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Factors Affecting the Job Satisfaction of Registered Nurses Working in the United States

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Master of Business Administration, University of Phoenix, 2008

Bachelor of Science in Nursing, Gwynedd Mercy College, 1995

Doctoral Study Submitted in Partial Fulfillment

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Doctor of Business Administration

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Abstract

As the health care sector in the United States undergoes transformation, job dissatisfaction has become a problem that is confounded by the challenge that nurse executives encounter in understanding the aspirations of an increasingly diverse workforce. A quantitative survey was conducted online using a representative sample of registered nurses (RNs) nationwide. Approximately 127,000 RNs from across the nation received an invitation, and 272 RNs participated. Factorial ANOVAs were performed to answer the research questions of whether aspects of job satisfaction differ across the demographic factors of a diverse RN workforce. No differences exist in personal satisfaction or satisfaction with workload as a function of generational cohort (Baby Boomers, Generation X, and Generation Y), gender (female and male), or origin of training (United States or international). With Herzberg's motivation-hygiene theory as the theoretical framework, multiple linear regression analyses were conducted to examine the relative importance of job factors. Satisfaction with workload was a stronger predictor of global job satisfaction than personal satisfaction; this contradicts the motivation-hygiene theory. Work environment is a crucial factor in understanding global job satisfaction. This research has implications for social change by raising the nurse executives' understanding of factors that affect the job satisfaction of nurses and by doing so, may support patient advocacy, promote human gratification, and endorse economic gain.

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Dedication

I dedicate this achievement to my husband, Jeffrey, and my daughter, Madison. Jeffrey, your love, wisdom, strength, and serenity have inspired me in every facet of living. Without your commitment to this project, my commitment would have been fruitless. We have settled ashore together and accomplished so many ambitions. You are my partner, my confidant, and the love of my life. Now it's time for us to enjoy more! Madison, your tolerance for Mommy's homework has been remarkable. You have learned about the importance of family, you have learned about responsibility, commitment and having faith, and hopefully you will remember most, that all things in life are possible. You make me feel so proud, you are bright and cheerful and charming. You are my inspiration, and I love you very much. Now it's time for you to start first grade!

Acknowledgments

I am sincerely appreciative of my chairperson, Dr. Jennifer Scott, for her diligence in providing me with the guidance, encouragement, reassurance, and friendship necessary to endure this doctoral journey. I also want to acknowledge my second committee member, Dr. Jose Lopez, for advocating, inspiring, and influencing my path onward from 8437, Quantitative Decision-Making in Professional Practice. As well, Dr. John Caruso, Dr. Michael Ewald, Dr. Gene Fusch, Timothy McIndoo, Dr. Michael Milestone, Dr. Lawrence Ness, and Dr. Freda Turner, each of whom played an important role by imparting valuable insights to inform me on key components of this research study. I am thankful to Dr. Michael Traynor for his dedicated and ongoing commitment to discovering factors that affect the job satisfaction of nurses. Finally, beyond a doubt, my tenacious spirit is a result of the strength, courage, and love my mother and father have always shown me, and for that, I am eternally grateful. Likewise, to family and friends who have endured my pursuit. Cheers!

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Section 1: Foundation of the Study

The health care sector in the United States is undergoing a transformation. It has become apparent that significant challenges exist in achieving sustainability, both related to the quality and cost of care across the continuum (Institute of Medicine [IOM], 2011). The transformation of health care systems across the nation will require strong and effective leadership at the points of services (Porter-O'Grady & Malloch, 2009). Nurses must act as full partners with physicians and other health care professionals to improve health care systems in America (IOM, 2011). Being a full partner involves accountability for identifying inefficiencies and inadequacies, for developing and implementing plans for improvement, and for managing adjustments to attain national goals (IOM, 2011). If the nursing profession is to realize its full potential, nurse executives should consider issues that surround registered nurse (RN) job satisfaction, as these issues could hinder change management initiatives (Bordia, Restubog, Jimmieson, & Irmer, 2011). In this research study, I have examined the demographic factors of generational cohort, gender, and origin of training to determine if differences exist in aspects of RN job satisfaction. I have also analyzed the relative importance of job factors in order to determine the extent to which motivational theory is a useful framework for understanding RN job satisfaction. Evidence-based knowledge of factors that affect RN job satisfaction may provide the catalyst for 21st-century workforce solutions.

Background of the Problem

Managing a diverse workforce can be a challenge because nurse executives need to acknowledge the fundamental motivational drive of each employee (Kramer, 2010).

Capitalizing on the workforce differences enhances teamwork and supports sustainability (Kramer, 2010). In 2008, RNs comprised the largest health care occupation in the United States (U.S. Department of Labor, 2010). According to the U.S. Department of Health Resources and Services Administration (HRSA), the total estimated population of RNs in 2008 was 3,063,163 (2010, p. 3). Despite ongoing efforts to address the nursing shortage in the nation, the demand for nurses continues to exceed the supply (Robert Wood Johnson Foundation [RWJF], 2010). This demand is projected to escalate over the next decade as the nation's aging population increases and a significant proportion of nurses in the workforce approach retirement age (HRSA, 2010).

While the nursing shortage problem was curtailed by the economic state of the nation in 2009, employers and policy makers may have been tempted to divert their focus to other organizational priorities (Buerhaus, Auerbach, & Staiger, 2009). The temporary relief of the nursing shortage was driven by the recession in 2009 and consequently, the urgency of the problem was masked (Buerhaus et al., 2009, IOM, 2011). Organizational leaders should not have diverted their focus because significant progress is necessary to attain the goals of health care reform in the United States (Buerhaus et al., 2009). Organizations across the nation have collaborated to leverage resources and implement strategies to cope with the nursing shortage. At the same time, these organizations are seeking governmental assistance to educate and deploy a sustainable 21st-century nursing workforce (RWJF, 2010).

The forecasted nursing shortage is compounded by the issue of job dissatisfaction, which has become increasingly problematic (Hong Lu, Barriball, Zhang, & While, 2011;

Wieck, Dols, & Northam, 2009). That job dissatisfaction is a problem is evidenced by the high turnover rate of nurses and by millions of dollars spent annually hiring replacements (Castle, 2008; Jones, 2008; Kash, Naufal, Cortes, & Johnson, 2010; Maas, Specht, Buckwalter, Gittler, & Bechen, 2008; Wisotzkey, 2011). The adverse effects of turnover were evident in a sample of hospitals nationwide where the average RN turnover rate of 19.4% approximated an annual organizational cost of $5.9 million to $6.4 million (Jones, 2008, p. 12). Castle asserted that the turnover rate in long-term care facilities nationwide was higher, cited as 46% (2008, p. 616). In Texas, these facilities had higher than average turnover rates, cited as 126%, despite the fact that 71% of the sample perceived their salary to be competitive (Kash et al., 2010, p. 117). The social implication of a high nurse turnover rate is the care deficits that occur when facilities are understaffed (Maas et al., 2008). After examining hospital outcomes in nine countries and discovering that poor work environments were prevalent, Aiken et al. (2011) emphasized that nurse burnout and job dissatisfaction were problems associated with negative professional outcomes and negative clinical outcomes.

The job dissatisfaction problem is confounded by the challenge nurse executives encounter in understanding the aspirations of an increasingly diverse workforce. An increasingly diverse nursing workforce is universally strategic to providing culturally relevant care to an increasingly diverse population of citizens (Diamond, Wilson-Stronks, & Jacobs, 2010; IOM, 2011). Providing culturally relevant care fosters a therapeutic relationship between the patient and the nurse, which promotes a rapport where patients can contribute positively to their own care (IOM, 2011). According to the IOM (2011),

the nursing profession must strive to increase its appeal to younger generations, men, and diverse ethnic groups.

According to Wieck et al. (2009), for the first time in U.S. history, four distinct generations coexist within the nursing workforce. The four generations of RN colleagues are: (a) *Veterans*, born between 1922 and 1945; (b) *Baby Boomers*, born between 1946 and 1964; (c) *Generation X*, born between 1965 and 1980; and (d) *Generation Y*, born between 1981 and 2000 (Kramer, 2010; Lavoie-Tremblay, Leclerc, Marchionni, & Drevniok, 2010; Wieck et al., 2009). The values, beliefs, styles, and approaches of each generation are cited as sources of conflict in the workplace (Kramer, 2010). The two most common sources of conflict are perceived differences in work ethics and the use of technology (Kramer, 2010, p. 127). Wieck et al. (2009) emphasized the importance of resolving generational conflict. The most valuable benefit of employment for nurses was cited as a positive work environment, which was described as a cohesive work environment where colleagues shared the workload and pulled together as a team (Wieck et al., 2009, p. 6). In supporting generational diversity, nurse executives should consider that differences might exist in aspects of job satisfaction. With an understanding of those differences, generation specific workforce solutions could emerge.

In addition to generational diversity, nurse executives should consider *gender* diversity because the issues faced by male nurses may be different from those faced by female nurses. A growing number of male nurses have enlisted the nursing profession, while an increasing number of male nursing school graduates have entered the workforce (HRSA, 2010). Prior to 1990, only 4.1% of nurses who completed their basic RN

education were male, as compared with 9.6% after 1990 (HRSA, 2010, p. 13). In a study of male nurses in Taiwan, Hsiu-Yueh, Sheng-Hwang, Hsing-Yi, and Jiunn-Horng (2010) used multiple regression analyses to examine predictors of occupational burnout. Hsiu-Yueh et al. (2010, p. 1592) found that job stress was strongly correlated to occupational burnout and that job loading, organizational interaction, and role conflict accounted for 45.8% of all occupational burnout variance. Furthermore, Hsiu-Yueh et al. discovered that the turnover rate for a male nurse in Taiwan was twice that of a female nurse. The nursing profession has long been recognized as a female profession. Hsiu-Yueh et al. has identified role conflict as a factor accounting for occupational burnout of male nurses. Hence, it is important to consider factors that might affect RN job satisfaction among male nurses in the United States. Nurse executives may use the findings of this study to identify and implement workforce solutions, targeting reductions in gender role conflict.

The last element in the background of the problem is the diversity associated with the *internationally educated nurse* (IEN). Health care organizations in the United States are increasingly employing nurses who originate from foreign countries (HRSA, 2010). Although the literature reveals an increase in the number of foreign-born RNs employed in the United States (Buerhaus et al., 2009), how these nurses arrived, where they completed their basic nursing education, and what the intrinsic motivational needs are, is less understood (Pittman, Folsom, & Bass, 2010). An IEN received his or her basic nursing education overseas and later migrated from his or her country of origin to practice nursing (Adeniran et al., 2008). For the purpose of this research study, the term

IEN describes an international nurse who is actively licensed to practice as a RN in the United States, and who is currently employed as a RN in the United States.

In 2008, 5.6% of the total RN population nationwide received their basic nursing education overseas, an increase from 3.7% in 2004 (HRSA, 2010, p. 5). Pittman et al. (2010) conducted focus group discussions with IENs and discovered inadequate orientation programs and multiple types of breaches in labor law. Pittman et al. (2010) also found that IENs had received inadequate predeparture information about U.S. immigration processes, and their employee rights under U.S. law.

In exploring the stress and coping mechanisms of nurses working abroad, Setyowati, Sustanti, Yetti, Hirano, and Kawaguchi (2010) identified seven sociocultural job stressors: (a) language and communications barriers, (b) reward and salary issues, (c) working as an assistant nurse until passing the necessary examination, (d) loneliness, (e) unsuitable placement, (f) stress related to passing the national board examination, and (g) insufficient predeparture information regarding employee rights. By examining factors that affect job satisfaction, fundamental differences in IEN perceptions of the U.S. health care systems might emerge. Nurse executives may use the findings of this study to plan for appropriate IEN transition and thereby support sustainable workforce solutions.

Problem Statement

Despite collaborative efforts to identify strategies, leverage resources, and enact legislation (RWJF, 2010), the magnitude of the nursing shortage forecasted for 2025 is the largest the United States has encountered in 50 years (Buerhaus et al., 2009). The general business problem is that the forecasted nursing shortage problem may be

compounded by job dissatisfaction (Aiken et al., 2011; Jones, 2008; McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011). In U.S. hospitals nationwide, 22% to 24% of nurses reported job dissatisfaction (Aiken et al., 2011, p. 360; McHugh et al., 2011, p. 204). When the elements necessary to provide quality care are not available, or staffing is perceived as inadequate, nurses reported increased job dissatisfaction (Kalisch, Tschanen, & Lee, 2011). The specific business problem is insufficient, evidence-based knowledge as to whether aspects of RN job satisfaction differ among the factors of generational cohort, gender, and origin of training. With compelling organizational pressure to enhance workforce diversity (IOM, 2011), strategic to providing culturally relevant service, nurse executives might benefit from multivariate statistical analyses of aspects of job satisfaction, as reported by the 21st-century RN workforce employed in the United States.

Purpose Statement

The purpose of this quantitative research was to advance knowledge of factors that might affect RN job satisfaction including generational cohort, gender, and origin of training. I collected empirical data through participants' scores on the Measure of Job Satisfaction (MJS) survey instrument, and then conducted multivariate statistical analyses to examine the relationships between the independent variables of generational cohort, gender, and origin of training, and the dependent variables of personal satisfaction and satisfaction with workload. I used multiple linear regression analyses to examine the relative importance of job factors in order to determine the extent to which motivational theory is a useful framework for understanding RN job satisfaction.

I conducted the online survey research in the United States using a computer-generated sample of RNs selected from an electronic database retained by U.S. Data Corporation. Approximately 127,000 RNs from across the nation received a virtual invitation to participate via e-mail. Representative sampling provides the researcher an increased ability to generalize results to the target population (Cooper & Schindler, 2006; Creswell, 2009). Power analyses by G*Power (Faul, Erdfelder, Lang, & Buchner, 2007) indicated an a priori minimum sample size of $N = 158$. Nurse executives must discover how to keep their workforce satisfied because job dissatisfaction may undermine innovation and increase turnover in a profession already facing a forecasted shortage. I may promote social change by raising the nurse executives' understanding of factors that affect RN job satisfaction, and thereby strengthening patient advocacy through improved business practice.

