., 2016). Indeed, a comprehensive understanding of empowerment in the workplace can be attained if both structural and psychological empowerment perspectives are considered (Thuss et al., 2016). I had considered using the theory of psychological empowerment by Spreitzer (2008), especially the way it naturally results from an empowered environment but did not use it because I wanted to focus more on structures or the organization.

Perioperative nursing involved the three phases of surgery which are preoperative, intraoperative, and postoperative. Because of the wide spectrum of perioperative nursing, the multiple nursing roles in the perioperative environment (Arakelian et al., 2017), and the ambiguity of what encompasses the perioperative role or practice (Blomberg et al., 2014), defining the role of a perioperative nurse for this study is important. This research

study was focused on experienced, part-time, or full-time registered or licensed vocational nurses who scrubs or circulates in surgery and resides in the US and its territories. Inclusion of part-time or full-time perioperative nurses ensured a sample that is immersed in the work environment since sufficient access to an organization's supportive structures involves recurrent information discussion and appraisal dialogues between nursing leaders and staff (Wiens et al., 2014). Limiting the sample to perioperative nurses in the US to include its territories provided a homogenous sample of nurses from the same cultural values and healthcare delivery system (Wei et al., 2018). In this study, an experienced nurse is a nurse who has worked in the OR for 12 months or more. An unhealthy work environment is often the reason why new graduate nurses leave the organization within 6 months of hire, hereby contributing to a lower retention rate (Wei et al., 2018). Capturing those who stayed in the organization for more than a year may broaden studies in nursing retention. Perioperative nurses in key leadership positions and advanced nursing roles are excluded from this study. Power is derived from a leader's formal and informal systems of the organization (Kanter, 1977; Kanter, 1979) and nurse leaders are positioned critically through their job description and connections to provide and establish empowering structures for their staff (Laschinger et al., 2014b), and therefore, were not a part of this study.

Limitations

One of the limitations of this research study was its correlational research design. Correlational or observational studies involved defining and testing the existence of a relationship between a group of variables, and not whether a variable caused the other

(Markauskaite et al., 2011). Correlational studies can be in a cross-sectional design, which allows a researcher to assess the study population in a single time, therefore, unable to detect any variance or development in the population's characteristics (Lau, 2017; Markauskaite et al., 2011). Phrasing the RQ to highlight the main aim of the study, which is to determine the relationship between variables rather than determining whether these variables cause one or the other, fits the correlational research design paradigm. Despite the fact that empowerment is better appreciated in a longitudinal study especially against background variables such as age or perioperative years of experience, the cross-sectional design remained a limitation and is reported.

This research study was likewise limited by a sampling bias due to the use of convenience sampling to recruit participants. In a convenience sample, it is difficult to detect any differences in the population subgroup and can result in the underrepresentation of the sample, therefore, research study results are not generalizable to the target population (Bornstein et al., 2013). To mitigate this bias, an inclusion criterion for participants was specified. This research study also involved conducting a survey therefore, misinterpretation of a survey item and the probability of a low response rate are limitations (Burkholder et al., 2016). Moreover, the findings in a survey study served only as estimates rather than the precise measurements of the true population, therefore limiting its generalizability (Burkholder et al., 2016). Using self-reported survey questionnaires is also a limitation. Concern for common method variance by using the same method of self-report surveys to measure all variables may result in the inflation of observe correlations (Spector, 2006). However, Spector (2006) also argues that it is

more important to address the specific biases in the operationalization of variables, and through the use of psychometrically sound measures (Laschinger et al., 2015). To mitigate the limitations and bias of this research study, participants were informed that their participation is anonymous and that their honesty is valued. Only instruments that had been tested and were reliable was used.

Last, this research study may be vulnerable to a researcher bias. I had been interested on the topic of empowerment due to my personal experience in the workplace. Because of this, I had developed my own view of empowerment and would want to bring this to the perioperative arena but it may be lacking. Thus, the use of objective and reliable measures and appropriate statistical data helped prevent my personal bias in the examination of the research findings.

Significance

Perioperative nurses are advocates for surgical patients in a highly technical and stressful environment. Perioperative nursing is a careful balance of nursing care, surgical interventions, and technology (Sørensen et al., 2014). The challenge in the perioperative nursing shortage is intricate as it includes the lack of clinical nursing education of new nurses, the financial impact of perioperative nursing orientation, high-quality surgical throughput demands, and the complexity of the OR environment (Ball et al., 2015; Beitz, 2019). The perioperative nursing shortage is difficult to solve, as there is no global solution (Björn et al., 2015b). Rather retention strategies are to fit the needs of the workplace and the organization (Björn et al., 2015b). Uncovering the factors that lead to

the attractiveness of a healthy work environment is an essential step to direct retention strategies where it is needed.

There are a lot of driving forces that contribute nurses to stay in the profession. Attrition is a vicious process as it puts a strain on the remaining employees, causing a decrease in morale, productivity, and job satisfaction (Gellasch, 2015). Nurses do leave the profession due to personal reasons, but job satisfaction is the primary factor for nursing retention and attrition (Gellasch, 2015; Wei et al., 2018). The personal choice of staying or leaving in the organization is a result of multiple elements, but the work environment and lack of support are considered a driving factor (Gellasch, 2015). Therefore, using the template of structural empowerment to provide a positive and healthy work environment by creating a decentralized organizational structure through shared decision making is imperative (Arslan Yürümezoğlu & Kocaman, 2019). A healthy work environment that provides a structure for nurses to be autonomous and engaged (Laschinger et al., 2014b) often described as safe, empowering, and satisfying is posited to impact a nurses' job satisfaction and retention (Wei et al., 2018). Establishing an empowered workforce is also vital to meet the demands and complexity of the perioperative environment. Through this research study, a strategy to improve a nurse's work environment will contribute to the wealth of literature in structural empowerment. The result of this study generated data about the relationship of empowerment with job satisfaction and intent to stay in the perioperative environment; in addition, it augmented empowerment studies conducted in specialized nursing areas. This research study also provided a rich insight into the predictors and factors that equates to empowerment in the

organization. Nursing leaders should be aware that empowerment is a change in organizational systems (Rapp et al., 2016) and that they are best positioned to promote a positive work environment that promotes nurse's performance, hence ultimately resulting to nursing retention, and quality patient care (Laschinger et al., 2014a; Wei et al., 2018). Nursing leaders are also key in establishing policies and practices that contribute to a healthy, empowered work environment (Gellasch, 2015; Wei et al., 2018). Evidence-based strategies to lead and empower staff are instrumental in social change. These strategies are essential in developing the competencies of nursing leaders in addressing the nursing shortage through effective work relationships and cultivating an empowering work culture.

Summary

The profundity of the nursing shortage extends well to the everyday operation of the work environment and specialized areas in nursing such as the perioperative arena is very susceptible. Many researchers agreed that a positive work environment can bring about job satisfaction, resulting in increased retention and decrease attrition (Björn et al., 2015a; Chang et al., 2015; De Almeida et al., 2017; Goodare, 2017; Graystone, 2018). This chapter covered the current state of the nursing shortage from a global to the perioperative nursing perspective. The purpose of this study, RQs, nature of the study, overview to the theoretical framework, key term definitions, delimitations and limitations, and significance of the issue was discussed. The plan was to conduct a quantitative correlational survey study that investigates the level of empowerment among perioperative nurses and its relationship to job satisfaction and intent to stay in the

organization. In Chapter 2, Kanter's theoretical framework is expounded deeply, and key variables discussed.

Chapter 2: Literature Review

Introduction

The nursing shortage shows no signs of waning. The complex issues of nursing retention and attrition persist in part due to dwindling human resources and a dynamic healthcare environment (Castro Lopes et al, 2017). Specialized nursing environments, such as the OR, are not immune to the ongoing nursing shortage. Staff nurse vacancy rates in the perioperative area are increasing and replacing retiring or other staff leaving the organization proves to be challenging (Sherman et al., 2014). Perioperative leaders reported struggling to recruit qualified staff partly due to the lack of perioperative education and training and the dwindling workforce pipeline (Sherman et al., 2014).

Providing a structure of empowerment in the workplace has been posited by many experts as one of the ways to curb the problem of retention and attrition at the organizational level. Empowering work structure that delineates a nurse's participation and access to information, resources, support, and opportunity is a strategy to create a positive work environment (Twigg& McCullough, 2014). It is crucial to prioritize establishing strategies that impact the work environment positively since it directly impacts retention and quality patient care (Twigg& McCullough, 2014). Kanter's theory of structural empowerment essentially is a framework for multiple empowerment research studies and explains the relationship of empowerment with the work environment.

In Chapter 2, the literature search strategy is presented. Kanter's theory of structural empowerment, its major propositions, and applicability are discussed

comprehensively. Key variables on empowerment, job satisfaction, and intent to stay are examined. An extensive review of the literature is instrumental in identifying the gap in the current literature and justifying the need for further research on the issue of structural empowerment among perioperative nurses.

Literature Search Strategy

I conducted a search of the literature using multiple databases in business, management, health sciences, leadership, psychology, and nursing. Databases included Academic Search, Business Search, Elton Bryson Stephens Company (EBSCO), Education Source, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System Online (MEDLINE), Ovid, PsychINFO, Sage Science Direct, Science Citation Index, Social Sciences Citation, and Thoreau. I also used the Google Scholar search engine. The key search terms used were *empowerment*, *structural empowerment*, *Kanter*, *job satisfaction*, *intent to stay*, *nursing retention*, and n*ursing shortage*. I also used Boolean search terms to combine key words. The literature search included published peer-reviewed articles from 2014 to 2019. Older references include the seminal work of Kanter, which was the theoretical framework for this study, as well as the dissertation of Chandler (1986), who was the first researcher to use Kanter's theory in nursing.

Theoretical Foundation

The foundation of this study is Kanter's theory of structural empowerment, which has evolved and was derived from Kanter's 1977 seminal work. Kanter studied how an organization shapes employee experiences and explained how organizational structures

could influence an employee personality and motivation toward work (Kanter, 1977). She described how employees, especially women, can be trapped powerless in an organization with no room for promotion or advancement resulting in frustration and indifference towards organization goals (Kanter, 1977). In immersing herself within the organization practices of big corporations, she was able to present several characteristics of how an organization determines empowerment. Kanter (1977) contended that a job influences a person's workplace attitude and behaviors. The influential nature of the job stems from how an organization is structured, how the organization allows individuals to thrive, and if an organization demands unquestioning obedience and loyalty to the organization, growth is somehow stifled (Kanter, 1977). Kanter also recognizes certain organizational behavior of endowing power to employees can result in positive behavioral responses that are beneficial to the organization. She argues that workplace characteristics are more influential than employee behavior and attitude towards the organization rather than their personality (Kanter, 1977; Meng et al., 2014).

However, Kanter's (1977) work was not fully realized and used empirically until a decade later when the face of the corporation and career opportunities, especially for women, changed. Kanter's theory also starting filtering into the nursing literature when Chandler (1986) wrote a dissertation about the relationship of nursing work environment to empowerment and powerlessness (Chandler, 1986).

Major Theoretical Propositions

Structural empowerment is the presence social structures of power and opportunity in the work environment, facilitating the mobilization of resources,

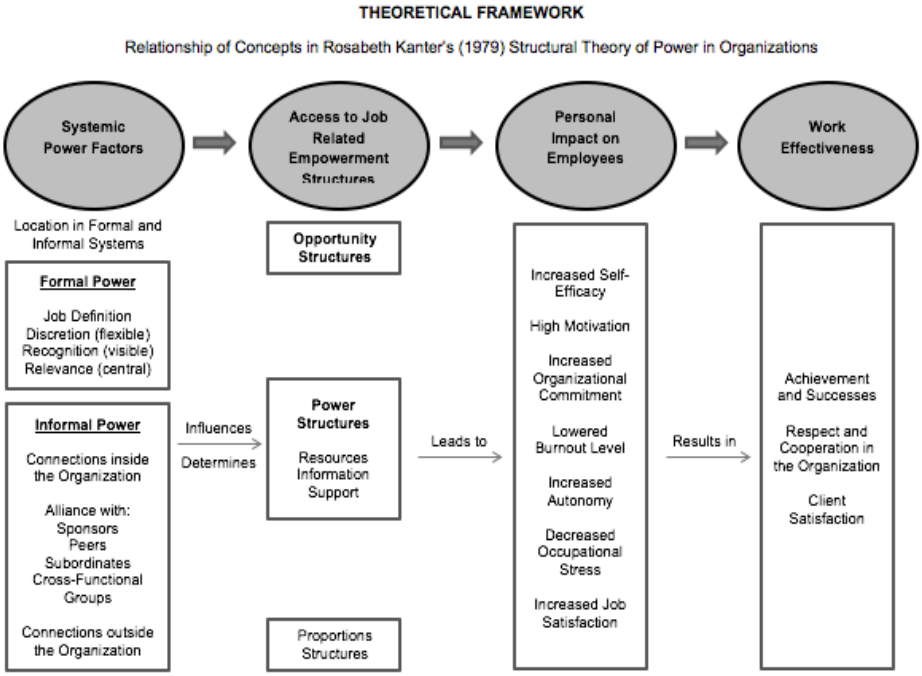
information, and support in the achievement of organizational goals (Kanter, 1977; Kanter, 1979). Management should be responsible for creating conditions that promote accessibility to resources to achieve work goals and accomplishments (Kanter, 1977). Structural empowerment impacts organizational effectiveness through the use of human resources in the participation and engagement of organizational duties (Orgambídez-Ramos & Borrego-Alés, 2014). A healthy working environment is associated with positive nursing outcomes that include job satisfaction and organizational commitment, thus affecting positive patient outcomes (Cicolini et al., 2014; Dahinten et al., 2016; Havaei & Dahinten, 2017; Meng et al., 2014).