Nature of the Study

This was a quantitative research study, reflecting a positivist approach, an approach that begins with a theory. A positivist researcher collects and analyzes data to support or refute the theory (Creswell, 2009). Applied researchers—such as administrators, marketing researchers, policy analysts, and criminologists—embrace positivist views (Neuman, 2003) and often use quantitative methods to obtain precise, rigorous, objective measures that can be carefully analyzed to test hypotheses (Creswell, 2009; Vogt, 2007). Positivists using multivariate statistical procedures have become increasingly popular as statistical software programs, such as SPSS, have streamlined the processes needed to conduct complex, multivariate analyses (Grice & Iwasaki, 2008).

The increase in quantitative, multivariate statistical procedures may also be attributed to researchers' beliefs that contemporary models of human behavior often consider multiple, interrelated variables that are conceptualized simultaneously (Grice & Iwasaki, 2008). Critics charge that researchers who subscribe to positivist views reduce the participant to a number, as they are concerned solely with abstract laws or formulas that are distantly relevant to the genuine opinions of actual people (Cooper & Schindler, 2006; Neuman, 2003).

I selected the online survey research design because of the practical advantages it offered in answering the research questions. The decreasing cost of computer hardware fosters increasing Internet use, consequently, large segments of society access the Internet to communicate daily (Wright, 2005). Thousands of groups and organizations have online discussion boards, which researchers can use to access member affiliated populations (Wright, 2005). As computer technology is increasingly integrated into society, the Internet sample may become more representative of the general population (Singh, Taneja, & Mangalaraj, 2009).

Other advantages to an online survey include the swift turnaround in data collection, which, in turn, fosters the swift analysis of participant survey scores (Cooper & Schindler, 2006; Neuman, 2003; Singh et al., 2009). By contrast, paper-based surveys require more resources to administer since postal mail must be processed and data must be manually entered into a software analysis program (Singh et al., 2009). Participant privacy, another important consideration, is infringed upon less with an online survey because the participant's physical address remains undisclosed (Singh et al., 2009).

Finally, when sensitive topics are examined, online participants are more likely to respond honestly (Hart, Brennan, Sym, & Larson, 2009; Neuman, 2003).

To mitigate the disadvantages to online survey research, predominantly cited as sampling difficulties (Singh et al., 2009), I invited a representative sample of RNs nationwide to participate in this research study. The prospective participants were selected from an electronic database of RNs in the United States. The electronic database was retained by U.S. Data Corporation, a leading provider of mailing lists, marketing data, and research data. According to U.S. Data Corporation, the electronic database was created from public records, licensing boards, and associations or organizations providing opt-in marketing lists. The limitations of the survey research sample are disclosed in Section 1 under Limitations.

Although quantitative and qualitative study designs have similar principles, quantitative researchers use objective participant data, whereas qualitative researchers commonly use face-to-face unstructured interviews, which are subjective and in-depth inquiries (Rubin & Babbie, 2009). The strengths that emerge from qualitative methods are often considered the weaknesses of quantitative methods (Cooper & Schindler, 2006). Qualitative researchers decipher, interpret, and decode phenomena that occur naturally in the social world (Cooper & Schindler, 2006). By interviewing and observing participants in their own environment, researchers can generate rich, qualitative data that are not accessible through other research methods (Green & Salkind, 2011). With valuable and abundant insight into a participant's personal meanings, qualitative researchers can often generate new theories at the conclusion of their study (Cooper & Schindler, 2006).

There are disadvantages to qualitative research methods, too. Researchers must be concerned about bias oversight when interviewing peer populations (Creswell, 2009). As a RN proposing to investigate a RN problem, this disadvantage was considered in the early phase of research design. Another disadvantage of qualitative research is expenditures. Although the sample size would be predictably smaller and perhaps offer the researcher an opportunity for faster turnaround of findings (Cooper & Schindler, 2006), qualitative research requires the allocation of multiple resources, considering means associated with time, travel, and process to interview participants (Neuman, 2003). Another challenge is the coding of qualitative responses, and although computer software is available to facilitate (Cooper & Schindler, 2006), the processes can be demanding and difficult (Neuman, 2003). Accurately coded qualitative data is the heart of qualitative research. Framing, coding, and interpreting qualitative data are founded on the experience of the researcher (Cooper & Schindler, 2006). Principally because of bias in data collection, and human error in interpretation, qualitative methods do not possess the unqualified endorsement of many senior managers (Cooper & Schindler, 2006). The qualitative approach was not chosen for this study because the method is not best suited to answer the research questions.

According to Creswell (2009), mixed methods approaches have evolved since the first comprehensive overview of the research strategy was published in 2003. Mixed methods approaches are perceived as legitimate and have become popular in the social and human sciences (Creswell, 2009). Mixed method approaches have gained attractiveness with research teams seeking to employ diverse methodological interests

and approaches (Creswell, 2009). The combination of quantitative and qualitative data can be especially beneficial to researchers seeking to triangulate results, a technique used to validate results by cross-examining data from two independent sources (Denzin, 2010). The mixed methods approach was not chosen for this study, as the method is not best suited to answer the research questions.

With a positivist worldview, I have examined factors that might affect RN job satisfaction. The factors considered were those in which I collected empirical data using the MJS survey instrument. I conducted multivariate statistical procedures to examine if the population means of the dependent variables, personal satisfaction and satisfaction with workload, differed across the demographic factors of the independent variables: generational cohort, gender, and origin of training. In addition, I conducted multiple linear regression analyses to examine the relative importance of job factors in order to determine the extent to which motivational theory is a useful framework for understanding RN job satisfaction. Evidence-based knowledge of factors that affect RN job satisfaction may provide the catalyst for 21st-century workforce solutions.

Research Questions

I developed the first two research questions in order to determine if differences exist on two reported aspects of RN job satisfaction, personal satisfaction and satisfaction with workload, as assessed by the MJS instrument and based on generational cohort, gender, or origin of training. I developed the third research question as a test of Herzberg's motivational theory, it relates to whether personal satisfaction or satisfaction with workload is more strongly correlated with global satisfaction.

1. To what extent, if any, do the personal satisfaction scores of RNs vary as a function of generational cohort, gender, or origin of training?
2. To what extent, if any, do the satisfaction with workload scores of RNs vary as a function of generational cohort, gender, or origin of training?
3. To what extent do personal satisfaction scores and satisfaction with workload scores correlate with global satisfaction scores?

Hypotheses

$H1_0$: There is no difference in personal satisfaction scores as a function of generational cohort (Baby Boomers, Generation X, and Generation Y).

$H1_a$: There is a difference in personal satisfaction scores as a function of generational cohort (Baby Boomers, Generation X, and Generation Y).

$H2_0$: There is no difference in satisfaction with workload scores as a function of generational cohort (Baby Boomers, Generation X, and Generation Y).

$H2_a$: There is a difference in satisfaction with workload scores as a function of generational cohort (Baby Boomers, Generation X, and Generation Y).

$H3_0$: There is no difference in personal satisfaction scores as a function of gender (female and male).

$H3_a$: There is a difference in personal satisfaction scores as a function of gender (female and male).

$H4_0$: There is no difference in satisfaction with workload scores as a function of gender (female and male).

$H4_a$: There is a difference in satisfaction with workload scores as a function of gender (female and male).

$H5_0$: There is no difference in personal satisfaction scores as a function of origin of training (United States or international).

$H5_a$: There is a difference in personal satisfaction scores as a function of origin of training (United States or international).

$H6_0$: There is no difference in satisfaction with workload scores as a function of origin of training (United States or international).

$H6_a$: There is a difference in satisfaction with workload scores as a function of origin of training (United States or international).

$H7_0$: Personal satisfaction scores do not correlate higher with global satisfaction scores than satisfaction with workload scores.

$H7_a$: Personal satisfaction scores correlate higher with global satisfaction scores than satisfaction with workload scores.

Theoretical Framework

This study is based on Herzberg's motivation-hygiene theory (Herzberg, 2003; Herzberg, Mausner, & Snyderman, 1959/2010). Although Herzberg's work was originally published in the late 1950s, Herzberg's model continues to inspire contemporary research globally (Dalton, 2010; Guha, 2010; Lundberg, Gudmundson, & Andersson, 2009). According to Herzberg (2003), intrinsic motivational factors are the foundation for understanding employee behavior. Herzberg (2003) asserted that employees are most motivated by stimulating work, an engaging challenge, and

appreciable responsibility (p. 87). Under Herzberg's (2003) motivation-hygiene theory, extreme job satisfaction can result from satisfying an employee's *intrinsic factors,* that is, an employee's opportunity for growth, advancement, and responsibility, in addition to the work itself, including the prospect of achievement and recognition for a job well done. On the other hand, *hygiene factors* act to mitigate feelings of job dissatisfaction, and if unfulfilled, can lead to extreme job dissatisfaction. Hygiene factors are described as: (a) job security, (b) job status, (c) relationship with subordinates, (d) personal life, (e) relationship with peers, (f) salary and work conditions, (g) relationship with supervisor, and (h) company policy and administration (Herzberg, 2003).

In applying the motivation-hygiene theory, it was important to recognize that factors that lead to job satisfaction are distinctly different from, but not in opposition to, factors that lead to job dissatisfaction (Herzberg, 2003, p. 91). For example, the opposite of job satisfaction is not dissatisfaction but rather, no satisfaction (Herzberg, 2003, p. 91). Likewise, the opposite of job dissatisfaction is not satisfaction but rather, no dissatisfaction (Herzberg, 2003, p. 91). It is valuable for health care organizations to distinguish this fundamental element of theory because organizational leaders may place tremendous emphasis on competitive wage and benefit packages, neither of which necessarily results in increased job satisfaction.

Herzberg (2003) advocated that managers systematically enrich the work of employees by influencing the intrinsic motivational factors that drive production. Herzberg used the term *job enrichment* to describe this growing movement. Job enrichment initiatives provide an opportunity for an employee to mature psychologically

and are different from *job enlargement* initiatives, which merely seek to make the job structurally larger (Herzberg, 2003, p. 95). While proclaiming job enrichment, managers must be cognizant of issues that surround *job loading*, vertical or horizontal. Herzberg illustrated job loading and cautioned managers about the unfavorable effects of horizontal job loading. Horizontal job loading can reduce the employee's individual contribution rather than provide an opportunity for growth. For the employee, horizontal job loading amplifies and intensifies the meaninglessness of the job (Herzberg, 2003). An example of horizontal job loading is when a manager adds additional tasks to a nurse's daily routine without offering autonomy, input, or recognition for how those additional tasks will be performed. Unlike the negative effects of horizontal job loading, vertical job loading can enhance intrinsic motivational factors and consequently promote job enrichment (Herzberg, 2003). An example of vertical job loading is when a manager removes the bureaucratic controls over a nurse's daily routine, fosters accountability, and provides full decision-making authority over the process in which to complete assigned tasks. Herzberg (2003) proposed that managers foster the following elements, which are a result of vertical job loading: (a) responsibility, (b) personal achievement, (c) recognition, (d) internal recognition, (e) growth and learning, and (f) advancement. Herzberg (2003) advocated that organizational leaders devote time and energy to create awareness of job enrichment, highlighting the benefits to society as both human gratification and economic gain (p. 96).

To demonstrate the job factors as described by Herzberg et al. (1959/2010), I have created Figure 1 as an illustration. The intrinsic motivational factors or job satisfiers

have the potential to advance positive job attitudes and are essential for employees to sense job satisfaction. The hygiene factors or job dissatisfiers, when unfilled or inadequate, have the potential to advance negative job attitudes or job dissatisfaction. Although hygiene factors are major job dissatisfiers, satisfying hygiene factors alone are not compelling enough to affect job attitudes in a positive direction (Herzberg et al., 1959/2010). By distinction, intrinsic factors stand out strongly as major job satisfiers and are essential to affecting job attitudes in a positive direction (Herzberg et al., 1959/2010).

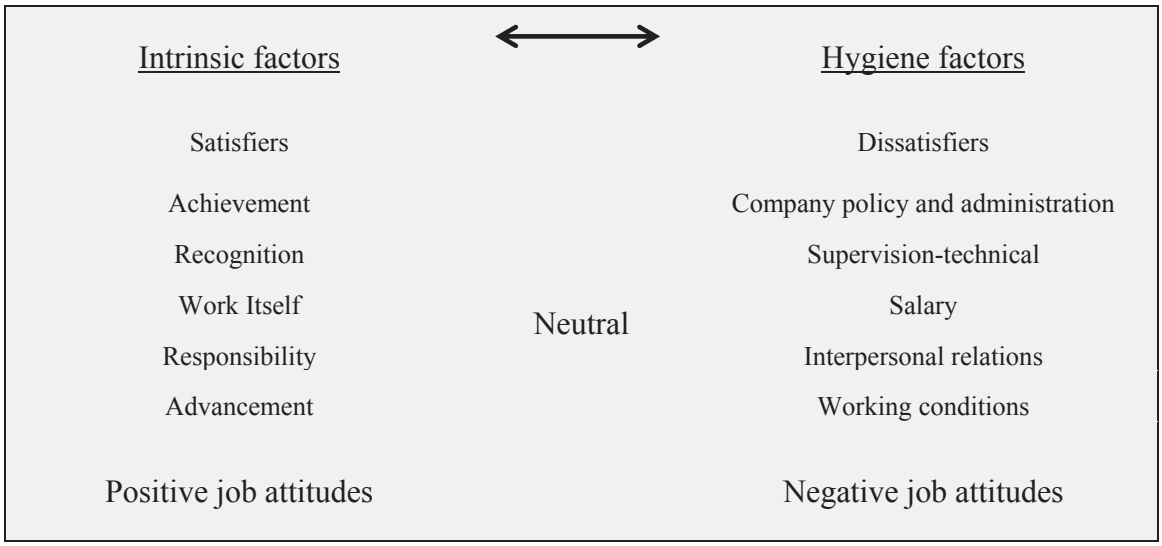

Figure 1. Job factors described by Herzberg, Mausner, and Snyderman (1959/2010).

Herzberg's motivation-hygiene theory was subject to criticism. Critics of Herzberg's theory defended individualism and hence argued that motivational differences exist between employees (Tietjen & Myers, 1998). They maintained that motivational factors are ambiguous and that personal needs, desires, and values must be considered in order to understand an employee's inspiration to work (Tietjen & Myers, 1998).

Another notable model to consider when examining factors that might affect RN job satisfaction is Maslow's theory of human needs (1962). According to Maslow (1962), healthy people are motivated primarily by self-actualization. Self-actualization occurs when all basic and mental needs are met, and hence the actualization of full human potential takes place (Maslow, 1962). Maslow asserted that the actualization of human potential occurs when one's capacities and talents are accepted as one's own intrinsic nature, which thereby promotes the fulfillment of one's desired mission, intention, or vocation. Healthy people are described as having the following clinically observable characteristics:

- a superior perception of reality with increased acceptance of self, others, and nature;
- increased spontaneity;
- increased problem-centering or an increased ability to focus on finding solutions to problems that affect others;
- increased detachment and desire for privacy;
- increased autonomy and resistance to enculturation;
- greater freshness of appreciation and richness of emotional reaction, with higher frequency of peak experiences;
- increased identification with the human species;
- changed or improved interpersonal relations;
- democratic character structure with significantly increased creativeness; and
- amenable to changes in their value systems (Maslow, 1962, p. 32).

In attempting to understand the opposing notion of basic human needs, Maslow (1962) asked the question, "What makes people neurotic?" (p. 23). According to Maslow (1962), neurosis is fundamentally a deficiency disease that accordingly involves complex determinants, such as ungratified wishes for safety, belongingness, and identification, and a yearning desire for close love relationships, respect, and prestige (p. 23). Maslow's (1962) theory of a hierarchy of needs is based on Maslow's conclusions about neurosis. Essentially, human beings are primarily motivated by unsatisfied basic needs that must be fulfilled before any higher needs can be pursued (Maslow, 1962). Maslow (1962) described the hierarchy of needs as having five levels, beginning at the most basic and advancing respectively: (a) *physiological* encompasses hunger, thirst, shelter, and sexual relations; (b) *safety* encompasses security and protection from physical and emotional harm; (c) *social* encompasses affection, belonging, acceptance, and friendship; (d) *esteem* or *ego* encompasses internally feeling self-respect, autonomy, and achievement while externally feeling status, recognition, and attention; and (e) *self-actualization* encompasses achieving one's maximum potential (p. 168). To demonstrate Maslow's hierarchy of human needs, I have created Figure 2 as an illustration. As the pyramid denotes, a person's lower level needs must be fulfilled before the higher level needs can be targeted and achieved. Maslow (1962) concluded that the hierarchy of human needs is a dynamic force as needs shift often, and once a need is satisfied, the promise of fulfillment no longer motivates.

Figure 2. Maslow's (1962) hierarchy of human needs.

Another prominent model used to understand employee motivation is Vroom's expectancy theory (1964/1995). In examining the motivational roots of labor, Vroom presented two types of conditions that determine whether people will work: economic and motivational. According to Vroom, the economic drive is stimulated by the employer's demand. In response to the demand, goods are manufactured, or services are provided. In other words, people must have an opportunity to work, which is typically fueled by members of society who have placed a demand on production or provision of goods or services. According to Vroom (1964/1995), the motivational drive is intrinsic as people must choose employment over unemployment (p. 35). Vroom predicted that given the opportunity to work, people will elect to work, as long as the valence of outcomes is more positive than negative.

The concept of valence is the first principle of Vroom's expectancy theory (1964/1995). The positive prediction of valences or outcomes was described by Vroom

as the motivational implications of work roles. Vroom (1964/1995) asserted that work roles should (a) provide wages to the role occupant in return for services; (b) require from the role occupant the expenditure of mental or physical energy; (c) permit the work occupant to contribute to the production of goods or services; (d) permit or require the work occupant to have social interaction with other persons; and (e) define, at least in part, the social status of the role occupant (p. 115). With regard to valence, Vroom asserted that differences in performance may be relative to the strength of force the person applies to achieve different outcomes.

The second principle of Vroom's expectancy theory (1964/1995) is the concept of expectancy, or the motivational criteria that would likely affect an employee's level of job performance (p. 244). The relationship between one's ability and one's performance emerged as a key component of the expectancy theory. Vroom (1964/1995) discovered that motivation was lower for those employees who were low in ability and higher for those employees who were high in ability. In 1964, Vroom acknowledged that, according to the research, the relationship of expectancy was not a constantly increasing paradigm but rather an approximated one. For example, Vroom noted that high-level mental tasks combined with extremely high-level motivation may result in lower performance. The explanation offered by Vroom was that strong motivation may result in narrowing of the cognitive process, or highly motivated people may be anxious about failure. Vroom recommended future researchers examine factors that surround performance impairment when intense employee motivation is present.

The third principle of Vroom's expectancy theory (1964/1995) is the concept of instrumentality, which relates largely to job satisfaction. As Vroom (1964/1995) stated, periodically there may be discrepancies between anticipated satisfaction from an outcome, which is valence, and the actual satisfaction from an outcome, which is value (p. 252). Vroom believed the anticipation of receiving positive outcomes or rewards was an important component of predicting job satisfaction, although Mitchell (1974) suggested that anticipation plays a less important role than receiving rewards. In 1974, Mitchell discussed the development and refinement of Vroom's expectancy theory and raised concerns about the methods, observations, and assumptions. Although Mitchell (1974) agreed that valences, expectancies, and instrumentalities were suitable criterion in motivational theory, Mitchell suggested that Vroom's assumptions about the combined properties were basically untested.

In attempting to understand and predict human behaviors, contemporary researchers have continued to explore the validity of motivational theories (Guha, 2010; Nyberg, 2010; Wie, Liew, & Mustaffa, 2011). For example, in 2010, Guha analyzed Herzberg's motivation-hygiene theory by studying a stratified sample of professionals working in India ($N = 202$). Engineering, medical, academic, and legal credentials were proportionately represented in the sample. The participants were chosen to explore the validity of Herzberg's motivation-hygiene theory on a modern generation. Guha (2010) examined whether differences existed between the survey responses of Generation X ($n = 114$) and Generation Y ($n = 88$). Using confirmatory factor analysis (CFA), Guha concluded that Herzberg's motivation-hygiene theory was not supported among

contemporary generations. Guha thereby suggested that researchers direct future efforts to understanding the complex nature of human behavior in modern-day generational cohorts.

Contemporary researchers have examined Maslow's theory, too. For example, Wie et al. (2011) sought to understand job satisfaction among health care workers employed in community clinics in Malaysia ($N = 141$). Surveying this population, Wei et al. discovered that pay, benefits, and working conditions, were the most potent predictors of job satisfaction. Aligning this discovery with Maslow's theory and the model's five categories of basic needs, Wei et al. maintained that pay, benefits, and working conditions fall under the category of safety. Hence, Wie et al. revealed that health care workers were functioning in the basic levels of Maslow's motivational needs theory. Foremost, Wei et al. emphasized that the effect of satisfaction on lower levels needs was not sustainable. The implication for managers is that they should seek to fulfill the basic needs of the employee while concurrently strengthening his or her desire to push his or her needs up Maslow's pyramid to achieve higher levels (Wie et al., 2011).

Nyberg (2010) examined the relationship between job satisfaction and the voluntary turnover of high-performing employees working in the insurance industry ($N = 12,545$). In considering Vroom's expectancy theory, Nyberg hypothesized that high-performing employees would be less inclined to leave a position voluntarily that linked performance with rewards. Nyberg (2010) discovered that the negative relationship between performance and voluntary turnover was strongest when pay growth was highest and hence concluded that, high-performing employees displayed behaviors

that were consistent with Vroom's expectancy theory (p. 449). However, the voluntary turnover of the lowest performing employees was not statistically influenced by pay. Nyberg stated that low-performing employees may place higher emphasis on job retention than pay growth, and consequently, that they are less influenced by external opportunities for growth. Nyberg (2010) emphasized the practical implications of the research conducted on Vroom's expectancy theory:

- Organizational rewards affect employees differently across performance levels. Managers should consider implementing policy that is tailored to retain specific performance groups.
- Managers should recognize pay growth as an important factor in retaining high-performing employees.
- Pay growth influences job turnover independently of job satisfaction. Unsolicited job offers can influence turnover in employees who are satisfied with their jobs.
- The voluntary turnover of high-performing employees increased when the relevant unemployment rate rose. Managers must be cognizant of risk in losing high-performing employees during difficult economic times when the business inclination may be to slow pay growth (p. 451).

Herzberg's, Maslow's, and Vroom's motivational theories were presented in this section along with contemporary research that sought to confirm or disconfirm the assumptions of their theories. In quantitative studies, the theoretical framework may act as a deductive model, not to develop a new theory, but rather to test, verify, or advance

an existing theory (Creswell, 2009). For this research study, I used a representative sample of RNs in the United States and collected empirical data on personal satisfaction, satisfaction with workload, and global satisfaction. Herzberg's (2003) theory claimed that satisfied intrinsic factors lead to job satisfaction, and that conversely, unfilled hygiene factors lead to job dissatisfaction. I appraised intrinsic factors by examining the participant's personal satisfaction score on the MJS survey instrument. I appraised hygiene factors by examining the participant's satisfaction with workload score on the MJS survey instrument. To confirm or disconfirm Herzberg's (2003) motivation-hygiene theory, I examined the extent to which personal satisfaction scores and satisfaction with workload scores correlated with scores on global satisfaction. Figure 3 is an illustration of the variables included in this study.

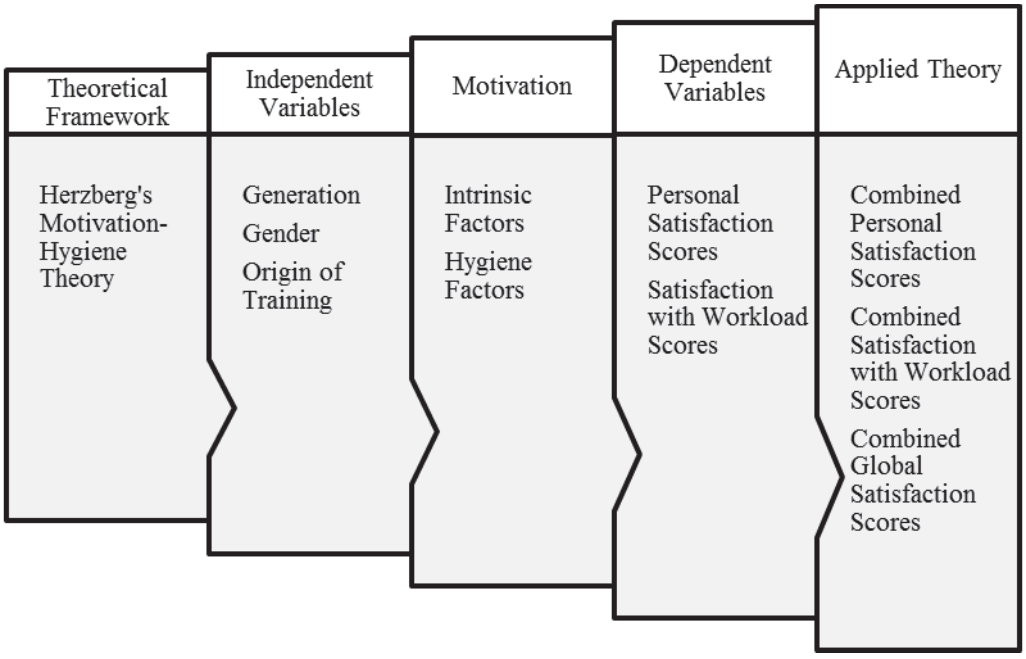

Figure 3. Theoretical framework to investigate factors of RN job satisfaction.

Definition of Terms

Actively licensed registered nurse (RN): A person who holds a state issued registered nurse license in good standing (National Council of State Boards of Nursing, 2011). This excludes a RN who holds an expired, inactive, lapsed, retired, restricted, suspended, delinquent, or encumbered license.

Baby Boomer: A generation of members born between the years 1946 and 1964, also referred to as boomers (Kramer, 2010; Wieck et al., 2009).

Foreign-born RN: An individual who is born in a foreign country, is licensed to practice as a RN, and is employed in the United States (Pittman et al., 2010). For the purpose of this study, a foreign-born RN was not considered an internationally educated nurse unless the participant indicated that his or her basic nursing education occurred in a setting outside the United States.

Generation X: A generation of members born between the years 1965 and 1980 (Kramer, 2010; Wieck et al., 2009).

Generation Y: A generation of members born between the years 1981 and 2000 (Kramer, 2010; Wieck et al., 2009).

Health care systems: An organization of people, resources, and institutions, academic or otherwise, which integrate networks of health care providers who accept responsibility to care for particular segments of populations within the United States (Rundio & Wilson, 2010).

Hygiene factors: Herzberg's (2003) motivation-hygiene theory proposed unfulfilled or unsatisfied hygiene factors lead to job dissatisfaction. According to

Herzberg, hygiene factors are: (a) security, (b) status, (c) relationship with subordinates, (d) personal life, (e) relationship with peers, (f) salary and work conditions, (g) relationship with supervisor, and (h) company policy and administration.