Kanter (1977) posited that structural empowerment is built upon formal power, informal power, and the four structures of power that include access to information, support, resources, and opportunity for advancement. Formal power is derived from specific job characteristics and position in the organization while informal power is cultivated through social connection and communication channels within individuals and groups resulting to effective alliances (Kanter, 1977). With the presence of power among employees, the four structures of power are then easily accessed. Access to opportunities for advancements provides individual with challenging tasks, rewards, and prospect for professional growth and development (Kanter, 1977). Access to information refers to having the organizational knowledge and expertise required to effectively get the job done (Kanter, 1977). Access to support not only means receiving feedback, guidance, and support from superiors, peers, and colleagues but also involves strong organizational policies that enable work effectiveness (Kanter, 1977). Last, access to resources denotes

to the ability to acquire materials, funds, equipment, and time to complete the task at hand (Kanter, 1977). For empowerment to occur, power and the four organizational structures of power must be present. Figure 1 below illustrates Kanter's theory as conceptualized in this study.

Figure 1

Kanter's Theory of Structural Empowerment



Note. Adapted from "*Conditions for work effectiveness questionnaire I and II: User manual*." By H. Laschinger, 2012, Heather Laschinger Research Measurement Tools. (http://www.uwo.ca/fhs/hkl/files/cweq.docx)

Literature and Research-Based Analysis of How the Theory is Applied

Kanter's theory of structural empowerment is used extensively in the literature to describe the characteristics of an empowered organization. Kanter also developed the

CWEQ to test her theory in structural empowerment and was further examined and modified by Chandler (1986) to determine its applicability in a nursing environment. Since then, empowerment was brought into the forefront by Laschinger, with her multiple works on empowerment using Kanter's theory of structural empowerment as her theoretical framework. Laschinger had published numerous research studies on the perception of empowerment and its relationship on job satisfaction, burnout, leadership, commitment, and turnover intention (Laschinger et al., 2015; Laschinger & Fida, 2014; Laschinger & Fida, 2015; Wong & Laschinger, 2015).

Empowerment is a challenging concept to define due to its significance and use in literature. Kanter's theory of structural empowerment is often used to explain the concept of empowerment, and its multicultural applicability is outstanding. For instance, Scanlan and Hernandez (2014) critically analyzed and presented the successful components in the implementation of a nursing doctoral program in Cuba using Kanter's theory of structural empowerment. In a project of this magnitude, this doctoral program required not only strong partnerships between two countries but socio-structural resources and support, especially on funding (Scanlan & Hernandez, 2014). Furthermore, Scanlan and Hernandéz (2014), concluded that shared power through student engagement and desire to learn opens an opportunity for ingenuity, insightfulness, and the ability to innovate. Moore and Ward (2017) further expounded that empowered students are motivated and uphold self-directed learning, which ultimately transitions to empowering clinical learning and professional nursing behaviors in practice. Effective communication skills by speaking up on behalf of patients receiving care are one such empowering

feature in actual nursing practice behaviors (Moore &Ward, 2017). Mansour and Mattukoyya (2018) argued that as nursing students, speaking up requires empowerment and moral courage. Assertive communication behaviors are the result of being confident about clinical knowledge and relationship with peers, allowing these students to speak up and challenge unsafe practices without fear of retribution (Mansour & Mattukoyya, 2018). These positive gains in clinical performance translate into a positive work environment that encourages commitment to the organization (Moore & Ward, 2017; Mansour & Mattukoyya, 2018). In Rwanda, Thuss et al. (2016) explored the clinical instructor's experience with empowerment and its importance in academia. Thuss et al. (2016) hypothesized that exploring empowerment can result in the added knowledge of improving the clinical experience of both clinical instructors and students. Indeed, the lack of resources such as educational materials, skills lab, and human resources are prominent challenges identified (Thuss et al., 2016). Nevertheless, empowerment is still perceived in the form of informal power through collegial relationships and support of colleagues and students (Thuss et al., 2016). But, in a country where cultural values are dictated by collectivism, formal power is more available and manageable than informal power (Cheng & Boey, 2016). Structural empowerment is domain-specific, as it is analogous to organizational characteristics of the workplace and a positive concept emphasizing on strengths rather than weaknesses (Cheng & Boey, 2016).

The majority of Kanter's theory of structural empowerment is used in the workplace to explain occupational phenomena surrounding employees. A literature review by Cicolini et al. (2014) included 12 research studies, the majority of which used

Kanter's theory of structural empowerment to expound on the relationship between empowerment with job satisfaction. Empowerment was differentiated through this literature review, with structural empowerment as the "application of management," while psychological empowerment is how structural empowerment is accepted and experienced by employees (Cicolini et al., 2014, p. 856). The studies analyzed by Cicolini et al. (2014) and a study conducted by Dahinten et al. (2016) indicated that both structural and psychological empowerment has a positive relationship with job satisfaction and organizational commitment. Despite these two overlapping empowerment constructs, structural empowerment is the strongest predictor of job satisfaction (Cicolini et al., 2014; Dahinten et al., 2016). Also, in using the lone construct of structural empowerment, De Almeida et al. (2017), Orgambídez-Ramos and Borrego-Alés (2014), and Yang et al. (2014) not only acknowledges that structural factors in the workplace are conditions that empower an employee but can be a framework of intervention plans for organizations to improve satisfaction in the workplace. In a specialized area such as hemodialysis, the organizational structure of the work environment is fundamental in improving job satisfaction and, ultimately, retention of nurses (Hayes et al., 2015). Even in a collectivist culture, structural empowerment is applicable and experienced similarly by nurses (Cheng & Boey, 2016). Due to structural empowerment's emphasis on strengths, resources, and capacities, its effect with job satisfaction is more impactful compared to its effect with a nurse's psychological well-being (Cheng & Boey, 2016). To further breakdown the applicability of Kanter's theory in the work environment, Laschinger et al. (2014a) established that a unit level structural

empowerment supports professional nursing practice and positively affects unit level effectiveness. Assessing the environment though active listening and evaluating the presence of empowering organizational structures are strategies that can result in a positive work environment (Hayes et al., 2015).

Other occupational phenomena that used Kanter's theory of structural empowerment include burnout and workplace incivility. Burnout and workplace incivility are imperative to cite as they mediate a nurse's intent to stay or leave the organization. Burnout, though not a medical condition, can be a public health problem and is now classified by the World Health Organization (2019) as an occupational phenomenon worthy of being included in their latest revision of the International Classification of Diseases. Kanter's theory of structural empowerment is used to extract the relationship and confirm if structural empowerment can predict core burnout (Meng et al., 2014; Orgambídez-Ramos et al., 2017). Meng et al. (2014) further postulated that structural empowerment positively affects the level of psychological empowerment. Furthermore, empowerment as a whole, decrease burnout, and increase the likelihood of a nurse's intent to stay in the organization (Meng et al., 2014; Orgambídez-Ramos et al., 2017). To augment this study, Arslan Yürümezoğlu and Kocaman (2019) and Gholami et al., 2019) concluded that if a nurse perceives the presence of structural empowerment, it reduces workplace incivility and intent to leave the organization. Furthermore, Arslan et al. (2019) and Gholami et al. (2019) also postulated that structural empowerment indirectly decreases a nurse's intent to leave the profession by decreasing the intent to leave the organization. However, in a study by Eskandari et al., 2017), they surmised that even if a

high level of structural empowerment increases organizational commitment, low level of empowerment does not necessarily lead to a decrease in organizational commitment. Emphasizing on gender, male nurses have a higher perception of structural empowerment and may be due to power as being a masculine trait (Eskandari et al., 2017).

The wealth of information on these research studies is often found on which of the major theoretical propositions are significantly important. Out of four structures of power, access to resources is often mentioned as the priority. For clinical instructors, access to resources such as the availability of course materials, research resources, and the human aspect of care among colleagues are the most significant structural components of empowerment perceived (Thuss et al., 2016). Orgambídez-Ramos et al. (2017) also determined that access to resources is the most impactful in predicting burnout. If an organization lacks funding and health services, it puts a strain on available resources and generating stress and burnout among employees (Orgambídez-Ramos et al., 2017). Access to resources is essential in formulating strategies that can help the workload of nurses while demanding quality care (Meng et al., 2014). Giving opportunities for nurses to access organizational resources and strategies can result from a more collaborative approach in dealing with day-to-day work issues, thus resulting in shared decision making and, ultimately, finding ownership and meaning with work (Laschinger et al., 2014a). In contrast, De Almeida et al. (2017) and Orgambídez-Ramos and Borrego-Alés (2014) argued that access to opportunities is the most powerful predictor of job satisfaction. Engstrom et al. (2015) also concluded that access to opportunity is significant in addition to having available resources for a nurse's ability to

work according to evidence-based practice. Through evidence-based resources, individual career development plans that creates opportunities can create supporting structures to establish a workplace designed to follow the latest practice evidence and guidelines (Engstrom et al., 2015). Also, opportunity and power that is made available to staff nurses can maximize organizational effectiveness (De Almeida et al., 2017). When a nurse is able to use their skills and competencies to grow professionally, they ultimately benefit the needs of the organization (De Almeida et al., 2017). Pursuing professional growth when opportunities exist is also a result of formal power and often result in self-efficacy and autonomy, and ultimately, job satisfaction (Orgambídez-Ramos & Borrego-Alés, 2014). In the research study of Eskandari et al. (2017), access to opportunity was also identified as the principal component of structural empowerment followed by informal empowerment. In a collectivist culture, access to opportunity is readily available and easily related to access to training opportunities rather than pursuing professional growth (Cheng & Boey, 2016). Formal power was the least important but is higher on nurses who have a longer work history (Eskandari et al., 2017). Lastly, formal power, even if perceivably low, still influences structural empowerment (Cheng & Boey, 2016).

Building and accessing the structures of a positive and empowered environment is not through happenstance. Nursing leaders are in the best position for creating structurally empowering conditions in the workplace (Laschinger et al., 2014b; Meng et al., 2014). A nursing leader's role has grown from one that not only establishes a practice environment but to one that demands to balance the needs of the internal and external

customers of the organization and of the whole organization despite fiscal limitations (Laschinger et al., 2014b). Using Kanter's theory of structural empowerment as a framework, Laschinger et al. (2014b) claimed that resonant leaders, due to its foundation in emotional intelligence, are able to share their expertise and knowledge to subordinates and subsequently empower them. In addition to this contention, resonant leadership also increases job satisfaction, and through empowerment, decreases workplace incivility and burnout (Laschinger et al., 2014b). Bawafaa et al. (2015) determined that structural empowerment partially mediates resonant leadership and job satisfaction. Nurses have more access to empowerment structures and therefore are happy and able to do their work if nurse leaders demonstrate resonant leadership behaviors (Bawafaa et al., 2015). Even if nurse leaders often implement actions not supportive of their personal values, supporting staff teamwork and enhancing group relationships ensure work effectiveness and improves job satisfaction. Other than resonant leadership, transformational leadership behaviors had been associated with an increase in job satisfaction and decreased turnover and burnout (Khan et al., 2018). Transformational leadership behavior is designed to inspire and motivate the staff (Khan et al., 2018). Staff nurse's perception of leadership behaviors is essential, and transformational leadership is perceived to achieve a higher level of organizational effectiveness (Khan et al., 2018).

The application of Kanter's theory of structural empowerment is varied and comprehensive. The theory of structural empowerment guides an organization on how it's to be structured in a way that it exudes shared power despite challenges in resources. Occupational phenomena such as burnout, workplace incivility, job satisfaction, and

organizational commitment are just some of the variables that are influenced by structural empowerment. In addition to staff experiences, perceived leadership behaviors such as resonant and transformational leadership were indispensable in the use of structural empowerment to create a positive work environment.

Rationale for the Choice of Theory and How it relates to the Present Study

A satisfied workforce is an important aspect of a healthy organization. Kanter's theory of structural empowerment was chosen because of its application in an organizational level. Furthermore, its applicability in different industries and specifically in nursing is valuable. Kanter's theory is an excellent framework for my RQ 1) which of the demographic factors (age, gender, education, perioperative experience, and certification) can reliably predict empowerment among perioperative nurses; and RQ 2) do empowerment, and job satisfaction predict intent to stay in the organization for perioperative nurses. Kanter's theory of structural empowerment and its concepts as depicted on Figure 1, focused on the how organizational structures can increase job satisfaction and organizational commitment. Using Kanter's theory will further expand the literature around job satisfaction and intent to stay among a highly specialized group of nurses.