Internationally educated nurse (IEN): A RN who completed his or her basic nursing education in a setting outside the United States (Adeniran et al., 2008; Pittman et al., 2010). For the purpose of this research study, the term IEN describes an internationally educated nurse who is actively licensed to practice as a RN in the United States, and who is currently employed as a RN in the United States.

Intrinsic factors: Herzberg's (2003) motivation-hygiene theory proposed job satisfaction exclusively as it relates to satisfying intrinsic motivational factors. According to Herzberg, intrinsic motivational factors are: (a) growth, (b) advancement, (c) responsibility, (d) work itself, (e) recognition, and (f) achievement.

Job enrichment: Herzberg's (2003) motivation-hygiene theory advocated that managers enrich the work of employees by positively influencing intrinsic motivational factors that drive production. Herzberg used the term job enrichment to describe initiatives that provide an opportunity for an employee to mature psychologically.

Registered nurse (RN): There are three educational paths to becoming a RN in the United States: baccalaureate degree, diploma degree, or associate degree from an approved nursing school program. To obtain a RN license, a graduate candidate is required to pass the national council licensure examination or NCLEX-RN examination (U.S. Department of Labor, 2010).

Veterans: A generation of members born between the years 1922 to 1945 (Kramer, 2010; Wieck et al., 2009).

Assumptions, Limitations, and Delimitations

Assumptions are factors that I consider true, although not verified. It is acknowledged that assumptions can create risk, which may later pose disputes in credibility. The limitations of the research are weaknesses or drawbacks that have been identified and are disclosed to stakeholders. The delimitations of the research refer to the scope or the confines of the study.

Assumptions

There were several assumptions to this research study. The first assumption was that U.S. Data Corporation's electronic database of RNs included actively managed e-mail addresses of RNs in the United States. Second, that participants who opted to take part in this research study were actively licensed RNs employed in the United States, and the sample was diverse enough to test the study's constructs. In addition, there was an assumption that the participants would answer the survey questions honestly and that those participants would remain anonymous.

Another assumption was that the MJS survey instrument had the appropriate content validity to measure aspects of RN job satisfaction. Additionally, that the MJS instrument had been validated and that high levels of reliability and construct validity promoted accurate statistical conclusions. There was an assumption that the MJS survey scores could be used to confirm or disconfirm Herzberg's (2003) motivation-hygiene theory in the representative sample of RN participants.

The last two assumptions relate to the statistical procedures conducted for this research. There was an assumption that the significance tests associated with factorial analysis of variance (ANOVA) were met: (a) the dependent variable was normally distributed for each population, (b) the population variances of the dependent variable were the same across the independent variables, and (c) the scores of variables for each case were independent (Green & Salkind, 2011). There was also an assumption that the significance tests associated with multiple regression analyses were met: (a) the dependent variables were normally distributed, (b) the population variances of the dependent variable were the same across the independent variables, and (c) the scores of variables for each case were independent (Green & Salkind, 2011).

The assumptions of this study may have been mitigated by using an informed consent. The informed consent (a) provided an overview of the study, (b) explained the relationship of variables to be investigated, (c) discussed the voluntary nature of participants, (d) explained the participatory right to withdraw or decline the research at any point, (e) disclosed the risks and benefits of the study, (f) provided a statement of confidentially, and (g) conveyed a contact person for questions that may arise. Furthermore, to mitigate issues surrounding sampling, the electronic survey instrument configuration prohibited a prospective participant from proceeding with the survey unless he or she answered a preliminary set of eligibility criteria questions. For example:

- Have you read and do you understand the information contained in the informed consent document? Hence, do you agree to participate in this research study voluntarily?

- Are you 18 years of age or older?
- Are you an actively licensed RN?
- Are you currently employed as a RN in the United States?

Limitations

There were several limitations to this research study. I conducted the survey research online with a sample of RN participants. The online survey approach may have induced bias, specifically bias pertaining to the omission of RNs who had limited or no access to the Internet or e-mail communication (Fleming & Bowden, 2009). The online survey approach may have inhibited participation from certain subpopulations. For example, some generational cohorts may have been less likely to participate in this study as it is plausible some generational cohorts may have been less actively engaged online. With that limitation considered, it is plausible that other independent variable subpopulations may have been less actively engaged online.

Nonresponse bias may occur when conducting an online survey, which is bias pertaining to the omission of participants who chose not to participate in the research study. The MJS uses a Likert-type scale that may induce response set or response bias, which is a tendency for some people to answer or score different questions in the same way (Neuman, 2003). The Likert-type scales may be a source of frustration for participants because their desired answer may not be a choice, or because they are forced to enter simple measures when scoring complex issues (Neuman, 2003). Furthermore, the online survey generated data on a participant's job satisfaction at a single point in

time, and changes that may have occurred in job satisfaction over time were not examined.

Although participants affirmed by response to a survey question that they had completed the online survey only once, there was no way for me to detect if a participant opted to complete the survey more than once. To assure that participant responses remained anonymous, I disabled any survey software option that enabled tracking of the Internet Protocol (IP) address. The decision to disable IP tracking was further supported by my concern that RN colleagues may have been deterred from participating, should they have been selected, and should they have opted to participate in this survey research via a single computer at the workplace.

Delimitations

There were several delimitations to this research study. I conducted the online survey research in the United States and limited participation to RNs who were (a) 18 years of age or older, (b) actively licensed to practice as a RN in the United States, and (c) currently employed as a RN in the United States. Registered nurses who were retired, unemployed, or working in a setting outside the United States were excluded. Registered nurses who did not have Internet access or e-mail access were excluded from participating in this online survey research. Registered nurses who were not included in the U.S. Data Corporation electronic database were excluded from participating in this online survey research, as they were not selected to receive a virtual invitation to participate. The licensed practical nurse (LPN) or licensed vocational nurse (LVN) was excluded from participating in this online survey research.

I omitted the generational cohort Veterans from the multivariate statistical analyses I conducted. Foremost, the majority of members in this cohort were actively transitioning into retirement when the data were collected, and consequently, I presumed that scholar practitioners would not devote organizational resources to the development of workforce solutions, aimed at this specific cohort. Furthermore, a serious limitation of multivariate statistical analyses is sensitivity to outlier populations (Tabachnick & Fidell, 2007). The generational cohort Veterans were identified as an outlier population for Internet usage per household (U.S. Census Bureau, 2009). In conducting the descriptive analyses of the participants' demographic data, I determined that the response rate from the generational cohort Veterans were not adequate to test the constructs of this research study. Hence, to control for Type I and Type II error, I excluded the outlier generational cohort Veterans from the multivariate statistical analyses I conducted.

Another limitation to this research study pertains to the variables selected. After careful deliberation of the fiscal resources available for this project, I determined it was cost-prohibitive for me to broaden the scope of variables examined. To further advance knowledge of factors that might affect RN job satisfaction, future researchers may consider the allocation of resources necessary to examine the participant data collected in its entirety.

Significance of the Study

Reduction of Gaps

This research study will complement existing literature, which shows that researchers have previously discovered factors that affect RN job satisfaction (Aiken et

al., 2011; Kalisch et al., 2010; McHugh et al., 2011). The nursing profession is changing, and the current workforce is more diverse than ever before (HRSA, 2010). Building and sustaining a diverse nursing workforce is universally strategic to effectively providing culturally relevant care to citizens of the United States (IOM, 2011). Previous studies have examined RN generational differences (Kramer, 2010; Wieck et al., 2009). However, there was a gap in the literature to compare aspects of job satisfaction in the male nurse population, with the female nurse population, employed in the United States. There was also a gap in the literature to compare aspects of job satisfaction in the U.S. trained nurse population, with the internationally trained nurse population, employed in the United States. Encompassing diverse demographic factors of generation, gender, and origin of training, I have examined if population mean differences exist in aspects of RN job satisfaction.

Implications for Social Change

In 2010, President Obama signed into law the Patient Protection and Affordable Care Act (Public Law 111-148), which advances an opportunity for the United States to transform its health care system (IOM, 2011). To achieve the transformation, many facets of the U.S. health care system will need to be amended (IOM, 2011). According to the IOM (2011), the nursing professions' response to the challenge of transformation is pivotal to attaining the goals of the Act, as the nursing workforce represents the largest portion of the health care workers in America (U.S. Department of Labor, 2010).

The model for a transformed health care system includes (a) quality care that is accessible to a diverse population of citizens, (b) processes that focus on wellness and

disease prevention, (c) reliably improved patient outcomes, and (d) provisions for compassionate care across the life span (IOM, 2011). In the envisioned future, nurses ensuring regimented care coordination and interdisciplinary collaboration provide the mechanism for seamless delivery of patient-centered quality care (IOM, 2011). Primary care services and disease prevention initiatives are central to the success of an amended health care system (IOM, 2011). By virtue of sheer numbers, adaptive abilities, and scientific understanding of care practices across the health care continuum, RNs have the potential to propel comprehensive transformational change in the U.S. health care system (IOM, 2011).

However, nursing professionals must work together diligently to overcome challenges that could hinder the professions' role in the successful transformation of health care systems. The challenges that may impede the nursing professions' success include: (a) lack of workforce diversity with respect to race, ethnicity, gender, and age; (b) consequential inability to provide culturally relevant care to all populations; (c) ill preparedness to adapt to a rapidly changing health care environment and health care system; (d) restriction on nursing scope of practice, federal policy, and reimbursement limitation; and (e) consequential mounting professional tension that has undermined the professions' ability to provide and improve conventional and advanced nursing care (IOM, 2011, p. 25).

Nurses advocate for the patient and have long been recognized for their commitment to patient safety (Mahlin, 2010). Based on judgments of honesty and ethical standard, nurses have been voted the most trusted professional in America for

consecutive years (Donelan, Buerhaus, DesRoches, Dittus, & Dutwin, 2008). Furthermore, nurses are distinguished as one of the most trusted sources of health and health care information in America (Hader, 2011). I may promote social change by raising the nurse executives' understanding of factors that affect RN job satisfaction, and thereby strengthening patient advocacy through improved business practice.

A Review of the Professional and Academic Literature

Introduction

The section on the review of the literature begins with a brief overview of the history of management theory before the review of the literature that is relevant to the variables of this study. Some scholars consider management to be an art, while other scholars consider management to be a science. Despite these scholarly considerations, most executives agree that the purpose of management is to create a surplus. Surplus is achieved by fostering an environment where people can accomplish their work with the least amount of time, capital, resources, and personal dissatisfaction (Rundio & Wilson, 2010, p. 15). Management theory was developed in the 19th-century in retort to industry petitions for mass production (Rundio & Wilson, 2010). As a means to achieve a company's production demands, management was appointed with the expectation of fulfilling the company's goals through the work of the employees (Rundio & Wilson, 2010). A traditional function of management was to lead and inspire employees so that they eagerly and devotedly performed to actualize the objectives of the organization (Rundio & Wilson, 2010, p. 15).

In considering the 19th-century industrial age management theory, Hamel (2009) declared that the work of management in the 21st-century must serve a higher purpose. Hamel avowed that in many respects maximizing shareholder wealth is an inadequate goal, as it fails to mobilize human energies. Furthermore, maximizing shareholder wealth is an insufficient defense when the question of legitimacy in corporate power emerges. Moreover, shareholder wealth is not compelling enough to spur human renewal. Hamel referred to the shift in prioritizing organizational goals as seeking to create genuinely human organizations. With innovative management, organizations must strive to be as genuinely human as the employees who labor there, this is a moral imperative, which has now become an inescapable business imperative (Hamel, 2009, p. 98).

Barsh (2008) interviewed Hamel and discussed the emerging importance of innovative management. During the interview, Hamel asserted that outmoded managerial approaches are barriers, which are preventing the adaption of good innovations. Hamel explained that the impacts of technologies will drastically alter the work of management (Barsh, 2008, p. 30). Hamel emphasized in this respect, change management is a revolution in expectations, explaining companies must strive to become adaptable, innovative, and exciting places to work (Barsh, 2008). Moreover, cyberspace has created a generation of employees who expect that their contributions be judged on merit rather than credentials, providence, or anything else (Barsh, 2008). Hamel described the combination of technology and human capital as a powerful catalyst for value creation (Barsh, 2008). When managing talented, creative thinking people, traditional hierarchical

management models fail, as highly talented people do not need, and are unlikely to put up with, outmoded management styles (Barsh, 2008, p. 31).

Scholars have emphasized the importance of innovative management and asserted that nurse executives consider evidence-based knowledge as a necessary catalyst for 21st-century solutions (Hyrkas & Harvey, 2010). The modern day health care setting is a fast-paced and complex environment, which requires effective and efficient, dynamic leaders who comprehend and appreciate innovation (Hyrkas & Harvey, 2010). Nurse executives who are to be successful in the 21st-century will recognize, embrace, promote, and nurture innovation throughout a diverse workforce (Hyrkas & Harvey, 2010). The nursing profession must undergo a fundamental transformation, nurses educated and practiced in the 20th-century are insufficiently prepared to manage the complex issues that surround the reality of 21st-century health care (IOM, 2011). Benner (2012) has appealed for a radical transformation in nursing education, affirming that nurses must be skillfully prepared for contemporary challenges. Given the crucial role of RNs with respect to providing accessible and affordable, high-quality health care, nurse executives should strive to confine outdated policies, practices, opinions, and behaviors that dampen and impede innovation (IOM, 2011).

Although the foundations of management and leadership are essential background considerations for this study, the literature review in this section is broader and will focus on research that has been conducted to explore RN job satisfaction. I have organized the literature review into four sections. The first three sections will consider the variables: generational factors, gender factors, and origin of training factors. The last section,

aspects of RN job satisfaction, will be organized by job satisfaction subscales that are measured using the MJS instrument (Traynor & Wade, 1993). The MJS instrument measures the following subscales or aspects of RN job satisfaction: personal satisfaction, satisfaction with workload, satisfaction with professional support, satisfaction with training, satisfaction with pay, satisfaction with prospects, and satisfaction with standards of care (Traynor, 1991). I have omitted subsections on satisfaction with training and satisfaction with prospects from the literature review, as I found no current and relevant research on those aspects of RN job satisfaction.

In conducting the review of literature in this section, I considered published peer-reviewed research articles pertaining to RN job satisfaction. The following Walden University library research databases were accessed in completing the literature review:

- Management and Business (ScienceDirect, SAGE Collection, ProQuest Central, and Business Source Complete),
- Health Sciences and Nursing (CINAHL & Medline, PubMed, and Ovid Nursing Journals),
- Behavioral Studies and Psychology (SocINDEX and PsycINFO), and
- ProQuest Dissertations and Thesis.

In addition, the Google Scholar search engine, trustworthy Web sites, and published books were used to discover data by searching for the following terms, entered alone or in combination: *registered nurse* or *RN*, *job satisfaction* or *dissatisfaction*, *generation* or *Generation X* or *Generation Y*, *gender*, *male nurse*, *internationally educated nurse* or *foreign educated nurse*, *transcultural differences*, *stress*, *burnout*, *ethical issues*,

autonomy, *work environment*, and *innovation* or *innovative solutions*. The electronic searches were filtered by the date of publication, substantiating that peer-reviewed articles were current and limited to those published after 2008.

Generational Factors

The section on generational factors includes literature relevant to the research questions: To what extent, if any, do the personal satisfaction scores or the satisfaction with workload scores vary as a function of generational cohort? Scholars have asserted that nurse executives are not alone in the challenge to create an environment where generations work in harmony, to collaborate, enrich, prosper, and succeed (Stanley, 2010; Wieck et al., 2009). The challenge is broader and affects corporate America where the discovery of means to capitalize on generational differences is a 21st-century business mandate (Stanley, 2010). Parry and Urwin (2011) discussed the theoretical origin and empirical evidence of generational theory and explained the term *generation* is broadly defined although most agree it describes a group who share birth years, geographical locations, and significant life events. The grouping of individuals is largely motivated by the notion that groups share different values and different beliefs resultant from their shared experiences and shared events (Parry & Urwin, 2011). Researchers in the United States, United Kingdom, and Australia generally agree there are four generations (Parry & Urwin, 2011).

Cohort profiles. The total number of members in each generation varies widely depending on the researcher's definition of birth date (Parry & Urwin, 2011). The estimated membership of Generation X was 17 million people as compared with

Generation Y, which was three times more and estimated at 60 million people (Reisenwitz & Iyer, 2009). The combined estimated membership of Generation X and Generation Y slightly exceeded the estimated Baby Boomer cohort, which was 72 million people (Reisenwitz & Iyer, 2009). A widely debated birth date variation affects to the last two generational cohorts, sometimes cited as Generation X, born between 1965 and 1976; and Generation Y, born between 1977 and 1988 (Reisenwitz & Iyer, 2009). The narrower birth date definitions are grounded on the assumption that, as the pace of changes in society hastens, the time frame of each generation shortens (Reisenwitz & Iyer, 2009). As Veterans and Baby Boomers gradually reach retirement age, organizational leaders are wise to explore the dynamic needs of Generation X and Generation Y. Members of Generation X are maturing and advancing their careers, whereas members of Generation Y are developing skills and beginning their careers (Reisenwitz & Iyer, 2009).

Members of Generation X and Generation Y have witnessed transformations in the standard of living, in the United States (Reisenwitz & Iyer, 2009). As an example: (a) family divorce rates increased significantly during their combined years of childhood, (b) corporate downsizing became a model, (c) parameters for financial aid tightened, and (d) the job market weakened (Reisenwitz & Iyer, 2009). For these reasons, some scholars have viewed Generation X and Generation Y as a single market segment, whereas other scholars have viewed Generation X and Generation Y to have parallel outlooks on life but declared that genuine differences existed in other important preferences of living (Reisenwitz & Iyer, 2009). Australian researchers concluded

insignificant variations existed across three generations of employees (N = 3,535) responding to personality and motivational survey instruments (Wong, Gardiner, Lang, & Coulon, 2008). Age was found to be a more relevant factor than generational cohort (Wong et al., 2008). Consequently, Wong et al. suggested that managers should manage individual employees and individual behaviors, and thereby avoid stereotyping a generation.

Historical views. Although many scholars have asserted that genuine differences existed in generational work values, other scholars have asserted that the differences are just age related influences or cohort related environmental experiences (Parry & Urwin, 2011). If the differences were merely age related, or experience related, one would expect relatively stable attitudes across the cohorts. However, relatively stable attitudes across the cohorts were not evidenced (Parry & Urwin, 2011). Deliberation on generational differences dates back to the 1920s with Mannheim's formative work in the origins of sociology (Pilcher, 1994). Mannheim emphasized that generations are essential in understanding the social and intellectual movement of people (Pilcher, 1994). Nonetheless, Mannheim maintained that consideration to birth date alone should not determine an individual's generational cohort (Pilcher, 1994).

Modern day sociologists have broadened Mannheim's historical view of a generation to include perspectives of contemporary cultural elements such as affinities with music, clothing, pop stars, and significant regional events (Parry & Urwin, 2011). Keen awareness of a cohort's social and cultural values is an essential consideration in the U.S. marketing industry (Perry & Urwin, 2011). Parry and Urwin (2011) cited an

emerging view of the term generation, to be more collective, while the term cohort, to be more specific and perhaps more descriptive of subgroups that are formed in response to one's association to historical, social, cultural, and economic trends. The practical implications of the generational debate should drive researchers' efforts to ascertain the effects of age, career stage, cohort and period, while recognizing that generational analysis may be enhanced to consider cohort differences such as gender, ethnic background, and national culture (Parry & Urwin, 2011, p. 93). Moreover, efforts could be expanded to consider differences among first and second generation immigrants, or perhaps first and second generation working women (Parry & Urwin, 2011).

RN workforce. In 2008, the estimated population of RNs in the United States was 3,063,163 (HRSA, 2010, p. 3). There is consensus that four generations coexist in the U.S. nursing workforce: (a) Veterans, born between 1922 and 1954; (b) Baby Boomers, born between 1946 and 1954; (c) Generation X, born between 1965 and 1980; and (d) Generation Y, born between 1981 and 2000 (Keepnews, Brewer, Kovner, & Shin, 2010; Kramer, 2010; Wieck et al., 2009). The average age of the nursing workforce has steadily increased over the past 20 years (HRSA, 2010). In 2008, the average age of the RN workforce population was 47 years old (HRSA, 2010, p. 8). The aging trend is concerning as a large proportion of Baby Boomer RNs are predicted to collectively reach retirement age and consequently substantially reduce the workforce. This is expected in concurrence with an aging general population who predictably will display increased demands for nursing services (HRSA, 2010). Although the proportion of RNs younger than 40 years old increased to approximately 30% in 2008, much recruitment and

retention work is needed to build and sustain a younger RN workforce (HRSA, 2010, p. 9). Figure 4 is an illustration of the estimated RN population in 2008 by factors of age and generational cohort.

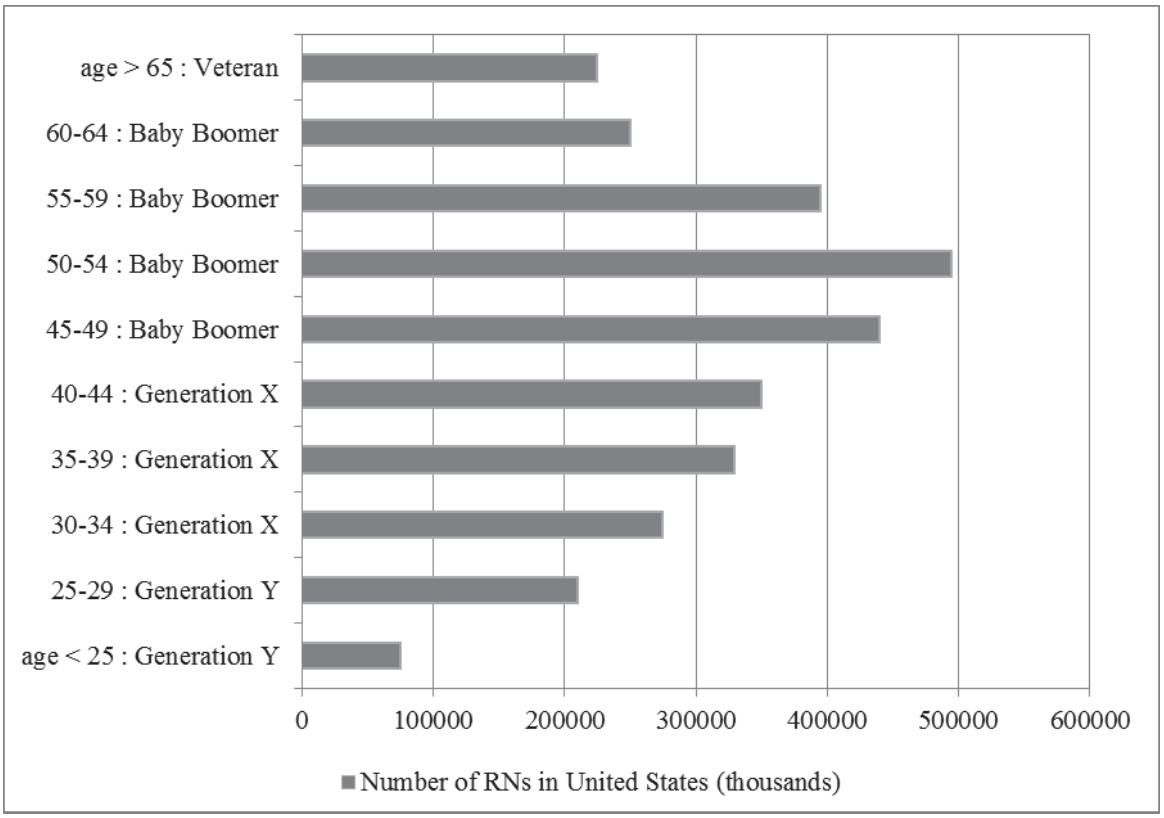

Figure 4. Estimated population of RNs in the United States, 2008. Adapted from "Age distribution of the registered nurse population, 1980-2008," by U.S. Department of Health Resources and Services Administration, 2010, *The registered nurse population: Initial findings from the 2008 national sample survey of registered nurses.* Retrieved from a public domain: http://bhpr.hrsa.gov/healthworkforce/rnsurveys/rnsurveyfinal.pdf

To contrast some observable differences in the RN workforce, characteristics that are cited as central to RN job satisfaction and RN retention efforts are presented.

Veteran nurses (1922-1945):

- Individuals who prefer cautious and conservative approaches (Kramer, 2010).
- Hold high levels of respect for authority (Kramer, 2010; Wieck et al., 2009).
- Dependable and trustworthy workers who get things done without questions (Wieck et al., 2009).
- Disciplined workers who adhere to the rules (Wieck et al., 2009).
- Desire respect for age, seniority, and past contributions (Kramer, 2010; Wieck et al., 2009).
- Fiercely loyal to organizations (Wieck et al., 2009).
- The most effective method of communication is face-to-face or written exchange that is exclusive and trustworthy (Kramer, 2010).
- Some individuals in this cohort may have technology limitations (Kramer, 2010).
- Most of this cohort is actively transitioning into retirement (Kramer, 2010).

Baby Boomer nurses (1946-1964):

- Largest cohort in the nursing workforce, governing many management positions (Kramer, 2010).
- Workaholics who live to work, rather than work to live (Kramer, 2010; Wieck et al., 2009).

- Egocentric employees who grew up being individuals, thus, are independent and creative workers (Kramer, 2010).
- Exhibit highly optimistic work approaches (Wieck et al., 2009).
- Self-centered workers who prefer that attention be paid to ideas and contributions (Wieck et al., 2009).
- Value group cohesion and teamwork (Wieck et al., 2009).
- Work hard and sacrifice for the group (Kramer, 2010; Wieck et al., 2009).
- Expect involvement and immersion in work; place emphasis on meetings (Wieck et al., 2009).
- Expect that managers provide public recognition and credit for innovative ideas (Kramer, 2010).
- Prefer open, direct, and less formal communication (Kramer, 2010).
- Many are eligible to retire after 2010 (Kramer, 2010).

Generation X nurses (1965-1980):

- Significantly smaller than the Baby Boomer cohort, Generation X nurses represent the second largest cohort in nursing (Kramer, 2010).
- Many in this cohort have entered nursing as a second career (Kramer, 2010).
- Independent, resourceful, and confident workers, who consequently have been referred to as selfish or pessimistic (Kramer, 2010; Wieck et al., 2009).
- As employees, they may be skeptical of workers older than they are (Wieck et al., 2009).

- Demand balance between work and life; work to live, not live to work (Kramer, 2010, Wieck et al., 2009).
- Hold high levels of comfort with technology (Kramer, 2010; Wieck et al., 2009).
- Desire fun on the job (Wieck et al., 2009).
- Value informality in job relationships (Wieck et al., 2009).
- Focus on outcomes, disliking conventional processes and micromanagement (Kramer, 2010; Wieck et al., 2009).
- Loyal to self and career goals; not necessarily loyal to the job or the organization (Kramer, 2010; Wieck et al., 2009).
- Believe that recognition and career advancements should be based on merit (Kramer, 2010).
- Prefer honest and tactful communication (Kramer, 2010).
- Respect and value human interactions with patients and families (Kramer, 2010).
- Believe that even repetitive menial tasks need to be done well (Kramer, 2010).