Literature Review Related to Key Variables and/or Concepts

Empowerment

Scholars agree that there is no single definition of empowerment. Complementary perspectives of empowerment in the literature involve either the macro level, which means organizational conditions, or the micro-level, which delves more on

the psychological impact of empowerment (Appelbaum et al., 2015; Appelbaum et al., 2014; Spreitzer, 2008). However, since empowerment is an evolving construct, it should be analyzed on how it is applied in a given context for it to be effective in a given situation (Appelbaum et al., 2014). In some research studies, especially those not using Kanter's theory of structural empowerment, the concept of empowerment is explained in the context of a positive work environment. A positive work environment is described as empowering, supportive, psychologically safe, and with a high level of respect and trust (Kol et al., 2017; Wei et al., 2018). An intervention study using empowering strategies to create a positive work environment conducted by Kol et al. (2017) increased the organization's nurse satisfaction significantly. These strategies include participatory management, promoting nurse autonomy, shared decision making, and, more importantly, having the right resources such as staffing and equipment (Kol et al., 2017). In a literature review by Wei et al. (2018), empowerment is a fundamental requirement not only for a positive work environment but for patient care. Since patient safety is crucial in an organization's reputation and finances, a positive work environment is instrumental in sustaining the nursing workforce, hence also improving quality patient care (Wei et al., 2018).

For some organizations, empowerment is such a foreign construct that the challenge is not only on its definition but its characteristics. Rega et al. (2017) explained that there's no Italian equivalent of empowerment but surmised that it features "power, authorization, choice, and license" (p. 609). However, on the resulting qualitative study of Rega et al. (2017), empowerment is defined as value, not an exercise of shared power.

Providing individuals with resources for professional growth and creating an environment that values them is empowerment (Rega et al., 2017). Moreover, trust is the main effect of empowerment as individuals are trusted and valued, allowing them to be empowered (Rega et al. 2017). Eyuboglu and Duygulu (2019) further extrapolated that an empowered nurse perceives self to be an effective problem solver. Hence, empowerment is characterized by autonomous problem solving that can affect nurses, their practice, and organization and enables an increase in responsibility, autonomy, and participation (Eyuboglu & Duygulu, 2019).

Empowerment is also not a common lexicon in practice. A phenomenological study by Van Bogaert et al. (2016) described that staff is mostly unaware of empowering strategies implemented by management. Additionally, conflicting top-down initiatives and staff-driven solutions often confuse the staff resulting in their inability to feel empowered (Van Bogaert et al., 2016). Despite these negative experiences on empowerment, involvement in decision making, participating in the organization's internal governance and policy, and contributing to the practice initiatives are characteristics of empowerment (Van Bogaert et al., 2016).

Empowerment affects several other demographical variables. As mentioned, in a study by Eskandari et al. (2017), male nurses have a higher perception of structural empowerment. What is also included in this analysis are nurses aged 40 years old and above, employed in a nonteaching hospital, works at the emergency department, higher salary, and increasing job experience of over 20 years all have a higher perception of structural empowerment. In contrast, Fitzpatrick et al. (2014) determined that there's no

differences in the global perception of empowerment between genders, except on the empowerment structure of opportunity, wherein female nurses perceive more access to opportunity. There is also no significant difference on a nurse's intent to leave the organization or profession between certified and noncertified nurses (Fitzpatrick et al., 2014). Lastly, certified nurses have higher informal power compared to noncertified nurses (Fitzpatrick et al., 2014).

The construct of structural empowerment indeed varies on its application. Likewise, results from research studies not using Kanter's theory of structural empowerment is congruent with the overall paradigm of an empowered environment. A positive work environment is an outcome of the availability of resources and staff opportunities, shared decision making, and staff autonomy. A positive work environment is characterized by empowerment.

Empowerment and Job Satisfaction

Job satisfaction has been studied extensively in literature due to the endless nursing shortage problem. Job satisfaction is a degree to which an individual love his or her job (Yang et al., 2014), a sign of quality of life characterized by the sense of value and autonomy at work (De Almeida et al., 2017; Hayes et al., 2015), partly comprised of extrinsic job performance in the workplace (Yang et al., 2014), and is influenced by both the working environment and the individual's personal characteristics (Cicolini et al., 2014). Similarly, in a conceptual analysis study conducted by Lu et al. (2019), the attributes of job satisfaction include a gratifying response and fulfillment of needs to work conditions and, more importantly, job value. The antecedents of job satisfaction

included internal factors such as individual and emotional variables, and external factors to include work character and environmental variables (Lu et al., 2019). A literature review by Liu et al. (2015) showed how varied the factors influencing job satisfaction and how structural empowerment can have a significant direct, mediating, or even moderating effect on job satisfaction (Liu et al., 2015). Liu et al. (2015) and Lu et al. (2019), emphasized that job satisfaction is critical to ensure an adequate nursing workforce and quality healthcare.

Most empowerment studies determined that structural empowerment is the most significant predictor of job satisfaction (Cicolini et al., 2014; Dahinten et al., 2016; De Almeida et al., 2017). In the literature review by Cicolini et al. (2014), most studies used Kanter's theory of structural empowerment as it consistently explains the structures of an empowered environment. Furthermore, there is a significant relationship between age and educational level to structural empowerment (Cicolini et al., 2014). Additionally, age (Dahinten et al., 2016; Hayes et al., 2015), a leader's empowering behavior (Dahinten et al., 2016), and years of experience (Hayes et al., 2015) is associated with higher job satisfaction. Yang et al. (2014) described that the components of structural empowerment that predict job satisfaction are access to resources, support, and informal power. Work objective, described as the love for nursing, significantly predicted job satisfaction (Yang et al., 2014). More so, a nurse's satisfaction with extrinsic rewards or professional opportunities are dimensions of job satisfaction that is influenced highly by the organization and not by individual motivation (Dahinten et al., 2016). De Almeida et al. (2017) comparably concludes that access to opportunities is an element in a nurse's

job satisfaction since it is fundamental to personal achievement, hence professional satisfaction. Moreover, global empowerment contributes to an increased level of autonomy, appreciation of work, and effective work performance (De Almeida et al., 2017). Hayes et al. (2015) emphasized that the core component of job satisfaction is autonomy since it allows job independence, freedom, and outlines competence. In the perioperative environment, autonomy was also the most crucial component of professional satisfaction (de Oliveira et al., 2017), and professional satisfaction is the most reported concept of job satisfaction (Eskola et al., 2016). Job satisfaction eventually depends on the individual's worldview to perform work activities with "pleasure, not obligation" (de Oliveira et al., 2017, p. 10). Other than autonomy, staff satisfaction is the result not only by providing a safe and healthy workplace culture for staff but, more importantly, staff involvement in decision making, and process improvement projects (Brunges & Foley-Brinza, 2014). Björn et al. (2015a) contend that job satisfaction is an attractive quality in the perioperative environment and defined by staff status and acknowledgment.

The relationship between empowerment and job satisfaction is well established in the literature. The organization is also a critical fixture that provides the means for staff to experience job satisfaction. Even though job satisfaction is one of the most studied concepts in nursing, there are a limited number of studies that outlined the relationship of job satisfaction with empowerment and its impact on the perioperative environment. For instance, a literature review by Lu et al. (2019) is confined to acute care hospitals to capture the spectrum of clinical areas but none that studied the perioperative environment

exclusively. Though a complicated concept, ultimately, job satisfaction is a vital component to ensure that staff desires to stay and engage in the attainment of organizational goals.

Empowerment and Intent to Stay

Due to the issue of the nursing shortage, understanding a staff's intention to stay is vital in retention. Intent to stay is the anticipated long-term stay of an employee in their job (Meng et al., 2014) and is a behavioral intention of remaining in the organization (Cowden & Cummings, 2015), resulting in retention (Ke & Hung, 2017). In testing a proposed theoretical model for intent to stay, Cowden and Cummings (2015) identified empowerment as a cognitive response to work. Empowerment strongly influences a nurse's intent to stay due to its positive effect on organizational commitment and desire to stay (Cowden & Cummings, 2015). Cowden and Cummings (2015) identified multiple, simultaneous factors that contributes to a nurse's intent to stay in the organization, hence, retention. In addition to work empowerment, intent to stay has been linked to job satisfaction (Meng et al., 2014) and used interchangeably with retention and counter to the concept of intent to quit or leave in the literature (Ke & Hung, 2017). Overall, an empowered staff is inspired and motivated to practice and feels valued in the organization (Meng et al, 2014). In turn, being valued and motivated to practice optimally gives an empowered employee, the sense of loyalty through aligning with organizational goals, therefore, staying in the organization (Meng et al., 2014). Al-Hamdan et al. (2016) also posited that a work environment that facilitates professional practice and with constructs of participation, quality of care, leadership support,

resources, and collegial relationships is a positive contributor to intent to stay and job satisfaction. Intent to stay is posited to have more of an emotional component as it is the result of both affective and cognitive responses to the work environment (Al-Hamdan et al., 2016).

In an attempt to understand the nuances of a nurse's intent to stay in the organization, Chen et al. (2014) examined work values and personality traits and their relationship with intent to stay. A staff nurse's age, the type of hospital, emotional stability, conscientiousness, and work values all predict a nurse's intent to stay (Chen et al., 2014). Additionally, Ke and Hung (2017) concluded that nurse's increase in age and years of experience, being married, and organizational commitment is significantly and positively correlated with intent to stay in the organization. In the perioperative environment, there is limited literature to a nurse's intent to stay but, Lögde et al. (2018) discovered that OR nurses decide to leave the organization because of poor leadership and working conditions, lack of work-life balance, and unsupportive colleagues' behavior. Though the negative concept of intent to stay was the focus of Lögde et al. (2018), recognizing the value as a person and a nurse ranks highly with staff is critical to retain perioperative nurses. Leadership behaviors such as instilling an empathetic, safe, and healthy environment that supports participation, decision making, staff engagement, and discourages workplace incivility and bullying are strategies to motivate nurses to stay in the organization (Lögde et al., 2018).

Literature does illustrate the importance of the work environment in a nurse's decision to stay or leave the organization. Though empowerment is just one of the many

factors that promote a nurses' intent to stay, it is still worth noting how the structures of empowerment, though not defined, are essential and similar in any work environment. Opportunities to be heard, grow, autonomous, and feel valued, together with a leader's empowering behavior are simple but effective strategies for a nurse to stay in the organization.

Summary and Conclusions

Empowerment is a powerful construct due to its reach and multiple applicability. Kanter's theory of structural empowerment was used to define empowerment, guide empowerment strategies, and academic programs, and provide researchers with a guide to expand on their model of empowerment. The nursing literature was full of empowerment studies, surprisingly impacting, and crossing multicultural boundaries. The majority of empowerment studies were on its relationship to occupational phenomena, including job satisfaction and intent to stay. Through this literature review, the themes that were common across the concepts of empowerment, job satisfaction, and intent to stay were autonomy, shared decision making, and opportunities. Multiple studies had also underscored empowerment and job satisfaction, empowerment, and intent to stay, but minimal studies depicted all three variables in the perioperative setting. What was surprising from this literature review was the limited research studies that involved the perioperative setting and job satisfaction as most organizations conduct an employee survey to monitor satisfaction annually. Nonetheless, the literature was supportive of the hypotheses declared in this study that there was a relationship between empowerment, job satisfaction, and the staff's intent to stay in the organization. In summary, Chapter 2

outlined the literature search strategy, the theoretical framework for this study and its major prepositions, the use of Kanter's theory of structural empowerment in literature, the variables empowerment, job satisfaction, and intent to stay.

Chapter 3: Research Method

Introduction

The purposes of this study were to determine (a) the relationship between age, gender, level of education, years of perioperative experience, and specialty certification and empowerment in perioperative nurses and (b) the relationship between the level of empowerment, job satisfaction, and intent to stay in the organization among perioperative nurses. In Chapter 3, I discuss the research design and rationale, target population, sampling procedures, sampling design, participation, data collection, instrumentation, data analysis, potential threats to validity and ethical considerations for the study.

Research Design and Rationale

For the first RQ, the independent variables are age, gender, level of education, years of perioperative experience, and specialty certification empowerment was the dependent variable. I used a quantitative correlational survey design for this study. In a correlational design, the relationship and magnitude of the variables are estimated and may even predict the performance of the criterion variables (Mertens & McLaughlin, 2004). In the second RQ, the independent/predictor variables were empowerment and job satisfaction, and intent to stay was the dependent/outcome variable. Descriptive studies are used when there is existing literature on the variables, but the construct has not been studied on a particular population of interest to the researcher (Wood & Ross-Kerr, 2010).

Time and Research Constraint

I used an anonymous, online survey deployed for 8 weeks, or once it reached the sample size, whichever came first. If the sample size was not attained, I planned to state it as a limitation in the reporting and generalization of the results. Using an online survey is easy, inexpensive, and feasible but is severely constrained only to individuals with access and technical competence in using the internet and email (Burkholder et al., 2016). Furthermore, lower response rates are observed in online surveys partly because of over surveying and detailed and longer use of questionnaires (Sauermann & Roach, 2013). This study had three separate questionnaires with a total of 49 questions, not including the initial screening and demographical data gathered. Online surveys usually suffer from lower response rates at around 10-25% (Sauermann & Roach, 2013). Low response rates may result in nonresponse bias, causing a diminished sample size thus reducing statistical power and ultimately affecting the validity and generalizability of the results (Sauermann & Roach, 2013). Furthermore, this was a correlational study with a cross-sectional design. Cross-sectional design studies are taken at one point in time. Unlike longitudinal studies, cross-sectional data are often used in correlational studies making it very limiting as it is unable to provide a unique variance (Irwin et al., 2011), with measurement that did not document changes over time (Wood & Ross-Kerr, 2010).

Methodology

Population

The target population was perioperative nurses who have been working in the OR for more than 1 year. The role of the perioperative nurse was defined by being a licensed

nurse who scrubs or circulates a surgical procedure for more than 20 hours a week. A circulating nurse circulates and coordinates the needs of the surgical team while ensuring a patient's safety and well-being while in surgery (Staff, 2017). A scrub nurse provides skilled assistance during surgery by maintaining surgical asepsis while ensuring that items used in the surgical field are accounted for (Kang et al., 2015). The actual number of OR nurses in the United States was not known since there is no available database containing a nurse's specialization. However, AORN reported that there were more than 160,000 perioperative nurses, including 43,000 members of their organization (AORN, 2019). In unknown population parameters, using characteristics of the population from another study with the same or similar variables are acceptable (Wood & Ross-Kerr, 2010).

Sampling and Sampling Procedures

The sampling strategy of this research study was nonprobability convenience sampling. Convenience sampling is the procedure when participants are selected based on their availability (Drew et al., 2008). The online study survey was generated using Survey Monkey and posted in a Facebook account, Facebook perioperative nurses' group to which I belong, and a LinkedIn Profile. I also emailed the membership list that was provided by AORN to recruit participants. There was no fee or added approvals in the recruitment of participants.

The inclusion criteria were: (a) must be a Registered or Licensed-Vocational Nurse, (b) must scrub or circulate for a surgical procedure for more than 20 hours/week, (c) has worked in the OR for 12 months or more, and (d) works as an OR nurse within the

United States and its territories. The exclusion criteria were: (a) must not be in any management or leadership position, including perioperative director, nurse manager, assistant nurse manager, nurse educator, or clinical nurse specialist, and (b) must not be a Registered Nurse First Assist, Nurse Practitioner, Certified Registered Nurse Anesthetist, or a Physician's Assistant. These inclusion/exclusion criteria are included in the screening questionnaire in Appendix A.

For RQ 1, I calculated the sample to be 55 participants using the software program G* power for a two-tailed multiple regression with 5 predictors, a medium effect size of $f_2 = .15$, power 0.8, and significance tests at $\alpha = .05$. G*power is a power analysis program that enables researchers to compute for sample sizes from a given effect, power level, and alpha value (Erdfelder et al., 1996). The medium effect size of 0.15 was set according to Cohen's power primer, as this represents an "effect likely to be visible" to the researcher (Cohen, 1992, p. 156).

For RQ 2, I calculated the sample size using the software program G* power for a two-tailed multiple regression with 2 predictors, a medium effect size of $f_2 = .15$, power 0.8, and significance tests at .05 which yielded a sample size of 55.

Procedures for Recruitment, Participation, and Data Collection

Participants was recruited using the membership information from the professional organization AORN, as well those interested in the survey as posted on my Facebook, LinkedIn, Facebook Groups account or on information flyers handed out personally during monthly AORN local chapter meetings. AORN allowed access to their membership database if the request met the criteria set by the AORN's Nursing Research

Committee (Appendix B). I obtained access to the members of the AORN after the approval was granted by the AORN's Nursing Research Committee. The AORN do not have an Institutional Review Board (IRB) and they require IRB approval prior to membership access. Walden IRB (Study approval # 07-14-20-0583899) and AORN approval were both obtained prior to data collection.

Recruitment of participants started with a short introduction of the study. I used the feature in SurveyMonkey that delinked the email from the data to assure anonymity. No monetary or similar form of compensation was offered. Post incentives for respondents do not entice nor affect retention rate (Sanchez-Fernandez et al., 2012). Screening questions pertinent to the study's inclusion and exclusion criteria were initially presented (Appendix A). If the individual answered "yes" to all of these questions, an electronic statement outlining the survey intent, invitation to join the study, and how anonymity is ensured appeared on screen. If one or more questions were answered as "no," then the individual will be thanked and informed that they do not qualify for the study. Once the participant accepted to join the study, a consent form to participate and a reiteration of how anonymity is maintained appeared on the screen. Once the participant signed the consent form, the demographic questionnaire appeared (Appendix C). After the demographic data sheet is completed, the participant was taken to the survey containing the operationalized constructs of structural empowerment, job satisfaction, and intent to stay. Once the participant completed the survey, a thank you screen appeared, and the survey closed.

Data were collected anonymously through SurveyMonkey using the feature that delinked any information and only those who agreed to continue with the survey was used. No personal identifying data was asked from the participants nor placed in the survey. There was no follow-up communication with the participants once the survey was completed. I, however, provided my contact information at the end of the survey if the participants wanted a summary of the study results. Data collected were stored electronically using a secure cloud storage that only I have access to the data with a password.

Instrumentation and Operationalization of Constructs

Background variables were gathered using a demographic questionnaire that contained the variables of age, gender, education, perioperative experience, and nursing certification (Appendix C). Empowerment was operationally defined using the CWEQ-II. Permissions to use the CWEQ-II is found in Appendix D. CWEQ-II was appropriate in this study as it not only measured the overall empowerment but also all its construct. CWEQ-II evolved from the CWEQ-I developed by Chandler (1986) who used Kanter's work on structural empowerment (Laschinger et al., 2000). Laschinger et al. (2001) modified the original CWEQ-I for use in research studies making it significantly shorter with 19 items measuring the six construct of empowerment and a two-item global empowerment scale that measured construct validity. Structural empowerment was assessed on a five-point scale that ranged from one to five. One example of a question included a subscale on access to opportunity with the question of "how much of each

kind of opportunity do you have in your present job?" and the item measured was challenging work. The CWEQ-II can be found in Appendix E.

The construct validity of the CWEQ was determined using a confirmatory factor analysis (CFA). The fit indexes for the CWEQ-II in the original study by Lashinger et al. (2001) were $\chi 2/df$: 2.17, CFI: 1, IFI: 0.992, RMSEA: 0.054, and the Cronbach's alpha coefficient was 0.89 for the total scale. CFA is used to assess the viability of the tool using goodness-of-fit indices and if found a good fit, is acceptable (Cole, 1987). In a study by Arslan Yürümezoğlu and Kocaman (2019), the CWEQ-II used was in Turkish and yielded a Cronbach's alpha of 0.93 to determine the relationship between structural empowerment, supervisor and coworker incivility, and the intent to leave the organization and profession among hospital nurses. The Swedish version on the CWEQ-II was tested by Eriksson and Engström (2018) among internationally educated nurses to examine their experiences on empowerment, with the total scale Cronbach's alpha of 0.90. Lashinger et al. (2001) also tested the reliability of the six subscales of empowerment: opportunity (0.81), information (0.80), support (0.89), resources (0.84), job activities scale (JAS) to measure formal power (0.69), and organizational relationships scale (ORS) to measure informal power (0.67). Similarly, Khan et al. (2018), used the CWEQ-II to scrutinize the nurse's perception of empowerment and leadership behaviors of their nurse leaders. The reliability of the CWEQ-II revealed a Cronbach's alpha of the six subscales ranging from 0.68 to 0.89 and 0.82 for the total empowerment scale Khan et al. (2018).

Job satisfaction was operationalized using the nursing workplace satisfaction questionnaire (NWSQ). I received permissions for the use of NWSQ (Appendix F). Fairbrother et al. (2010), developed the NWSQ as a 14-item tool for Australian nurses, measuring job satisfaction into three quantifiable domains: intrinsic, extrinsic, and relational job satisfaction. The intrinsic domain deals with a nurse's perception of job satisfaction, extrinsic domain on the work environment, and relational on a nurse's relationship with coworkers (Fairbrother et al., 2010; Newman et al., 2013). The NWSQ was applicable for this study because it was developed for nurses to canvas a specific working environment, not the overall organization (Fairbrother et al., 2010). Using the NWSQ, job satisfaction was assessed on a five-point Likert-type scale that ranges from 1-5 where 1=*strongly agree* and 5=*strongly disagree*, with one item reversed score. An example of a question includes the intrinsic domain item of "How much you enjoy your job" by answering questions such as 'my job gives me a lot of satisfaction." The NWSQ appears in Appendix G.

An exploratory factor analysis was used to determine the NWSQ validity with results showing the components eigen values at >1 and 59.8% of variance explained. Internal consistency and reliability were also tested, revealing a total Cronbach's alpha of, 0.90, and the following domains: intrinsic (0.89), extrinsic (0.74), and relational (0.87). Newman et al. (2013) used the NWSQ to provide insight of job satisfaction among nursing leaders during the crucial time of leadership development. Newman et al. (2013) did not conduct a separate reliability and validity testing on the NWSQ but rather reported the reliability and validity testing by Fairbrother et al. (2010). To elucidate the

relationship between a nursing student's sense of satisfaction on their clinical placements, Borrott et al. (2016) used the NWSQ. Internal consistency reliability of the NWSQ to overall job satisfaction was measured, with a Cronbach's alpha at 0.83 (Borrott et al., 2016).

Intent to stay was operationalized using the intent to stay scale. Permissions for the use of this scale is in Appendix H. Kosmoski and Calkin (1986) developed the 6-item intent to stay scale while adapting two of the items originally from Price and Mueller (1981). The increase in the number of items of the tool by Kosmoski and Calkin (1986) was to improve the reliability while incorporating more the characteristics of intent. Questions asked how long an individual plan to stay in the unit and hospital contained a 7-point rating scale, while questions such as "Do you expect to leave this unit in the near future?" are in a 5-point rating scale. The scale is in Appendix I. The intent to stay scale was appropriate for this study because it measured the strength of intention to stay in one's present position, unit, and organization. Internal reliability of the intent to stay scale was reported to be Cronbach's alpha 0.90 while the validity of the tool was not mentioned other than the two questions adapted from Price and Mueller (1981) with a reported discriminant, validity and reliability from -.40 and .85 using exploratory analysis. Most of the study in the literature cited the study of Kosmoski and Calkin (1986) to explain intent to stay but not to use their researcher-made tool to test intent to stay scale.

Data Analysis Plan

I used the International Business Machines Statistical Package for the Social Sciences (IBM SPSS) v. 25 to collate, store, and analyze data. IBM SPSS is a statistical software package that can execute statistical procedures from simple descriptive statistics to multivariate procedures (Meyers et al., 2013). Since this study involved self-reported survey data, data screening and cleaning procedures was conducted. The inability to directly observe the research participants in an online data collection is a major disadvantage of a self-reported survey data (DeSimone et al., 2014). Social desirability bias can also occur on a self-reported survey or a participant may accidentally skip a question (Warner, 2013). Screening data started with proofreading scores in the SPSS data worksheet against original data source and identified inconsistencies of responses. Missing data will be left blank in the SPSS data view worksheet, which then be treated as a system missing value (Warner, 2013). Missing data was handled by listwise deletion. Listwise deletion handles missing data by excluding all cases with missing values (Kang, 2013). Warner (2013) warned that deleting missing values which then were excluded from computation, can reduce sample size (Warner, 2013).

RQ 1 stated: Which of the demographic factors (age, gender, education, perioperative experience, and certification) can reliably predict empowerment among perioperative nurses?

In RQ 1, background variables of respondent's age, gender, level of education, years of perioperative experience, and certification were the independent/predictor variables and empowerment, the dependent variable, and analyzed using multiple

regression. Empowerment was measured using CWEQ-II. Categorical variables such as gender, level of education, and specialty education was assigned to groups depending on the number of categories and transformed to dummy variables. I calculated regression diagnostics with the multiple regression analysis test to check if the data met all the required assumptions. Independence of observation was analyzed using the Durbin-Watson statistic, linearity and homoscedasticity was checked using a scatterplot, the tolerance/variance inflation factor (VIF) value for any problems with multicollinearity, undue influence checked using the Cooks distance value, and a histogram was appropriate to show the fulfillment of the assumption of normal distribution of residual errors. Zero, part, and partial correlations and *t* ratios of each predictor variable were run to assess each of these predictor's contribution to the overall regression model.

RQ 2 states: Do empowerment, and job satisfaction predict intent to stay in the organization for perioperative nurses?

In RQ 2, the independent or predictor variables were empowerment and job satisfaction and the dependent or outcome variable was intent to stay and analyzed using multiple regression. Empowerment was measured using the CWEQ-II, job satisfaction with NWSQ, and intent to stay with the intent to stay scale by Kosmoski and Calkin (1986). Just like the first RQ, regression diagnostics was ran together with the multiple regression analysis test to check if the data met all the required assumptions. Independence of observation was analyzed using the Durbin-Watson statistic, linearity and homoscedasticity was checked using a scatterplot, VIF value for any problems with multicollinearity, undue influence was checked using the Cooks distance value, and a

histogram was appropriate to show the fulfillment of the assumption of normal distribution of residual errors. Zero, part, and partial correlations and *t* ratios of each predictor variable were run to assess each of these predictor's contribution to the overall regression model.

Threats to Validity

The threats to validity and reliability of a research study can never be eliminated but minimized. Internal validity is essential to determine the technical dependability of a study (Drew et al., 2008; Martin et al., 2011) and the validity of the study itself (Drost, 2011). Internal threats for this study included instrumentation and experimenter effects to include research methods and personal biases. A specific population of perioperative nurses with their associated background may self-report very high or low scores. Extreme scores can influence data analysis and if it exists, may very well be removed from the data set (Field, 2013).

External validity ensures the generalizability of results (Drew et al., 2008; Martin et al., 2011). External validity for this study included selection biases and constructs, methods and confounding. Due to the convenience type of sampling that was performed, external validity was threatened due the difficulty in generalizing the results to a larger population (Drew et al., 2008). Given that I used the membership list of a recognized nursing association with members across the United States, the participants were representative of perioperative nurse population. Selecting a population that represented the general population being studied is a way to address the external validity of a study (Bernard, 2013). Bernard (2013) also pointed out that increasing the sample size and

conducting a longitudinal study are additional ways to add external validity to the study. The sample size was calculated using the software program G* power. This was not a longitudinal study, therefore, the threat to external validity of the type of research design will remain.