Generation Y nurses (1981-2000):

- Smallest cohort in the nursing workforce, second largest generational cohort in the general population (Kramer, 2010).
- Most supervised generation in history; exposure to violence, terrorism, abuse, and drugs are a reality (Kramer, 2010; Wieck et al., 2009).

- Less motivated by the promise of wealth or threats of firing; high turnover rates if individual needs are not met (Kramer, 2010; Wieck et al., 2009).
- Are often considered to be expert multitaskers (Wieck et al., 2009).
- Expect technology-rich environments (Kramer, 2010; Wieck et al., 2009).
- Demand work and life balance (Kramer, 2010; Wieck et al., 2009).
- Work well in teams but expect group input and meaningful responsibilities (Wieck et al., 2009).
- Multiculturalism, technology, and instant communication are important (Kramer, 2010).
- Prefer immediate feedback: e-mail exchange, text message, and chat rooms are favored for communication (Kramer, 2010).
- Expect more coaching and mentoring than other generations of nurses (Kramer, 2010).
- Want structure, guidance, and extensive orientation to the job (Kramer, 2010).
- Personal feedback and flexible scheduling are expected and desired (Kramer, 2010).

Succession planning. Stevens (2010) discussed challenges associated with a multigenerational workforce and justified the importance of effective *knowledge management* across the entire employee population. Capturing and transferring critical knowledge and experience can be problematical for members of a multigenerational workforce, where colleagues can encounter difficulties relating to age bias, conflicting values, and contrasting work habits (Stevens, 2010). Organizational leaders must strive

to integrate knowledge management principles, which effectively serve to decrease knowledge transfer barriers (Stevens, 2010). Organizational leaders must protect and manage intellectual capital across multigenerational workforces, doing so is strategic to generating sustainable, competitive advantage (Stevens, 2010). Wieck, Dols, and Landrum (2010) reaffirmed the importance of managing human capital and asserted measures to boost multigenerational employee retention. As a significant proportion of nurses will concurrently reach retirement eligibility, diligent succession planning strategies should include measures to identify, train, and develop future leaders (Wieck et al., 2010). Strong and effective nursing leadership is fundamental in efforts to advance respectful, supportive, cohesive coworker interactions (Simpson, 2009).

Generational studies. In Japan, Takase, Oba, and Yamashita (2009) examined generational differences in factors affecting job turnover of nurses employed in three public hospitals. The researchers discerned the three generations as birth date variations: 1946 to 1959, 1960 to 1974, and 1975 to present. Quantitative and qualitative data were collected using a convenience sample of RNs (N = 315). Quantitative data was analyzed by ANOVA, whereas qualitative data was analyzed by using content analysis. Registered nurses who were born between the years 1960 to 1974 placed a high value on professional privileges such as autonomy and recognition, and placed a high value on a balance between work and personal life (Takase et al., 2009). Furthermore, the 1960 to 1974 generation placed a high value on job security and economic return, more so than the 1946 to 1959 generation. The RNs born after 1975 conveyed a low value in opportunities for clinical challenges, while confirming *loss of confidence* as a major

reason for considering turnover (Takase et al., 2009, p. 963). Takase et al. (2009, p. 966) concluded generational differences exist in the RN workforce as the needs, values, and reasons for job turnover differ. The implications for professional practice include the development and implementation of cohort specific strategies, which seek to reduce staff turnover (Takase et al., 2009).

In Canada, Wilson, Squires, Widger, Cranely, and Tourangeau (2008) sought to explore job satisfaction differences in a multigenerational nursing workforce. Recognizing the international shortage of nurses and seeking to mitigate effects, Wilson et al. (2008) asserted that clarity in generational differences may promote understanding of generation specific retention strategies. Researchers declared that the affective aspects of job satisfaction had two dimensions: global satisfaction and facet satisfaction (Wilson et al., 2008). According to Wilson et al., global satisfaction refers to the job in its entirety, whereas facet satisfaction refers to specific components of the job. Wilson et al. recognized that a nurse's sentiments may fluctuate over time, and consequently, proposed the possibility of job satisfaction changing, by explaining realistically, one could have bad days or good weeks.

Wilson et al. (2008) used MANOVA to examine differences in aspects of RN job satisfaction ($N = 6,541$). In investigating generational cohorts, Baby Boomer nurses were significantly more satisfied overall, reporting significant satisfaction with pay, benefits, and scheduling (Wilson et al., 2008). Furthermore, in comparing Generation X to Baby Boomers, researchers discovered Baby Boomers reported significant satisfaction with professional opportunities, praise, recognition, control, and responsibility (Wilson et al.,

2008, p. 719). Because the majority of nurses in this research study worked in a unionized environment with collective bargaining agreements that reward tenure, the implications for change are noteworthy (Wilson et al., 2008). Wilson et al. asserted that nurse executives should seek to improve job satisfaction in the younger nurse cohort. Within the constraints of contractual labor agreements, younger nurses should be empowered to make decisions through the framework of shared governance, including self-scheduling or job sharing, and in conjunction with, enhanced support, education, and career development (Wilson et al., 2008).

Moreover, in Canada, seeking to understand the needs and expectations of Generation Y nurses ($N = 35$) employed in six acute care hospitals, focus groups discussions and semistructured interviews were conducted (Lavoie-Tremblay et al., 2010). According to Lavoie-Tremblay et al. (2010), Generation Y nurses reported monetary and peer recognition as a fundamental motivator. The Generation Y nurses indicated a desire to be challenged, a preference for stability, and an expectation for flexible scheduling, professional development, and adequate supervision. Some Generation Y nurses reported a desire to obtain the necessary knowledge to move ahead within the organization. With regard to retention strategies, the Generation Y nurses expressed distinct needs: (a) develop the necessary skills to specialize, (b) continue studying intellectually, (c) work for an organization that holds a good reputation, and (d) achieve a sense of belonging with all members of the care team (Lavoie-Tremblay et al., 2010). The researcher findings have implications for the staff developer, nurse educator,

and nurse manager. Discoveries should be sought on how to improve job satisfaction in the younger nurse cohort (Lavoie-Tremblay et al., 2010).

In China, Chan, Leong, Luk, Yeung, and Van (2010) sought to understand factors associated with nurses' job satisfaction. Nurses were recruited from two local hospitals, which represented a heterogeneous population (N = 649). The younger nurses were more educated, 65.4% held a baccalaureate degree, as compared to the senior nurses, 37.5% held an associate degree (Chan et al., 2010, p. 475). The younger nurses reported higher degrees of job dissatisfaction with regard to pay, benefits, scheduling, and perceived declines in standards of care (Chan et al., 2010, p. 474). Consequently, younger nurses reported more intent, than senior nurses did, to change careers. Senior nurses reported more satisfaction with their careers, with respect to peer support, autonomy, professional opportunities, scheduling, and interdisciplinary relationships. Senior nurses indicated lesser intent to change careers, even if the nursing shortage worsened and job dissatisfaction intensified. Chan et al. attributed the senior nurses' unyielding commitment to service to be a result of their years of experience, higher proficiency, and increased responsibility, both clinically and managerially. The implications for professional practice are initiatives to train and educate younger nurses to fulfill managerial roles, as senior nurses often default to this role because of proficiency. Second, with intent to increase job satisfaction altogether, nurse managers should seek to identify strategies that target specific cohorts of nurses (Chan et al., 2010).

In Belgian, DeCooman et al. (2008) sought to understand the job motives and work values of new graduate nurses. DeCooman et al. acknowledged the vital

importance of understanding the needs of the younger generation nurses, citing satisfied requests as fundamental to recruitment and retention efforts. Considering the global shortage of nurses, a nation's health care industry outlook is dependent upon recruitment and retention of the younger generation nurses. DeCooman et al. surveyed new graduate nurses (N = 344) and discovered many traditional nursing work values are still important for the younger generation. The younger generation nurses were primarily motivated by an opportunity to help others. The most important job motives were discovered to be altruistic and interpersonal. The second and third ranking job motives were job content and professional contact. The least important job motive was working conditions. The younger generation nurses valued the sincere and pleasant relationships they built with the people and the families they helped (DeCooman et al., 2008).

The DeCooman et al. (2008) research provides practitioners with an important source of information on the work motivation of the younger generation nurses. Intrinsic qualities such as altruism and the ability to provide quality patient care were rated as high motives for new graduate nurses, whereas extrinsic qualities such as working hours and salary were rated as low motives for new graduate nurses. In a time of budgetary constraint, it is imperative that organizational leaders restructure with prudence. Workforce solutions that hinder altruistic work qualities are ill advised. It appears that an increase in salary at the expense of time to provide care to patients does not support the work motivation of the younger generation nurses (DeCooman et al., 2008).

In the United States, Keepnews et al. (2010) examined a longitudinal sample of newly licensed RNs to understand generational differences in employee characteristics

and work related preferences (N = 2,369). Keepnews et al. (2010, p. 158) discovered the following significant differences between the three generations of employee participants: (a) job satisfaction, (b) organizational commitment, (c) work motivation, (d) work to family conflict, (e) family to work conflict, (f) distributive justice, (g) promotional opportunity, (h) supervisor support, (i) mentor support, and (j) procedural justice. Nurse executives should foster an environment where intergenerational colleagues respect one another, not only for their commitment to common goals, but also for their commitment to the safe delivery of patient care (Keepnews et al., 2010). Age differences are one of many factors that can lead to disruptive employee behavior, which profoundly affects nurse satisfaction and nurse retention, and can lead to negative clinical outcomes (IOM, 2011).

In summary, the literature review has revealed that nurse executives are encountering intensifying pressure to manage the intergenerational differences in the workforce. It emerges that the effective management of a multigenerational workforce is not only strategic to rendering positive clinical outcomes but also strategic to leveraging competitive, organizational advantage. The literature review has revealed that researchers concur that efforts should focus broadly on building multigenerational relationships, as each member's perspective is valuable to the nursing profession. Next is the literature review of factors associated with gender.

Gender Factors

The section on gender factors includes literature relevant to the research questions: To what extent, if any, do the personal satisfaction scores and the satisfaction

with workload scores vary as a function of gender? According to researchers, an adequate reserve of nurses will be necessary to achieve national goals, which seek to improve citizen health care access and affordability (Buerhaus, 2008; IOM, 2011; Rochlen, Good, & Carver, 2009). Occupational segregation is a crucial consideration in achieving national goals as men in the nursing workforce are underrepresented by significant proportions (Rochlen et al., 2009). Buerhaus (2008, p. 2424) affirmed the underrepresentation, citing the 2006 nursing workforce nationwide when males represented 8% of the population, as compared to the 2006 entire workforce nationwide when males represented 54% of the population. Although more men are choosing a career in nursing, the profession remains dominated by women (Buerhaus, 2008; Rochlen et al., 2009).

Gender theory is presented as a plausible explanation suggesting that the nursing profession remains dominated by women because of the necessary job attributes, caring and nurturing, which are gender stereotypes associated with women (Rochlen et al., 2009). Another plausible explanation to why the nursing profession remains dominated by women is gender role and vocational interest, both of which are theorized to influence career choices (Rambur, Palumbo, McIntosh, Cohen, & Naud, 2011). Gender role is established at an early age and shaped by factors of socialization (Rambur et al., 2011). In considering the notion of gender role, researchers asserted that boys in Western societies are often discouraged from crying, deterred from expressing grief, and persuaded to suppress their emotions, except anger (Brown, 2009). Gender role is different from vocational interest, which is shaped by the personal achievement goals that

one holds (Rambur et al., 2011). As an example of vocational interest, in past research, women have conveyed interpersonal, achievable, work goals more frequently than goals of high pay or goals of work status (Rambur et al., 2011). Conversely, men have more frequently expressed technical challenge, earning capacity, and prestige as achievable, work goals (Rambur et al., 2011). The societal view of the nursing profession as a gender-based career has consequences, which can be considered barriers to job entry (Buerhaus, 2008; Rambur et al., 2011).

Historical background. According to McMurry (2011), detailed records of religious orders demonstrated that males customarily performed nursing tasks during the Middle Ages. As an example, Saint Antonines was an order founded in 1095 and committed to caring for mentally ill patients, and the Knights of Lazarus was an order founded in 1490 and committed to caring for leprosy patients, in each circumstance, nursing was a career for the men of these religious orders (McMurry, 2011). Moreover, historical records confirmed that male nurses doubled as soldiers in the U.S. Civil War, World War I, and other battles including present day combat (McMurry, 2011). McMurry (2011) cited that labor intensive industries such as mining often reported a predominantly male nursing workforce. Furthermore, McMurry noted, in Islamic countries where women are not fully integrated into the workforce, the role of the nurse is commonly fulfilled by a man. Nightingale's transformation of the profession changed the prospect of nursing for men, prior to, evidence revealed they had customarily performed nursing tasks in diverse industries (McMurry, 2011).

Nightingale emerged in the mid-nineteenth century with an essentialist view that women were biologically bestowed with the caring and nurturing traits necessary to perform nursing tasks (McMurry, 2011). Nightingale believed that the nursing profession commenced as an unpretentious blossoming of pure and righteous womanhood (McMurry, 2011, p. 23). Nightingale introduced training reforms that marked the nursing profession as a secular sisterhood, which subsequently allowed marginal opportunity for male participation (McMurry, 2011). Men came to be viewed as maladroit and deficient, and incapable of caring for sick or injured patients (McMurry, 2011). Concurrently during the Nightingale era, patriarchal capitalism advanced as did the work of men outside the field of nursing (McMurry, 2011). According to McMurry, as the status of male work elevated, the caring work of nurses became devalued and consequently unworthy of masculine efforts.