Ethical Procedures

The two important ethical considerations in this study were on informed consent and ensuring a participant's anonymity. These two issues were addressed in the survey though a study disclosure and an informed consent using an online survey tool. Using SurveyMonkey, the delink feature on the participant's email address was applied to assure anonymity. If the participant passed the initial screening, the consent form appeared. The consent form ensured that participation is voluntary. The informed consent included the background information of the study, procedure, risks, benefits, nonpayment status, privacy, and researcher's contact information. The survey only opened after the participant digitally consented by pressing the "I consent" button. The participant may withdraw from the survey at any time.

Summary

In Chapter 3, the research plan was extensively discussed. This study was a descriptive, correlational, quantitative design with the purpose of determining the relationship between age, gender level of education, years of perioperative experience, and specialty certification with as well as the relationship between the level of empowerment and job satisfaction and intent to stay in the organization among perioperative nurses. Convenience sampling was used to recruit perioperative nurses and

data collection was dispersed using an online survey. Background variables as well as measures from validated instruments such as the CWEQ-II, NWSQ, and intent to stay scale was used in the survey. Data was analyzed through the use of multiple regression of both RQ1 and RQ2 using IBM SPSS. The threats to validity were identified and how to manage these threats were outlined. Ethical considerations were also discussed.

Chapter 4: Results

Introduction

The purpose of this study was to determine the level of empowerment and job satisfaction among perioperative nurses and their relationship to intent to stay in the organization. In addition, this study was also to determine if age, gender, education, perioperative experience, and national nursing certification can predict empowerment. To address this gap in the literature, the approach used was a quantitative, correlational survey design. The independent variables in this study were empowerment and job satisfaction, while the dependent variable was intent to stay. Background/demographic variables gathered in this study was explored and also used as independent variables and empowerment as the dependent variable.

The RQs and hypotheses for this study were:

RQ 1: Which of the demographic factors (age, gender, education, perioperative experience, and certification) can reliably predict empowerment among perioperative nurses?

$H_0$1: There is no relationship among age, gender, education, perioperative experience, certification, and empowerment among perioperative nurses.

H_A1: There is a relationship among age, gender, education, perioperative experience, certification, and empowerment among perioperative nurses.

RQ 2: Do empowerment, and job satisfaction predict intent to stay in the organization for perioperative nurses?

$H_0$2: There is no relationship between empowerment, job satisfaction, and intent to stay in the organization for perioperative nurses.

H_A2: There is a relationship between empowerment, job satisfaction, and intent to stay in the organization for perioperative nurses.

In this chapter, data collection, time frame of collection, demographic information, population representation, how the data collection plan was followed, and the results of the data analyzed by the prescribed statistical tests are presented and described. The results section includes the answers to the RQs by addressing the hypotheses.

Data Collection

Time Frame, Recruitment, and Response Rates

Data collection was conducted over the course of 10 weeks, 2 weeks prior to AORN's email to 4,483 members. According to the AORN's website, it has 42,000 members, but due to the different membership types, I was informed that only 4,483 of their members met my inclusion criteria. AORN sent my email twice at 1 month apart. The initial email has an email open rate of 26 and the second email has additional 30 of 4,483 possible respondents. I also posted the research study link in LinkedIn every 2 weeks since the start of the survey and on my Facebook page. I requested the survey link to be posted on 58 AORN Chapter's Facebook group and or page and have emailed their site administrators. I received positive responses from five AORN Chapters who shared my survey link on their Facebook page and/or group. I was also able to recruit respondents when I joined two virtual local AORN chapter meetings and was given the

chance to talk about my research and post my flyer through a chat option. I also was able to give a face-to face recruitment presentation with a local hospital and was able to distribute my study flyer during their staff monthly meeting. After 10 weeks, I had 105 opened survey responses. Initial data screening revealed that 35 respondents did not meet the inclusion criteria, 11 did not consent to the survey, and five consented but only answered the demographical data. There were two responses with missing data. Per the proposed plan, these data are part of the study but were treated with listwise deletion.

Data Screening Procedure

Data were downloaded from SurveyMonkey and saved into my personal cloud protected with a password. Initial data screening involved deleting responses that did not meet the inclusion criteria, then those who did not consent to the study, and responses that only answered the demographical questions. The demographical variables were then dummy coded, with the certification variable recoded to only two groups: none and certified. Reverse coding was performed on question 12 of the NWSQ and numbers four and six of the intent to stay scale.

Data Collection Discrepancies from Presented Plan

I initially proposed an 8-week data collection plan. After 8 weeks, I had received 86 responses and only 49 consented. Five of the responses had to be discarded because the responses were only on the demographic items and none of the rest of the variables. The total sample size after the initial data collection plan was n=44. Seeing the possibility of additional communication with multiple AORN/nursing Facebook pages or groups, data collection was extended for 2 more weeks. AORN was not involved at this

time and the focus was recruiting more people through social media and attending virtual chapter meetings. Prior to the data collection extension, I had received positive responses from two AORN Chapter Facebook pages who posted my survey link posted for their page/group members. After extending my recruitment timeline, I received positive responses from three additional chapters. Also, prior to the data collection extension, I was able to recruit through a virtual meeting set up by the local AORN chapter. Since the local AORN Chapter meet only once a month, I was able to get another invitation to recruit respondents during the 2-week data collection extension. I was able to get a total of 105 respondents after 10 weeks and after initial data screening, was able to reach the needed respondents for this study (N=55).

Descriptive and Demographic Sample Characteristics

Demographic questions were initially presented on the survey and also served as variables for the first RQ. There were five age groups in this study. Most of the sample (62%) were in the 31-50 age group, were female (78%) and 75% had a bachelor's degree or higher. There was a wealth of perioperative experience among the sample as 65.5% have a combined of more than 6 years or more of perioperative experience. Lack of qualified and experienced perioperative nurses is one of the top five reasons of perioperative nursing shortage (Bacon & Stewart, 2018). Over one-half of the participants (55%) were not certified. Certification is not a job requirement but may be a reason for increased compensation and promotion (Bacon & Stewart, 2018). Nineteen states were represented in this sample, and almost half of the participants were from California at 42%. Table 1 shows the descriptive and demographic sample characteristics.

Table 1

Descriptive and Demographic Sample Characteristics

Demographic	Characteristics	*f*	Percent of Sample *(N=55)*
Age	21-30 years old	7	12.7
	31-40 years old	17	30.9
	41-50 years old	17	30.9
	51-60 years old	7	12.7
	61+ years old	7	12.7
Gender	Female	43	78.2
	Male	12	21.8
Education	Diploma	4	7.3
	Associate Degree	10	18.2
	BS/BSN	35	63.6
	MS/MSN/MPH	6	10.9
Perioperative Experience	1-5 years	19	34.5
	6-10 years	10	18.2
	11-15 years	4	7.3
	16-20 years	5	9.1
	21-25 years	7	12.7
	26-30 years	3	5.5
	30 years+	7	12.7
Nursing Certification	None	30	54.5
	Certified Perioperative Nurse (CNOR)	20	36.4
	Others/RN-BC	1	1.8
State	Arkansas	4	7.3
	California	23	41.8
	Georgia	1	1.8
	Idaho	1	1.8
	Illinois	2	3.6
	Indiana	1	1.8
	Iowa	1	1.8
	Michigan	1	1.8
	Nebraska	1	1.8
	Nevada	1	1.8
	New York	3	5.5
	Ohio	3	5.5
	Pennsylvania	2	3.6
	Rhode Island	1	1.8
	South Carolina	2	3.6
	Tennessee	1	1.8
	Texas	3	5.5
	Virginia	2	3.6
	West Virginia	1	1.8

Proportionality of the Sample to the Population

There is currently no database to show how many perioperative nurses there are in the United States. AORN's website maintains that there are 42,000 members but not all of these members work in the OR. However, AORN conducts an annual salary and compensation survey, and in 2018, had 79,336 potential respondents and including 38,363 AORN members (Bacon & Stewart, 2018). The sample for this study was compared to the proportionality of the sample size of the 2018 AORN salary and compensation survey.

Majority of the sample from the AORN survey are within the age range of 30-60 years old at 76% (Bacon & Stewart, 2018), which is comparatively also the majority age group to participate in this survey at 61.8%. For gender, male nurses were well represented on this survey, comprising 21.8% of the sample, compared to 11% on the AORN survey (Bacon & Stewart, 2018). On perioperative experience, about a third and majority of the sample were from nurses with 5 years and less perioperative experience at 36.4% and is comparable to the respondents of the AORN survey at 30.8% of (Bacon & Stewart, 2018). There were 63.6% nurses in this survey that hold a bachelor's degree in Nursing, compared to 58.2% in the AORN survey. A trend in the AORN survey presented 15.6% of nurses with master's degree working as staff nurses. This trend is similarly observed on 10.9% of staff nurses in this sample with a master's degree but were not in any leadership position. Typically, a nurse's educational level is commensurate to their job title (Bacon & Stewart, 2018). Lastly, on nursing certification, more than half of the sample at 54.5% did not have any nursing certification. This lack

of certification differed greatly from the AORN survey wherein majority of the respondents at 60% have nursing certification, 48% of which are for CNOR. This may be because majority of nurse managers or perioperative directors hold nursing certifications compared to staff nurses (Bacon & Stewart, 2018).

Results

Descriptive Statistics and Data Screening

Fifty-five perioperative nurses participated in this study with a median age group of 41-50 years old and 6-10 years of perioperative experience. Sixty three percent of respondents held a bachelor's degree, majority were female (78%), and about half did not hold any nursing certification (55%). Structural empowerment sample scores are normally distributed with a skewness of .07 (*SE*=.33) and kurtosis of -.39 (*SE*=.64). Overall, the sample showed moderate level of empowerment. Empowerment scores are highest in the access to opportunity (*M*=3.95) and lowest in organizational relationships subscale (*M*=3.05). Job satisfaction scores were negatively skewed and platykurtic with a skewness of -.51 (*SE*=.33) and kurtosis of -.64 (*SE*=.63). Job satisfaction scores for this sample is above average and scored highest in the intrinsic subscale (*M*=3.84). The sample's intent to stay scores are also negatively skewed and platykurtic with a skewness of -.36 (*SE*=.33) and kurtosis of -.65 (*SE*=.64). As a whole, the sample's intent to stay is also above average. The means, standard deviations, and ranges for the CWEQ-II, NWSQ, and intent to stay scale and corresponding subscales are displayed in Table 2.

Table 2

Descriptive Statistics of Structural Empowerment and Job Satisfaction

Instrument	*N*	Mean	*SD*	Range
Total Empowerment (CWEQ-II)	54	19.23	4.40	11-29
Empowerment Subscales				
Access to Opportunity	55	3.95	.79	2-5
Access to Information	55	3.24	1.03	1-5
Access to Support	55	3.24	.98	1-5
Access to Resources	54	3.12	.86	1-5
JAS (Formal Power)	54	3.12	.86	1-5
ORS (Informal Power)	55	3.05	.91	2-5
Global Empowerment	55	3.38	1.15	1-5
Total Job Satisfaction (NWSQ)	55	3.74	.71	2-5
Job Satisfaction Subscales				
Intrinsic	55	3.84	.94	1-5
Extrinsic	55	3.53	.68	2-5
Relational	55	3.74	.71	2-5
Intent to Stay Scale	54	4.09	1.14	2-6

Measurement of Internal Reliability

All scale items were reviewed to evaluate the need for recoding for reverse questions. The CWEQ-II did not need to be recoded. The NWSQ had one and the intent

to stay scale had two items that needed to be recoded due to the reverse nature of the questionnaire statements. Recoding for reverse items was in alignment with statistical data analysis norms. The internal reliability for the three instruments used were calculated using Cronbach's alpha. Table 3 shows the summary of the internal reliability measurement of the survey instruments. The survey had an overall Cronbach's alpha of α=0.96.

Empowerment

The variable of Empowerment was measured using the 21-Likert item CWEQ-II scale. Nineteen of the items consisted of six empowerment subscales of opportunity, access to information, support, access to resources, formal power, and informal power. The last two items are validation index. The Cronbach's alpha of the CWEQ-II total score in this survey was α=0.94 which is consistent with previous reported reliability from multiple studies ranging from 0.82-0.93 (Arslan Yürümezoğlu & Kocaman, 2019; Eriksson & Engström, 2018; Khan et al., 2018; Lashinger et al., 2001). The reliability of the six subscales of empowerment in this study was also tested: opportunity (0.75), information (0.91), support (0.88), resources (0.81), JAS to measure formal power (0.83), and ORS to measure informal power (0.80).

Job Satisfaction

The variable Job Satisfaction was tested using the NWSQ, revealed an overall Cronbach's alpha α=0.93, and on the following domains: intrinsic (0.93), extrinsic (0.76), and relational (0.89). The NWSQ total score reliability in this study performed better than published works such was done by Borrott et al., 2016 with a Cronbach's alpha at 0.83.

Intent to Stay

Intent to stay variable was tested using the intent to stay scale and on this study, had a Cronbach's alpha α=0.91, similar to the study conducted by Kosmoski and Calkin (1986) who developed this scale.