The American military remained a predominantly male workforce until World War II when women were recruited to the military ranks, routinely fulfilling secretarial and nursing positions (McMurry, 2011). The military sought to recruit unmarried, youthful females to fill the role of the nurse, which further disseminated the essentialist view of excluding men from nursing (McMurry, 2011). According to McMurry (2011), with the exception, the Navy did enlist a limited number of male nurses, although they were not called nurses nor granted entry into the Nurse Corps. The ANA inadvertently reinforced the essentialist view of gendered stereotypes in the organization's lobbying efforts during this era (McMurry, 2011). In 1944, the ANA lobbied to change the military policy and permit men into the Nurse Corps arguing that the nursing profession

needed strong men to fill specialty roles in urology, psychiatry, management, and education (Williams, as cited in McMurry, 2011, p. 24).

Role strain. Role strain can occur when men feel their masculinity is challenged (Brown, 2009). Consequently, some male nurses attempt to distance themselves from the feminizing image of a nurse. In achieving such, men may seek more masculine positions, those that downplay the people-oriented aspects of the job and instead focus on the task-oriented aspects of the job (Brown, 2009). Other male nurses have reported mistreatment, victimized by homophobic fears or accused of sexual predation (Brown, 2009). Masculinity emerges as a twofold burden, men are vulnerable not only in upholding their personal identify, but men are disadvantaged by their minority membership in a profession dominated by woman (Brown, 2009). Consequently, according to Brown (2009), some male nurses feel victim to the challenging inequality.

Gender bias. Cases studies support that gender bias and gender discrimination does occur in the nursing profession. Kouta and Kaite (2011) cited litigation where a male nursing student was barred from participating or watching female examinations. In contrast, female nursing students were not restricted from participating or watching male examinations. The male nursing student charged the school with not providing equal learning opportunity. In another case, Kouta and Kaite cited litigation where a male RN charged a hospital with discrimination when policies prohibited hiring of male nurses in the obstetrics wards. When challenged, the hospital spokesperson responded that male nurses were barred from obstetric wards in order to protect patient privacy and advance quality of care. Although case studies are subjective, they do illustrate the challenge

nurse executives encounter in analyzing stakeholder views and implementing strategies to assure gender equality.

Elements of training. McLaughlin, Muldoon, and Moutray (2010) discussed factors surrounding nursing education and suggested that basic curriculum improvements must be sought to reduce gender stereotypes. McLaughlin et al. (2010) asserted that while the feminist movement has successfully diminished the use of masculine pronouns such as mankind, the nursing profession still implies a nurse is female by distinctly labeling men as male nurses. Additionally, McLaughlin et al. revealed (a) the difficulties male nursing students encounter providing intimate care to females, (b) the lack of male role models in the nursing profession, (c) the lack of reference to male nurses in textbooks, and (d) the discrimination and isolation that male nurse cohorts report. Kouta and Kaite (2011) supported that basic curriculum improvements must be sought citing evidence that male nursing students are rarely assigned female patients during clinical rotations. Moreover, according to Kouta and Kaite, the unique needs of the male learner should be considered and instructors should train or guide students on the appropriate use of touch in a therapeutic relationship. Furthermore, McLaughlin et al. (2010) emphasized the adverse effects of advantaging male nurses unduly and thus creating vertical segregation, which some researchers in nursing refer to as the glass escalator effect.

Glass escalator. According to McMurry (2011), prominent social scientists have described the vertical movement of men in the nursing profession as having a *glass escalator* to the top management positions. The escalator is theorized to be glass because it is invisible to the naked eye and therefore the casual observer may not notice the

effects. Wingfield (2009) stated that men in predominantly female professions distance themselves from the femininity and seek masculinity by aspiring for higher pay and higher status. Wingfield asserted that the upward push not only puts men into acceptable social arenas but also reinforces that greater societal value is placed on masculinity. Hence, men retain the prestige and privilege of masculinity while simultaneously empowering them to ride a glass escalator to top management positions (Wingfield, 2009).

Kouta and Kaite (2011) concurred that some men believe there are socially acceptable specialty practice areas of nursing that are more masculine than others. As an example, reportedly in England, 90% of nurses are female and 75% of nursing supervisors are male (Equal Opportunities Committee, as cited in Kouta & Kaite, 2011). Brown (2009) affirmed that inequalities can occur in the choice of specialty, and despite their minority representation in the profession, male nurses often earn more and are frequently promoted to management positions unhesitatingly (p. 120).

McMurry (2011) depicted this phenomenon as opposite and described a *concrete ceiling* that obstructs male nurses from achieving top management positions. Females in professions dominated by males have reported similar invisible barriers that prevented vertical advancement and referred to them as a *glass ceiling* effect (McMurry, 2011). Distinct negative stereotypes about men in nursing can push male nurses away from the bedside and into more acceptable masculine specialty practice areas. The discrimination in stereotyping actually advances the glass escalator effect and thereby perpetuates the

gender bias that occurs in the nursing profession (Kmec, McDonald, & Trimble, 2010; McMurry, 2011).

Gender studies. In Great Britain, using national census data from 1991 and 2001, Curtis, Robinson, and Netten (2009) sought to discover changes in the age at which female and male nurses exit their careers. Curtis et al. (2009, p. 843) discovered that although the working life of a female nurse decreased by only one year, the working life of a male nurse decreased by 9 years. Notably, the 1991 census data indicated that, in industries other than nursing, men experienced longer working lives than women did (Curtis et al., 2009). Several factors may have influenced the male nurse decision to exit the profession early. First, the glass escalator effect has curtailed in Great Britain as national health care systems have changed clinical grading so that the vertical progression of nurses occurs without loss of contact with patient care (Curtis et al., 2009). Upper level nursing management has been replaced with general nursing management. Consequently, men who entered nursing expecting swift vertical progression may have become dissatisfied with the lack of opportunity. Second, Curtis et al. speculated that the increased availability of less demanding work outside the nursing profession and the increased dissatisfaction with salary scales has played a significant role in male nurse retention. The findings of this study support that research should be directed at discovering strategies to retain male nurses (Curtis et al., 2009).

Black, Spetz, and Harrington (2010) sought to examine factors that may be considered a predictor as to whether RNs will work in positions other than nursing, described as *nonnursing* positions. Nonnursing positions were cited as positions in the

labor market that actively licensed RNs held although the positions did not require an active RN license (Black et al., 2010). The sociodemographic, market, and political factors of 122,178 RNs working in nonnursing positions were examined; this sample represented 4% of the total RN labor market in the United States (Black et al., 2010, p. 246). With regard to gender specific findings, male nurses were significantly more inclined to choose nonnursing positions. The market wage predictions indicated that nonnursing jobs paid an estimated $1 per hour more than nursing jobs (Black et al., 2010, p. 250). Married and unmarried male nurses earned more per hour than female nurses, estimated at $4 per hour more in both nursing and nonnursing jobs (Black et al., 2010, p. 250). The wage difference between nursing and nonnursing positions is an important consideration in nurse retention efforts. Future research should be directed at understanding the differences in wage predictions. According to Black et al. (2010), it is not clear if male nurses are influenced to a greater degree than female nurses by the higher wage in nonnursing positions. It is also not clear if nonnursing job opportunities present more prevalently to male nurses than female nurses. Strategies should be employed to bring gender equality to the nursing workforce, male nurses remain marginalized and consequently a vulnerable subset of the nursing workforce (Black et al., 2010, p. 253).

Taylor (2010) introduced the concept of *occupational minority* and described this term as a worker who was represented numerically less in his or her occupation. Examples of occupational minorities are men with a career in nursing or women with a career in engineering. The concept of occupational minority differs from the term *token,*

which refers to a minority in the workplace or at the firm level (Taylor, 2010). By contrast, occupational minorities are minorities on a larger scale, at national levels, regardless of the specific workplace or firm composition (Taylor, 2010).

Using a nationally representative sample of individuals in the United States (N = 1,808), Taylor (2010) sought to understand the occupational gender composition and the gendered availability of workplace support. The following factors were associated with occupational minority: (a) women are more likely to report gender based discrimination; (b) women are more likely to work in occupations with high proportions of part-time employees; (c) women are more likely to be in occupations that require high levels of verbal and nurturance communal skills; (d) men are more likely to be supervisors than women; (e) men are more likely to earn higher wages; and (f) men are more likely to be in occupations that require higher levels of physical strength and authority as well as math, analytical, and technical skills (Taylor, 2010).

Moreover, in mixed-gender occupations, women reported higher levels of workplace support than men and by contrast, in occupations dominated by men, women perceived relatively lower levels of support (Taylor, 2010, p. 189). By distinction, men perceived relatively higher levels of workplace support in occupations dominated by women (Taylor, 2010, p. 189). Taylor concluded that being a member of an occupational minority is advantageous for men and disadvantageous for women. The implications for professional practice include evidence that gender inequality occurs in the United States, efforts to reduce gender segregation should be sought at national levels, as well as at the workplace or firm levels.

Studying male nurses in Taiwan, Chen, Fu, Li, Lou, and Yu (2010) sought to understand the relationships between social support, professional empowerment, and nursing career development (N = 314). The researchers used a cross-sectional survey design to collect and analyze data with one-way ANOVA, Pearson's correlation (r), and stepwise regression analysis. Social support and professional empowerment were vital components of the male participant's nursing career development (Chen et al., 2010). In fact, professional empowerment was the most crucial predictor of the male participant's nursing career development. Other factors also significantly enhanced the male participant's nursing career development: salary, type of institution, type of clinical level, and nursing discipline (Chen et al., 2010). The implications for professional practice are indications that nurse managers consider supporting male nurse empowerment initiatives to promote male nurse career development, and to decrease male nurse turnover rates (Chen et al., 2010).

Rochlen et al. (2009) sought to understand men in gender-nontraditional professions such as nursing. Using a sample of male nurses (N = 174) employed throughout the United States, Rochlen et al. examined gender role conflict, social support, gender-related work barriers, and work and life satisfaction. Rochlen et al. discovered that the male participants were well adjusted and satisfied, both personally and professionally. The responses of the male nurses were similar to normative data of available groups of male adults. The single exception was that male nurses experienced less conflict between work and family relations as compared to normative data of available groups of male adults (Rochlen et al., 2009, p. 51). The implications for

professional practice include considerations for nurse retention efforts. Male nurses who reported less gender role conflict received greater support from their families, and assessed their careers more positively, with fewer perceived barriers in the workplace (Rochlen et al., 2009, p. 52). Hence, male nurses who experience job dissatisfaction might benefit from considering additional factors as a source of dissatisfaction. Social support from family and friends was found to be important and positively associated with the work and life satisfaction of male nurses (Rochlen et al., 2009, p. 52).

Seeking to understand young adult perception of an ideal career, Rambur et al. (2011) surveyed a sample of adults, 18 to 24 years old, who were attending a local job fair in an U.S. metropolitan area (N = 116). Men and women ranked similar key career attributes, thereby indicating that there was gender consistency in the six key attributes of an ideal career (Rambur et al., 2011). The six key attributes were: (a) job security, (b) knowledge level required, (c) use of one's intellect, (d) care for people, (e) power, and (f) leadership (Rambur et al., 2011, p. 21). However, men and women each ranked power and leadership as the least important of the six attributes. Furthermore, men and women each perceived a career in nursing to be different from their ideal career. Nursing was perceived by men and women as being: (a) too busy, (b) requiring too little decision making, and (c) yielding too little respect (Rambur et al., 2011, p. 22). The gender differences that researchers found in this study were that women perceived nursing as using more technology than ideal, and as being less than ideal in workplace safety (Rambur et al., 2011, p. 22). Additionally, men perceived nursing as being less than ideal in the area of educational requirements, and as less than ideal in the likelihood of making

a good salary. The implications for professional practice include support for research directed at recruitment strategies. There is a social obligation to discover recruitment strategies as human capital is recognized as a crucial factor in providing quality nursing care (Rambur et al., 2011).

Reviewing the literature on economic experiments, Croson and Gneezy (2009) examined gender differences in risk preferences, social preferences, and attitudes toward competition. Fundamental differences existed in male and female preferences. Women were significantly more adverse to risk than men. Affective reaction was identified as a factor that influences risk aversion. Affective reaction upholds that men and women differ in their emotional reactions, and this subsequently influences their risk taking. However, emotions were not the only consideration, men tended to view risky situations as a challenge, and this outlook heightened their risk tolerance. Moreover, gender differences diminished in managers and entrepreneurs. According to Croson and Gneezy (2009), gender differences were also lessened by experience and profession.

Social differences arose between genders and presented as a form of altruism. However, social differences were inconsistent. Men were more altruistic than women at times, while women were more altruistic than men at times (Croson & Gneezy, 2009). The conflicting outcomes are thought to be a result of women being more sensitive than men to cues in the experimental context. Psychology researchers concurred and determined that women are more responsive to social cues in ascertaining appropriate behavior (Croson & Gneezy, 2009). The fundamental difference is that women's behavior is more context dependent than men's behavior (Croson & Gneezy, 2009).

Gender differences also encompassed differences in attitudes toward competition. Women were disinclined to competitive dealings like sales or auctions, negotiating, and sports competitions (Croson & Gneezy, 2009). Moreover, relative to women's performance, men's performance improved under competition. As competitiveness in the male environment increased, so did performance and participation (Croson & Gneezy, 2009). Croson and Gneezy (2009) proposed that future research be directed at discovering whether gender differences are ingrained by nature or taught by nurture.

Kmec et al. (2010) examined gender segregated occupations and the influence of informal social networking on job referrals. In matching people with available jobs, the *nonsearch* process plays a significant role (Kmec et al., 2010). Nonsearch process occurs when people who are not actively seeking employment are advised about job opportunities through informal social networking (Kmec et al., 2010). Nonsearching process is important to consider as researchers cited 30% of a national sample of employees secured their positions through a nonsearch process (McDonald, as cited in Kmec et al., 2010, p. 214).