Table 3

Internal Reliability Measurement of Survey Instruments

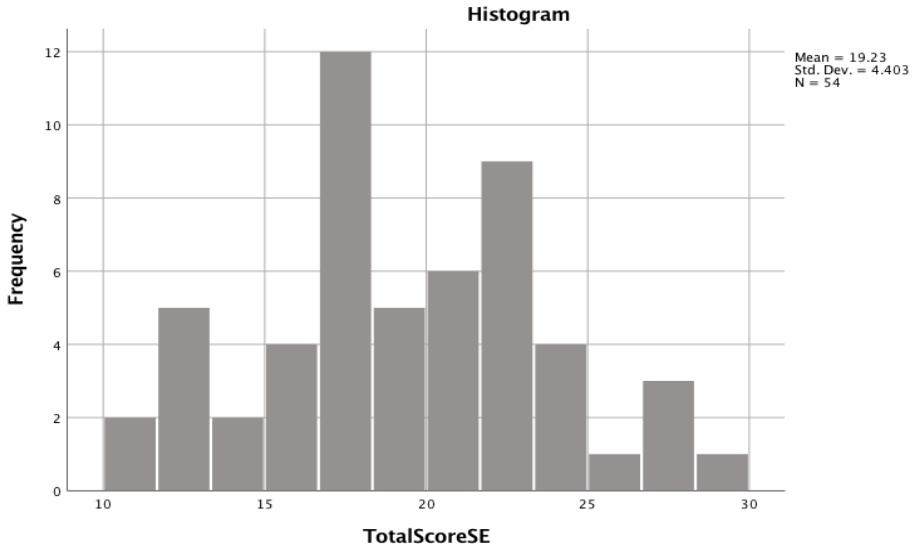
Variable	Scale	*N*	Items	*M*	*SD*	α
Empowerment	CWEQ-II	53	21	67.00	15.56	.94
Job Satisfaction	NWSQ	54	18	67.22	12.95	.93
Intent to Stay	Intent to Stay Scale	54	6	24.54	6.83	.91
Study Survey		51	45	158.98	31.78	.96

RQ 1: Demographic Factors Predicting Empowerment

Structural empowerment scores were predicted from the following demographic variables: age, gender, education, perioperative experience, and certification. The total *N* for this sample was 55. One case was dropped due to missing data on at least one variable and therefore, for this analysis, *N*=54. Preliminary data screening included examination of histogram of the dependent variable structural empowerment showing normal distribution (Figure 2) as well as a Shapiro-Wilks test of $W(54)=98$, $p=0.59$. Test to see if data met the assumption of collinearity indicated that multicollinearity was not a concern as all variables have VIF values of less than 10. The data also met the assumption of independence of observation with a Durbin Watson value of 2.13. The Cooks distance value ranges from .00 to .17 means meeting the assumption of undue influence.

Figure 2

Histogram, Dependent Variable: Structural Empowerment



Multiple regression was performed and the overall regression, including all five predictors was statistically significant, $F(14, 39)=2.28$, $p<.02$, $R^2=.45$, $R^2_{\text{Adjusted}}=.25$. Overall, the five demographic variables of age, gender, education, perioperative experience, and certification can predict structural empowerment. However, only 25% of the variance of structural empowerment scores are accounted by the regression. Table 4 contained the regression analysis for demographic variables and structural empowerment.

To assess the contribution of individual predictors and examine which demographic variables predict structural empowerment, the *F* value for the individual regression slopes were examined. Only two of the five predictors were significantly predictive of structural empowerment. These include age $F(3,39)=5.29$, $p<.02$, $R^2=.45$, $R^2_{\text{Adjusted}}=.25$) and certification $F(1,39)=6.60$ $p<.01$, $R^2=.45$, $R^2_{\text{Adjusted}}=.25$). Structural empowerment scores decrease 5.70 points on perioperative nurses aged 51-60 years old

and 3.74 for noncertified nurses and the decrease in these scores are statistically significant.

Table 4

Summary of Regression Analysis for Demographical Variables Predicting Structural Empowerment (N=54)

Variable	*B*	*SE B*	*β*	*p*
Perioperative Experience				
6-10 years	-2.18	1.77	-.19	.23
11-15 years	2.54	2.30	.15	.28
16-20 years	2.13	2.45	.14	.39
21-25 years	.23	2.24	.02	.92
26-30 years	-4.16	2.96	-.22	.17
Age				
21-30 years old	1.67	2.58	.13	.52
31-40 years old	.57	2.34	.06	.81
41-50 years old	1.41	2.71	.15	.61
51-60 years old	-5.70	2.62	-.44	.04*
Gender	-.30	1.29	-.03	.82
Educational Attainment				
Diploma	3.38	2.63	.20	.21
Associate Degree	2.86	2.16	.26	.19
BS/BSN	-.56	1.95	-.06	.78
Certification	-3.74	1.46	-.43	.01*

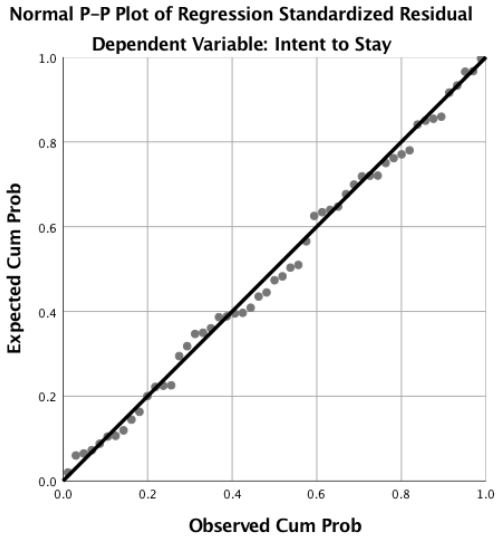
Note: $R^{2=}$.45; Adjusted R^2= .25; *p<0.05.

RQ 2: Empowerment and Job Satisfaction Predicting Intent to Stay

To assess whether empowerment and job satisfaction predicted the intent to stay in the organization for perioperative nurses, a multiple regression was performed using intent to stay as the dependent variable. Regression diagnostics was run together with the multiple regression analysis to test whether assumptions were violated. Assumptions are essential conditions for multiple regression to be unbiased and efficient (Allison 1999). The Durbin-Watson value of 2.23 met the assumption of independence of observation. Tests to see if the data met the assumption of collinearity indicated that multicollinearity was not a concern (structural empowerment, Tolerance = .38, VIF = 2.64; job satisfaction, Tolerance = .38, VIF = 2.64). The Cooks distance value ranges from .00 to .34 means meeting the assumption of undue influence. Preliminary data screening for job satisfaction and intent to stay scores revealed a slightly negatively skewed and platykurtic distribution. However, histogram indicated that data approximately normally distributed errors, as did the normal P-P plot of standardized residuals, which showed points near the regression line (Figure 3).

Figure 3

Normal P-P Plot of Regression, Dependent Variable: Intent to Stay



The overall regression model shows the overall fit and significance of the regression model, and that structural empowerment and job satisfaction statistically significantly predicted intent to stay $F(2,50)= 8.25$, $p<.001$, $R^2=.25$, $R^2_{\text{Adjusted}}=.22$. The adjusted R^2 of 0.22 means that as a set, the predictor variables of structural empowerment and job satisfaction account for 22% of the variance in a perioperative nurse's intent to stay in the organization. Table 5 presents the regression table summary to include the model's unstandardized and β coefficients. Unstandardized coefficients are usually expressed in their original unit of measurement while standardized coefficients or β are expressed in standard deviation units allowing comparison of variables (Hanneman et al., 2012). Only the job satisfaction variable coefficient has a $p<.001$ indicating that separate from structural empowerment, it statistically and significantly predicts intent to stay. A β of .43 indicated that a perioperative nurse's intent to stay increased by .43 standard

deviation for each increase of one standard deviation of job satisfaction while controlling for structural empowerment. In comparison, an increase of one standard deviation of structural empowerment was associated with an increase of .90 standard deviation in a perioperative nurse's intent to stay while controlling for job satisfaction, but this increase was not statistically significant.

Table 5

Summary of Regression Analysis for Structural Empowerment and Job Satisfaction Predicting Intent to Stay in the Organization (N=53)

	Intent to Stay	Structural Empowerment	Job Satisfaction	*B*	*SE B*	*β*	*p*
Structural Empowerment	.42			.02	.05	.90	.66
Job Satisfaction	.50	.79		.69	.32	.43	.04
M	4.09	19.25	3.74				
SD	1.15	4.44	.71				

Note. $R^{2=}$.25; Adjusted R^2= .22.

Additional Statistical Tests

Structural empowerment subscales are often reported in the literature. Structural empowerment is made of six subscales of access to opportunity, information, support, resources, JAS, and ORS. Overall, age is statistically significant predictors of access to information ($F(4,50)=2.72$, $p<.05$, $R^2=.18$, $R^2_{Adjusted}=.11$) and formal power ($F(4,49)=5.01$, $p<.05$, $R^2=.29$, $R^2_{Adjusted}=.23$) scores. Additionally with age, certification

is statistically significant predictors of access to information ($F(1,53)=4.04$, $p<.05$, $R^2=.07$, $R^2_{Adjusted}=.05$).

A Pearson product-moment correlation was conducted to determine the relationship between the subscales of both structural empowerment and job satisfaction. Only four of the six subscales had a statistically significant positive but weak to moderate correlation to intent to stay: access to opportunity ($r = .42$, $p = .01$), access to support ($r = .44$, $p = 01$), formal power ($r = .34$ $p = .01$), and informal power ($r = .40$, $p = .01$). On the other hand, all job satisfaction subscales of intrinsic ($r = .47$ $p = .00$), extrinsic ($r = .42$ $p = .01$), and relational ($r = .45$ $p = .01$) had a statistically significant moderately positive correlation to intent to stay. The results of this correlation analysis are in Table 6.

Table 6

Correlations between Structural Empowerment and Job Satisfaction Subscales with Intent to Stay

	Item	*N*	*M*	*SD*	1	2	3	4	5	6	7	8	9
Structural Empowerment													
1	Opportunity	55	3.95	.79	-								
2	Information	55	3.24	1.03	.49**								
3	Support	55	3.24	.98	.69**	.74**							
4	Resources	54	3.12	.86	.48**	.66**	.55**						
5	JAS	54	2.67	.97	.53**	.73**	.70**	.62**					
6	ORS	55	3.05	.91	.41**	.43**	.49**	.17	.55**				
Job Satisfaction													
7	Intrinsic	55	3.84	.94	.60**	.52**	.66**	.43**	.61**	.54**			
8	Extrinsic	55	3.53	.68	.57**	.64**	.69**	.63**	.72**	.57**	.73**		
9	Relational	55	4.02	.81	.46**	.36**	.49**	.36**	.49**	.46**	.68**	.69**	
10	Intent to Stay	54	4.09	1.14	.42**	.24	.44**	.20	.34*	.40**	.47**	.42**	.45**

Note. Listwise *N*= 53 **Correlation is significant at the 0.01 level (2-tailed), *Correlation is significant at the 0.05 level (2-tailed).

For RQ 1, a post hoc power analysis was conducted using the software package, G*Power with a sample size of *N*=54, 5 predictor variable, alpha error of α=.02, and effect size of f_2=0.82. The effect size was calculated using the sum of squares (SS) regression of 462.39 and residual variance of 565.30 resulting in a partial R^2 of 0.45 and

effect size of f_2=0.82. The post hoc analysis revealed that the statistical power of this study was .99 which is higher than the power that was initially proposed.

As for the RQ 2, a post hoc power analysis was also conducted using the software package, G*Power with a sample size of N=53, 2 predictor variable, alpha error of α=.001, and effect size of f_2=0.33. The effect size was calculated using the SS regression of 17.05 and residual variance of 51.65 resulting in a partial R^2 of 0.25 and effect size of f_2=0.33. The post hoc analysis revealed that the statistical power of this study was 0.75 which was lower than the power that was initially proposed.

Summary

In this chapter, I provided the data analysis for the two RQs of this study. The first question was: Which of the demographic factors (age, gender, education, perioperative experience, and certification) can reliably predict empowerment among perioperative nurses? The data showed that the only statistically significant predictors of empowerment are age and certification. Of the six subscales of structural empowerment, age is a statistically significant predictor of access to information and formal power. In addition, being certified is also a significant predictor of access to information.

The second RQ was: Do empowerment, and job satisfaction predict intent to stay in the organization for perioperative nurses? Data analysis showed that both structural empowerment and job satisfaction predicts intent to stay in the organization of perioperative nurses. However, as individual predictors, only job satisfaction significantly predicts intent to stay. Further correlation analysis showed that there is a significant correlation between four out of six structural empowerment subscales with

intent to stay: access to opportunity, access to support, JAS, and ORS. Last, job satisfaction subscales of intrinsic, extrinsic, and relational have a significant correlation with intent to stay. These findings present additional information of empowerment and job satisfaction predicting intent to stay in the organization. In Chapter 5, I will interpret further the findings of this study and compare it with existing literature.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purposes of this study were to determine the level of empowerment and job satisfaction among perioperative nurses and their relationship to intent to stay in the organization and if age, gender, education, perioperative experience, and national nursing certification predicted empowerment. Data analysis displayed key findings that age and being certified significantly predicted structural empowerment. For empowerment subscales, age and being certified significantly predicted access to opportunity. In addition, age also significantly predicted formal power. Another key finding was that structural empowerment and job satisfaction predicted intent to stay in the organization, though job satisfaction was a more significant predictor than structural empowerment. Structural empowerment subscales of opportunity, support, formal and informal power, and all job satisfaction subscales were significantly correlated to intent to stay. In this last chapter, interpretation of data analysis findings, limitation of the studies, recommendations, and implications are discussed.

Interpretation of the Findings

This study's findings added to the current literature in nursing retention, especially for nurses in specialized settings such as perioperative nursing. The findings yielded different results than the literature, mainly on structural empowerment and intent to stay. However, the study also contributed a rich overview of perioperative nursing, their quantitative view of empowerment and job satisfaction, and how this affects their decision to stay or leave their organization.

Perioperative Nurses

The sample of perioperative nurses in this study was moderately empowered, satisfied with their jobs, and intended to stay in their organization. Moderately empowered nurses are consistent with multiple studies in the literature to include Dan et al. (2018), Fitzpatrick et al. (2014), and Mansour & Mattukoyya (2018). Structural empowerment occurs in the presence of power and its four organizational structures. Out of the four organizational structures of access to opportunity, information, support, and resources, the respondents perceived greater access to opportunity. The perceived greater access to opportunity could be related to the fact that the majority of the participants had perioperative experience of more than 5 years, allowing more access to learning, growth, and being an expert on their surgical specialty. Similar studies lauded access to opportunity as the main driver of structural empowerment, leading to organizational effectiveness and job satisfaction (De Almeida et al., 2017; Eskandari et al., 2017; Orgambídez-Ramos & Borrego-Alés, 2014). Access to opportunity can manifest as education or training opportunities, professional growth, and autonomy (De Almeida et al., 2017; Orgambídez-Ramos & Borrego-Alés, 2014). In contrast, some empowerment studies presented access to resources as priority. Basic resources such as funding, staffing, and equipment availability are often pointed out as the most significant and visible component of empowerment perceived by staff (Meng et al., 2014; Orgambídez-Ramos et al., 2017; Thuss et al., 2016). Moreover, access to resources impacts the everyday operation in the workplace and if lacking, can cause stress and burnout (Thuss et al., 2016; Orgambídez-Ramos et al., 2017) and significantly decrease the quality of

patient care (Meng et al., 2014). However, Engstrom et al. (2015) showed that access to opportunity and resources is equally important because an organization needs resources to have the opportunity to create and implement career plans for their staff. Though scrutinizing empowerment structures separately is essential in the understanding of empowerment and how it is contextually perceived, these structures have to work synergistically to be effective.

The respondents also enjoyed and found their job meaningful having scored high on the intrinsic job satisfaction domain. The high intrinsic job satisfaction score suggested that the respondents viewed their job's value through a gratifying emotional response in providing quality patient care strengthening studies by de Oliveira et al. (2017) and Lu et al., (2019). Conversely, Dahinten et al. (2016) expressed that job satisfaction is highly influenced by extrinsic job factors, especially the organization, and not intrinsically by the individual. Organizational factors that epitomize structural empowerment such the availability of resources to the job, leadership support, and collegial relationships predict job satisfaction (Cicolini et al., 2014; Dahinten et al., 2016; De Almeida et al., 2017). Professional satisfaction is due to personal achievement from existing organizational opportunities for growth in the perioperative environment (De Almeida et al., 2017). However, the findings from my study enforce the notion that it is up to individual to perform the job accordingly not as an obligation but due to the satisfaction arising from the value, love, and autonomy of the job (de Oliveira et al., 2017; Hayes et al., 2015; Yang et al., 2014). Though the organization is instrumental in

driving professional satisfaction through the resources and opportunities it provides, an individual should still be motivated to do their part.

Demographic Variables and Empowerment

The demographic variables of age, gender, education, perioperative experience, and certification predicted structural empowerment. However, only age and certification were statistically significant. The significant relationship between age and structural empowerment supported the literature review conducted by Cicolini et al. (2014). In contrast to the study of Eskandari et al. (2017) identifying nurses aged 40 and above to have a higher level of structural empowerment, perioperative nurses 51-60 years old have a significant decrease in their structural empowerment level. This finding suggested that with increasing age, there is a decrease in opportunities for growth, innovative tasks, and the ability to acquire resources. Likewise, the significant relationship between nursing certification and structural empowerment expounded the literature review by Whitehead et al. (2019) and Fitzpatrick et al. (2014) that certified nurses have a higher perception of empowerment. Certification brings professional credibility and shows commitment to the perioperative profession hence, providing the opportunity for growth.

Structural Empowerment, Job Satisfaction, and Intent to Stay

Structural empowerment and job satisfaction predicted intent to stay. However, only job satisfaction predicted the decision for perioperative nurses to stay in the organization. The results of my study indicated that structural empowerment does not predict intent to stay which does not support the findings of Meng et al. (2014), Orgambídez-Ramos et al. (2017), Arslan Yürümezoğlu, and Kocaman (2019), and

Gholami et al. (2019). However, this study revealed that there was a strong relationship between four of the six dimensions of empowerment: access to opportunity, support, formal, and informal power with intent to stay. Structural empowerment is a job resource wherein nurses' access organizational resources and support to control and overcome stressors that affect job performance that overall adversely affects patient care (Kang, & Han, 2021). Participative management creating a bottom-up organizational structure is an effective strategy to create an empowered and positive work environment (Kol et al., 2017; Twigg & McCullough, 2014). Work environment facilitates professional practice through active participation, leadership support, and collegial relationships contributes not only to job satisfaction but the intent to stay in the organization (Al-Hamdan et al., 2016). Though this study revealed that structural empowerment does not predict a perioperative nurse's intent to stay in the organization, it is essential to note that this study showed that empowerment's dimension of access to opportunity, support, formal, and informal power have a relationship with intention to stay.

This study supported numerous studies of job satisfaction predicting a nurse's intent to stay. Additionally, intrinsic, extrinsic, and relational job satisfaction subscales have a strong correlation with intent to stay. Job satisfaction is a primary factor for nursing retention and attrition (Gellasch, 2015; Liu et al., 2015; Lu et al., 2019; Wei et al., 2018). The intrinsic dimension of job satisfaction described as how much enjoyable an individual's job is, and its resulting extrinsic rewards (Dahinten et al., 2016; Kosmoski & Calkin, 1986; Yang et al., 2014) is a predictor of intent to stay in the organization or staff retention (Ke & Hung, 2017; Meng et al., 2014). My findings also corroborate the

importance of recognizing the value of a nurse and as a person in retaining perioperative nurses (Lögde et al., 2018). Valued individuals become motivated to align their practice with organizational goals, giving them a work environment that is conducive for them to grow, thrive, and stay (Meng et al., 2014). The combination of having a positive work environment and finding the job enjoyable contributes to an increased sense of job satisfaction.

Kanter's Theory of Structural Empowerment

The unique contribution of this study is on expanding the literature on the structures of empowerment. In this study, age significantly predicted access to information and formal power. This study strengthens that of Sørensen et al. (2014) that older nurses predicted attractive work through the shared focus in the positive aspects of work engagement. Furthermore, clinical experience ensures a strong nursing identity, and for perioperative nurses, a strong clinical, social, and technical competence of the surgical event (Sørensen et al., 2014). Having the technical knowledge and expertise is a prerequisite to becoming a competent and skillful OR nurse. Concurrent to the study by Brown et al. (2017), a strong nursing orientation or residency and education program with a multidimensional learning approach can engage and empower perioperative nurses. As for formal power, this empowerment structure is endowed by the organization's position or job characteristics and is prominent on nurses who have longer work history (Eskandari et al., 2017). Scrubbing and circulating in surgery takes years of perioperative training, and with that experience comes age. Senior nurses are expected to be working competently as an effective room manager and who can keep up with the

surgeon's pace (Pupkiewicz et al., 2015). As such, formal power is attainable for senior nurses as most are preceptors, educators, or specialty coordinators (Pupkiewicz et al., 2015). This study also validated that of Brown et al. (2017) that a strong support system of senior nurses and leaders is critical in establishing a positive work environment with a strong culture of learning for the provision of safe patient care and importantly, retention of novice nurses.

This study also showed that certification predicted access to information. This is similar to the study by Fitzpatrick et al. (2014), which revealed that nursing certification is empowering as it provided more access to information and, therefore, power in their organization. Garrison et al. (2018) and Van Wicklin et al. (2020) detailed that the perceived value of certification not only includes the feelings of personal accomplishment and satisfaction, but more importantly, validates specialized knowledge. Certification means hours of preparation of studying for the certification examination, shaping an already competent nurse's knowledge and critical thinking skills. For instance, to achieve the CNOR credential, a perioperative nurse must have a minimum of 2 years of perioperative experience, with 1, 200 hours of that in the intraoperative setting just to qualify and take the CNOR examination (Competence and Credentialing Institute CCI, 2019). To recertify the CNOR credential, it may involve 125 continuing education hours or points accumulated from professional activity such as academic study, publishing, or serving in a professional nursing board or committee (CCI, 2019). The professional activities of a certified nurse make them accessible to information, and in turn,

demonstrated professionalism, a deeper understanding of the profession, and a connection to a strong network of perioperative professionals.

Limitations of the Study

Research Design

As a correlational research design, there is no variance or development in the population characteristics and is a limitation. Conducting a survey is a limitation as it can involve the misinterpretation of a survey item and incur the probability of a low response rate. The sample size was 55. However, due to missing data on specific variables, regression analysis of variables had only a sample size within the range of 53-55 participants. Due to missing data, the power level of the data analysis was lower than proposed. Even though the number of participants was met, any information with missing data on a specific variable was not included. For this study, the real power was 0.75 instead of the 0.8 proposed. Survey study findings are not precise measurements; therefore, this study's results are not generalizable to the whole population of OR nurses.

This study also has sampling bias due to the use of convenience sampling to recruit participants. Some participants were from the professional organization AORN, whose membership included OR nurses with voluntary membership. It is possible that the participants were motivated and committed to their career and profession compared to those who do not belong to the organization and, therefore, not a true representative of the target population. There is an inclusion criterion specified for participants to mitigate this bias, and recruitment was also made available to AORN nonmembers through online platforms and face-to-face meetings.

Instrumentation

Using self-reported survey questionnaires is a limitation due to common method variance causing an inflation of observed correlation (Spector, 2006) and an error of socially desirable responses (Zerbe & Paulhus, 1987). In addition, the length of the survey was a deterrent for participants wanting to finish the survey. There were 49 questions on this survey, plus five initial screening and six demographic questions. Five participants consented to the survey but dropped out after the demographic questions. The average survey completion time is eight minutes. To mitigate this limitation, the survey was anonymous, and the participant can easily opt-out of the survey at any time.

I also had developed my view of empowerment, and therefore, this study is vulnerable to research bias. To mitigate this bias, reliable and validated instruments to measure empowerment, job satisfaction, and intent to stay were used. The instrumentation's internal consistency was validated using Cronbach's alpha and are found to be consistently reliable. The Cronbach's alpha for the overall survey is α=0.96, and individually, the CWEQ-II is α=0.93, NWSQ at α=0.93, and intent to stay scale at α=0.91.

Recommendations for Further Research

The literature contains studies that show structural empowerment as a strong predictor of job satisfaction. Results of my study showed that structural empowerment was not a statistically significant predictor of intent to stay. Studying the moderating effects of structural empowerment with job satisfaction and intent to stay may explain these variables' relationship in a different lens. This study should be replicated by

increasing the sample size to address the sample's representativeness and enhance statistical power. To increase the study's generalizability, purposive sampling, such as quota sampling, especially on demographical predictors or the use of multi-site sampling, can be conducted instead of convenience sampling. Purposive sampling can ensure sufficient replicates among groups within the population, and heterogenous sampling can increase study findings' generalizability (Polit & Beck, 2010). Since nursing retention needs evidence worth repeating, replication of this study enhances knowledge through confirmation. Replication studies can significantly impact nursing research and evidence-based practice because they can result in either systematic and confirmatory evidence or restrictions (Polit & Beck, 2010). Further research can be conducted to compare the difference between demographic groups, especially in age and clinical experience, which may provide a better understanding of what contributes to the perception of structural empowerment. In addition, a longitudinal design may give a better grasp on the strength of perception of structural empowerment and even how it is attained. Lastly, a qualitative design that can elaborate the meaning of empowerment in the workplace on how it is perceived will give a more profound sense of what makes an empowered work environment and how it affects retention.

Implications

The issue of the perioperative nursing shortage is current, dynamic, and challenging. Furthermore, this issue's impact is felt throughout the healthcare system to include the patients receiving care, patient care team, and organization. Studies in nursing retention are indispensable in understanding its facets, and ultimately, developing

retention strategies instrumental in driving positive social change. Organizations have the monumental task of providing a safe and positive work environment for their nurses. It is necessary for organizations to provide an environment where nurses have the information and resources they need to do their job well and a place to continuously learn and professionally grow (Kang, & Han, 2021). Nursing leaders are instrumental in connecting with their nurses for them to express ideas, participate in decision making and interdisciplinary teamwork (Kang, & Han, 2021; Van Bogaert et al., 2014). As nurses excel in skill and competence, they not only realize the goals of the organization, rather, their personal aspiration (De Almedida et al., 2017). If all of these factors exist in their current environment, nurses are allowed to thrive, grow in their profession, and will be able to take care of their patients expertly. Nursing leaders are also responsible for providing an empowering work culture that supports professional governance and obligation, encourages accountability, and allows nurses take social responsibility for their roles, and in turn, transform practice (Clavelle et al., 2016; Kretzschmer et al., 2017). A work environment that engages nurses in change activities to transform practice is the path to positive social change as it ultimately affects the quality of perioperative nursing care provided to patients.

Job satisfaction is also an important predictor of a perioperative nurse intent to stay in the organization. Feelings of personal accomplishment and perceived rewards is crucial in determining a sense of empowerment and competence and is related to increase team collaboration and improved retention (Ciurzynski & Serwetnyk, 2015). For nurse leaders, it is important to understand that formally recognizing and utilizing expert

knowledge, experience, and competence contributes to a nurse's work satisfaction (Sveinsdóttir & Blöndal, 2014). Nursing leaders may have less influence on a nurse's intrinsic motivation to work but can lead their staff to recognize areas and practice where they can be autonomous and impactful (Dahinten et al., 2014). Involving staff in the decision-making process to come out with creative solutions, encourage sharing of ideas, and providing information are some participative management strategies that can be used (Dahinten et al., 2014). When nurses participate in the organization and exercise professional collegiality, this fosters autonomy and makes them feel that they are making a difference (Arslan Yürümezoğlu & Kocaman, 2019; Dahinten et al., 2014). To be recognized as a competent and active member of the healthcare team can drive a nurse to stay engaged with the work.

Conclusion

This study investigated whether structural empowerment and job satisfaction predicted a perioperative nurse's intent to stay in the organization. Despite several limitations involving the research design, the length of the survey tool, and the low power, the study added information to the literature about the level of empowerment and job satisfaction among perioperative nurses and their relationship to intent to stay in the organization and if age, gender, education, perioperative experience, and national nursing certification predicted empowerment. Though this study did not support previous studies of structural empowerment's affecting perioperative nurses' intent to stay, the wealth of information on what predicts structural empowerment in the form of age and certification is significant. This study also added the intrinsic, extrinsic, and relational aspects of job

satisfaction and how this correlated to the decision to stay in the organization. A positive and empowered environment is a structure conducive for workplace satisfaction and for perioperative nurses to experience job satisfaction, hence contributing to their intention to stay within their organization.

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Appendix A: Screening Questions

For a participant's data to be included in the study, the following screening questions data must be satisfied:

1) Are you a Registered or Licensed-Vocational Nurse within the United States and its territories?
2) Do you scrub or circulate for surgical procedures for more than 20 hours/week?
3) Have you worked in the Operating Room during the last 12 months?
4) Do you work as an OR nurse within the United States and its territories?
5) Do you work exclusively as a staff nurse and do not hold any leadership, management or advance practice role position (for instance, Nurse/Assistant Manager, Educator, Clinical Nurse Specialist, Perioperative Director; Registered Nurse First Assist (RNFA), Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Physician's Assistant (PA))?

Appendix B: Guidelines for use of AORN's Membership Database

AORN

Guidelines for use of AORN's Membership Database

Purpose: AORN supports the conduct of nursing research. AORN does allow access to the membership database for identifying potential subjects for research studies, evidence based practice projects or other scholarly endeavors. Approval is granted by the AORN's Nursing Research Committee provided the following criteria are met:

Criteria for requests:

1. Cover letter
2. Contact information of requestor
3. Summary of study (abstract)
4. Discuss the significance of study to perioperative nurses and or perioperative nursing practice and how the study will generate new knowledge for nursing education, nursing practice, and research and or health/public policy.
5. Literature review
6. Methods
    a. Appropriate to generate valid and reliable, unbiased results
    b. Justification for the sample size (e.g. power analysis)
    c. Research design
    d. Data collection methods
    e. Copy of all instruments
    f. Copy of all written communication inviting potential subjects
7. Data management methods
8. Data analysis
9. Limitations
10. Dissemination plan
11. Ethical considerations
    a. Is the content appropriate for perioperative nurses?
    b. Consider if members would be offended by the content of the survey
    c. Documentation of IRB approval
        i. This protects human subjects
        ii. The IRB must be from a university or facility. If the applicant does not have access to an IRB in his/her facility, an IRB service (e.g. Western IRB) may be used.
        iii. AORN does not require a national IRB for survey studies in which members are subjects.
12. Copy of requestor's CV

13. Faculty contact information and letter of support (if applicant is a student). Letter must state that the faculty member has reviewed the final application and believes that the methodology is sound.
14. Letter of support from facility if applicable

Additional Information:

All requests must be submitted to Dr. Lisa Spruce, Director of Evidence Based Perioperative Practice at AORN: lspruce@aorn.org
Requests will not be considered until all documents have been submitted. Documents are due the first of the month. Completed documents will be reviewed by AORN's Nursing Research Committee at the next scheduled monthly meeting. Decisions will be communicated to the requestor by Dr. Spruce in 4-6 weeks of submission.

Appeals to the decision of the Research Committee will be considered by contacting Dr. Spruce.

Appendix C: Demographic Data

1） How long have you worked in the operating room?

_____ 1-5 years ____ 6-10 years _____ 11-15 years ____ 16-20 years

____ 21-25 years ____ 26-30 years ____ 30 years+

2） Which State/United States territory do you currently work?

____ Indicate State _____ US Territory _____ N/A. I work overseas.

3） What is your current age?

____ 20 years old and below ____ 21-30 ____ 31-40

____ 41-50 ____ 51-60 ____ 61+

4） To which gender identity do you most identify?

____ Female ____ Male ____ Not listed

____ Prefers not to answer

5） What is your professional degree?

____ Diploma ____ BS/BSN ____ MSN

____ PhD/DNP ____ Other

6） What national nursing certifications do you hold?

____ Certified Surgical Services Manager (CSSM)

____ Certified Ambulatory Surgery Nurse (CNAMB)

____ Certified Perioperative Nurse (CNOR)

___ Registered Nurse Board Certified (RN-BC) (Specify)

___ Others (Specify)

Appendix D: Details and Permissions for Use for CWEQ-II

PsycTESTS®

Conditions of Work Effectiveness Questionnaire-II

PsycTESTS Citation:
Laschinger, H. K. S., Finegan, J. E., Wilk, P., & Shamian, J. (2000). Conditions of Work Effectiveness Questionnaire-II [Database record]. Retrieved from PsycTESTS. doi: https://dx.doi.org/10.1037/t31393-000

Instrument Type: Inventory/Questionnaire

Test Format:
Each of the 6 3-item uses a 5-point response ranging from 1 = None to 5 = A Lot. the 2-item validation measure of global empowerment uses a 5-point range from 1 = Strongly Disagree to 5 = Strongly Agree. An overall empowerment score can be calculated by summing the first four or all six subscales.

Source:
Supplied by author.

Original Publication:
Laschinger, Heather K. Spence, Finegan, Joan, Shamian, Judith, & Wilk, Piotr. (2001). Impact of structural and psychological empowerment on job strain in nursing work settings: Expanding Kanter's model. The Journal of Nursing Administration, Vol 31(5), 260-272. doi: https://dx.doi.org/10.1097/00005110-200105000-00006

Appendix E: CWEQ-II

CONDITIONS FOR WORK EFFECTIVENESS QUESTIONNAIRE-II

How much of each kind of opportunity do you have in your present job?

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

How much access to information do you have in your present job?

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

How much access to support do you have in your present job?

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

How much access to resources do you have in your present job?

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

In my work setting/job:
(JAS)

1 = None	2	3 = Some	4	5 = A Lot
1. the rewards for innovation on the job are			1	2 3 4 5
2. the amount of flexibility in my job is			1	2 3 4 5
3. the amount of visibility of my work-related activities within the institution is			1	2 3 4 5

How much opportunity do you have for these activities in your present job:
(ORS)

1 = None	2	3 = Some	4	5 = A Lot

1.	Collaborating on patient care with physicians	1	2	3	4	5
2.	Being sought out by peers for help with problems	1	2	3	4	5
3.	Being sought out by managers for help with problems	1	2	3	4	5
4.	Seeking out ideas from professionals other than physicians, e.g., physiotherapists, occupational therapists, dieticians	1	2	3	4	5

GLOBAL EMPOWERMENT

How much of each kind of opportunity do you have in your present job?

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

Appendix F: Details and Permissions for Use for NWSQ

Development and validation of the Nursing Workplace Satisfaction Questionnaire (NWSQ)

Author:
Greg Fairbrother,, Aaron Jones, et al
Publication:
Contemporary Nurse
Publisher:
Taylor & Francis
Date:
Jan 1, 2010

Thesis/Dissertation Reuse Request

Taylor & Francis is pleased to offer reuses of its content for a thesis or dissertation free of charge contingent on resubmission of permission request if work is published.

Appendix G: NWSQ

Nursing Workplace Satisfaction Questionnaire (NWSQ)

Items

Intrinsic (How much you enjoy your job)

1. My job gives me a lot of satisfaction.
2. My job is very meaningful for me.
3. I am enthusiastic about my work.
4. My work gives me the opportunity to show my worth.
5. In the last year, my work has grown more interesting.
6. It is worthwhile to make an effort in my job.

Extrinsic (Doing your job)

7. I have enough time to deliver good care to patients.
8. I have enough opportunity to discuss patient problems with my colleagues.
9. I have enough support from colleagues.
10. I would function better if it was less busy on the ward/unit.
11. I feel able to learn on the job.
12. I feel isolated from my colleagues at work.
13. I feel clinically confident.
14. I like the way my ward is run. Relational (The people you work with)
15. It's possible for me to make good friends among my colleagues.
16. I like my colleagues.
17. I feel that I belong to a team.
18. I feel that my colleagues like me.

Note . Item 10 was removed from domain scoring as accounted for by Item 7 (both items capturing workload related feelings). Items 13 and 14 were not included in the internal consistency analysis as they were considered as "fundamental" stand-alone respondent descriptors and were not theorized or utilized as contributors to the extrinsic domain score.

Appendix H: Details and Permissions for Intent to Stay Scale

BMDS Behavioral **Measurement** Database Services

Health and Psychosocial Instruments (HaPI)

Date: November 20, 2019

To: Leilani Hall

From: Evelyn Perloff, PhD

Enclosed is the:

Intent to Stay (AN 1481)
K. A. Kosmoski, J. L. Price, and C. W. Mueller

As I have indicated authors like to receive feedback on your study. All that is asked is that you provide a brief summary of your findings upon completion of your study/project. In addition, we encourage you to send a full report which we will consider for inclusion in Health and Psychosocial Instruments (HaPI) and which you may list on your vita/resume.

You have the author's permission to use the above instrument(s).

Please note that the instruments are for a single study only. It is, of course, necessary to provide the appropriate title and author credit in reproduced material and in your report.

PO Box 110287 Pittsburgh, PA 15232-0787
Phone: 412-687-6850 Fax: 412-687-5213 E-mail: bmdshapi@aol.com

Appendix I: Intent to Stay Scale

Intent To Stay

K. A. Kosmoski, J. L. Price, and C. W. Mueller

1. How long do you plan to stay in this unit?
   _____ 0-6 months
   _____ more than 6 months but less than 1year
   _____ 1 year or more but less than 2 years
   _____ 2 years or more but less than 5 years
   _____ 5 years or more
   _____ indefinitely
   _____ plan to retire here

2. How long do you plan to stay in this hospital?
   _____ 0-6 months
   _____ more than 6 months but less than 1year
   _____ 1 year or more but less than 2 years
   _____ 2 years or more but less than 5 years
   _____ 5 years or more
   _____ indefinitely
   _____ plan to retire here

The final four questions deal with your strength of intention to stay or leave your present unit position and/or the hospital. Please put an "X" in the appropriate space. Select only one response per question.

3. Which of the following statements most clearly reflects your feelings about your future in this unit?
   _____ Definitely will not leave
   _____ Probably will not leave
   _____ Uncertain
   _____ Probably will leave
   _____ Definitely will leave

4. Do you expect to leave this unit in the near future?
   _____ Will definitely leave in the near future
   _____ The chances are quite good that I will leave
   _____ The situation is unsure

_____ The chances are very slight that I will leave
_____ Definitely will not leave in the near future

5. Which of the following statements most clearly reflects your feelings about your future in this hospital?
   _____ Definitely will not leave
   _____ Probably will not leave
   _____ Uncertain
   _____ Probably will leave
   _____ Definitely will leave

6. Do you expect to leave this hospital in the near future?
   _____ Will definitely leave in the near future
   _____ The chances are quite good that I will leave
   _____ The situation is unsure
   _____ The chances are very slight that I will leave
   _____ Definitely will not leave in the near future

Appendix J: Permissions for Kanter's Men and Women of the Corporation

PG **permissions Generic** 12/16/19
To: Leilani Hall >

RE: Permission Request

Dear Leilani,

Thank you for your request regarding the use of **Men and Women of the Corporation**
Hachette Book Group has no objection to your using this material in the manner you have described (as long as you will not be reciting the entire book) in your permissions request dated **December 8th, 2019**.
Please be sure to credit the excerpts as follows:

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We appreciate your interest in our book. Please let us know if you have any further questions.

Sincerely,
Laura

From: Leilani Hall <maleilani.hall@outlook.com>
Sent: Sunday, December 8, 2019 10:00 PM
To: Generic, permissions (US) <permissions.Generic@hbgusa.com>
Subject: Permission Request

Hello Sir/Ma'am,

Attached is a request to use the work of Dr. Rosabeth Kanter - Men and Women from the Corporation for my dissertations study.

Thank you so much!

Sincerely yours,

Leilani Hall