Gender *misfits* are atypical workers, men working in professions dominated by women or women working in professions dominated by men (Kmec et al., 2010). Broadly accepted beliefs about masculinity and femininity can shape societal expectations about men's work or women's work (Kmec et al., 2010). According to Kmec et al., a negative consequence of stereotyping is that job informants may not pass along job information to job seekers because of preconceptions about gender and a

suitable job fit. For example, a job informant may not mention a construction job to a female or a daycare job to a male (Kmec et al., 2010).

Analyzing U.S. national data from 1996 and 1998, Kmec et al. (2010) examined detailed information of survey participant job matching process, which quantified, the nonsearch process directly (N = 1,119; n = 569 male; n = 550 female). Using MANOVA, Kmec et al. discovered that the nonsearching process largely sustained gender segregation and labor market inequity. Female misfits employed in gender-atypical jobs were commonly recruited through nonsearch process into socially acceptable gender-typical jobs (Kmec et al., 2010). In addition, female misfits who entered male dominated professions through nonsearch process did not receive the same benefits and rewards as male misfits who entered female dominated professions (Kmec et al., 2010). Moveover, male misfits who entered male dominated professions through nonsearch process received higher pay and more authority, which is consistent with the glass escalator effect (Kmec et al., 2010). In summation, the nonsearching process that emerged through informal social networking effectively served to correct gender misfits, thereby sustaining gender segregation and augmenting workplace inequality (Kmec et al., 2010).

In summary, the number of male RNs in the United States is steadily increasing, however, the nursing profession remains significantly nondiverse in male gender representation. The literature review on gender considerations has revealed that scholars agree that stereotyping, collegial acceptance, and role support continues to be a challenge for male nurses. Researchers have suggested that efforts should focus broadly on

recruiting and retaining male nurses as their perspectives are unique to the profession. Next is the literature review of factors associated with international education.

Origin of Training Factors

The section on origin of training factors includes literature relevant to the research questions: To what extent, if any, do the personal satisfaction scores or the satisfaction with workload scores vary as a function of origin of training? The IEN populations are RNs who received their basic nursing education overseas and later migrated from their countries of origin to practice nursing (Adeniran et al., 2008). Researchers sometimes refer to IENs as foreign educated nurses (IOM, 2011). According to researchers in the field, the IEN workforce is a vital component of the professional nursing workforce in the United States (Adeniran et al., 2008; IOM, 2011; Xu, Shen, Bolstad, Covelli, & Torpey, 2010). Adeniran et al. (2008) asserted that IENs bring a wealth of knowledge and clinical expertise to interdisciplinary workforce teams throughout the United States. Others have conferred concern over IEN language barriers and thereby yielded warnings for patient safety, although citing that more research is needed to discern factors (Buerhaus et al., 2009).

Analysis of the field. The international migration of workers is expected to increase in the 21st-century as globalization provides the catalyst for business ventures, which continue to flourish the world (Kingma, 2008). The influx of IENs is expected to increase in the 21st-century as the nursing shortage intensifies in the United States (Adeniran et al., 2008; Buerhaus et al., 2009; IOM, 2011). According to Kingma (2008), the overall number of international migrants in the world has doubled in the last four

decades. Females represent an increasing sum of migrant workers and now represent approximately half of all international migrants (Kingma, 2008). Consequently, female migrants have become economic agents of change as they penetrate the international workforce and share in the distributions of global wealth (Kingma, 2008). Professional nurses are part of this increasingly competitive global labor market (Kingma, 2008). Thousands of nurses migrate each year to the United States seeking: (a) better pay and better working condition, (b) career mobility, (c) professional development, (d) better quality of life, (e) personal safety, and (f) novelty of adventure (Kingma, 2008, Abstract, para. 1). Hence, IENs are an integral part of the nursing workforce and the health care industry in the United States (Adeniran et al., 2008; Kingma, 2008).

The migration flow pattern of health care professions has been acknowledged for many years. It has been observed that physicians sought a carousel mobility pattern in which they migrated to several countries over the course of their careers (Kingma, 2008). At each stop, in each country, they reportedly developed the necessary skills and credentials to seek employment in the United States (Kingma, 2008). Kingma stated researchers are now discovering professional nurses follow similar multistep migration flow patterns. For example, 40% of Filipino nurses employed in the United Kingdom had previously worked in Southeastern Asia and the Middle East (Opiniana, as cited in Kingma, 2008). Migration patterns are projected to evolve over time thereby increasingly permitting developing countries to contribute to the pool of international nurse migrants (Goode, 2008; Kingma, 2008).

Kingma (2008) discussed the adverse effect of the global nurse shortage on the actualization of the eight Millennium Development Goals (MDGs). The MDGs were reportedly accepted as goals for the world's countries, and the world's development institutions, with a target attainment of 2015 (Kingma, 2008, Introduction section, para. 2). The MDGs included measures to reduce extreme poverty, measures to halt the spread of HIV/AIDS, and measures to provide primary education to citizens (Kingma, 2008). Those nations encountering the greatest difficulties in meeting the MDGs are developing nations with pure and absolute shortages in the health care workforce (Kingma, 2008). Consequently, in those developing nations, the basic health care needs of society members continue to be unmet thus citizens continue to suffer. To demonstrate the outward migration of nurses on select developing nations, as described by Kingma (2008), I have created Figure 5 as an illustration.

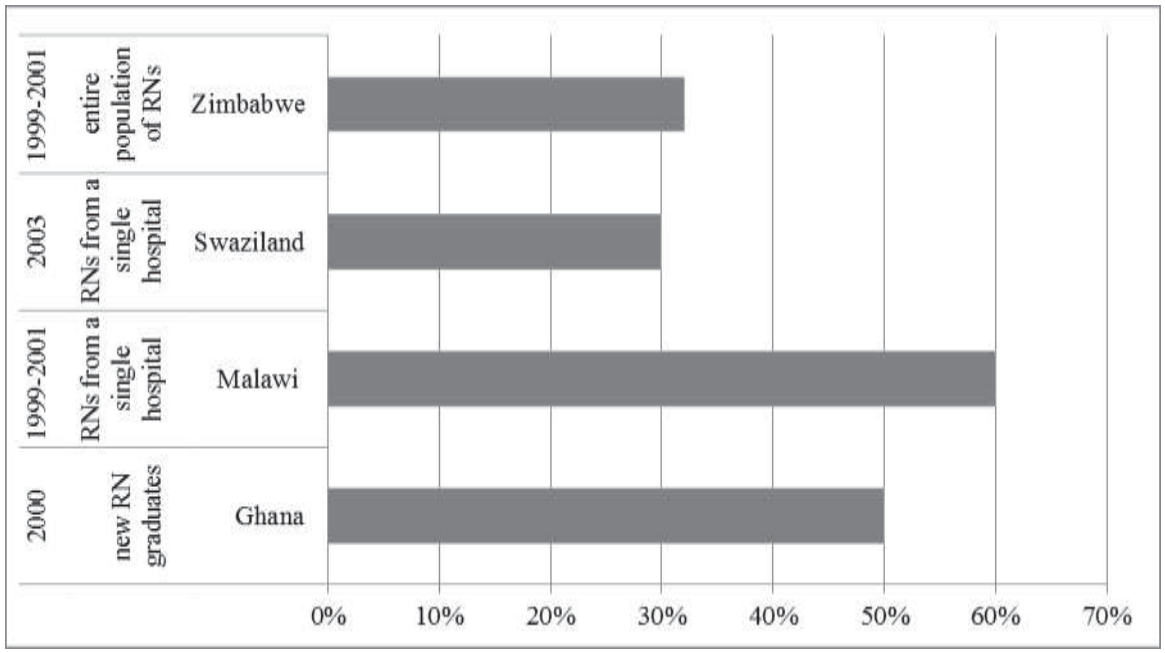

Figure 5. The outward migration of nurses from developing nations.

The recruitment and migration of health professionals from developing nations emerges as an ethical problem (Kingma, 2008). The problem of recruitment and migration quickly compounds as nurses left behind assume heavier assignments, which diminishes morale and reduces job satisfaction. Consequently, the quality of care delivered falls and inevitably feeds the desire to seek better working conditions, often outside their national boundaries (Kingma, 2008, Effects of Nurse Migration, para. 2). The IOM (2011) highlighted the ethical concerns surrounding human right issues and issues of equity. Emphasizing the effects of nurse migration on humanity, the IOM asserted that profound understanding of globalization is an essential component when considering the future of nursing in the United States (2011, p. 632).

The paradox of unemployed IEN nurses. Unemployment is a hardship that nurses encounter, which contributes to the international migration drive. Many graduate nurses in Uganda, Grenada, and Zambia encounter unemployment as health care systems do not have adequate funds to pay salaries (Kingma, 2008). Kenyan nurses encounter the same challenge, as roughly half of all nursing positions are unfilled at a time when one third of the workforce is unemployed (Volqvartz, as cited in Kingma, 2008). This phenomenon not only occurs in developing nations, professionally qualified nurses in Canada are unemployed and encountering the same struggle (IOM, 2011). Nurses in Tanzania, the Philippines, and regions of Eastern Europe are volunteering in order to remain competent and proficient. They are urged to volunteer so that they are in good standing when budgeted positions become available (Kingma, 2008). Some researchers consider this contemporary phenomenon disconcerting, as nurses are denied employment

when genuine needs exist (Kingma, 2008). Organizations lack the necessary funds to pay salaries or health care reform restricts new hires (Kingma, 2008; Rakuom, 2010).

Factors that drive nurse migration. When one considers that a nurse's salary in Australia and Canada is estimated at 14 times a nurse's salary in Ghana and approximately twice a nurse's salary in South Africa, one can easily conclude wages drive nurse migration (Kingma, 2008, Driving Factors of Nurse Mobility, para. 2). Although wages are a crucial consideration, wages are not the only contributing factor (Rakuom, 2010). There are other major motives that drive health care worker migration: better remuneration, safer environment, superior living condition, lack of support from supervisor, heavy workload, noninvolvement in decision making, lack of facility, lack of promotion, and lack of opportunity (Kingma, 2008). Additional factors can also drive nurse migration: political force, poverty, age of the migrant, employment, or educational opportunity (Kingma, 2008). Kingma emphasized that international migration is a reality that will not be regulated out of existence because it is an indication of a larger problem in the health care sector. No matter how strong the pull from destination country, migration would not take place unless substantial push drove nurses away from their jobs in source countries (Kingma, 2008). Kingma concluded it was difficult to appraise the influence that has had the grea effect, the recruitment pull or the migration push. The IOM (2011) discussed the phenomenon of pull versus push and contended another common factor is family members, many IENs have family members or friends living in the United States. Moreover, some countries intentionally train more nurses than needed for the region, which reinforces IEN migration and the benefits that come with it, for

example, returning money to the country of origin and thus supporting the economic well-being of family members left behind (Armstrong, 2010; Goode, 2009).

Issues associated with nurse migration. The migration of IENs has gained attention in political and media arenas in recent years. The notion of an international migration policy has arisen at various political and organizational levels (IOM, 2011). In fully considering the forces, the stakeholder must be identified. The stakeholder was defined as the consumer or the patient, the government or the employer, and the worker or the health care professional (Kingma, 2008). Society's right to health care manifests itself against the individual's right to practice nursing (Kingma, 2008). Industrialized nations look abroad to meet the domestic workforce demands to fulfill society's right to health care (Adeniran et al., 2008; Goode, 2009; Rakuom, 2010; Xu, Zaikina-Montgomery, & Shen, 2010). This global search manifests itself against an individual's right to practice nursing, which is at times limited to his or her basic language skills (Kingma, 2008). Communication is fundamental to the effectiveness of the interdisciplinary health care team. History has demonstrated that nurses are more inclined to migrate between to a country that shares a common language. Migrant Filipino nurses who are literate in English are treasured human capital, and when properly channeled, some researchers asserted, the nurses become a catalyst for economic development (Goode, 2009). Human capital is the largest export article of trade in the Philippines, which is the second largest exporter of human labor in the world (Goode, 2009).

Other factors to consider, in understanding an individual's right to practice as a nurse, surround the issues of exploitation and discrimination. According to Kingma (2008), a serious problem that some migrant nurses encounter is racism and discrimination. Migrant nurses have reportedly been victims of breaches in labor laws, company policies, and pervasive double standards (Kingma, 2008; Pittman et al., 2010). Migrant nurses have reported situations where colleagues have purposefully misunderstood their intentions, undermined their professional authority, refused to offer assistance, or bullied them (Kingma, 2008). Incidents are difficult to quantify as many IENs remain silent about the exact details, which increases their sense of isolation (Kingma, 2008).

The ethical considerations that surround the use of IENs continue to be heavily debated (Adeniran et al., 2008; Kingma, 2008; Pittman et al., 2010; Rakuom, 2010). The International Council of Nurses' (ICN) position statement on ethical recruitment practices protects a nurse's right to freedom of movement (ICN, 2007). Furthermore, the ICN (2007) emphasized good-faith bargaining between all parties and the right to decent work with protection from exploitation. According to Kingma (2008, Ethical Questions, para. 1), some questions remain unanswered and warrant further deliberation:

- Is it acceptable to withhold offers of migration to nurses who are without work in their own country?
- Is it acceptable to recruit nurses from countries with significant nurse shortages?

- Is it acceptable to refuse employment to nurses seeking to improve the living conditions of his or her family members?

IEN transition programs. Because of the unique challenges, many researchers believe the effective integration of IENs is largely dependent upon a successful transition program (Adeniran et al., 2008; Purnell et al., 2011; Singh & Sochan, 2010; Xu, 2010a). In the absence of an international migration policy, some organizations have developed and implemented corporate policies and procedures. Adeniran et al. (2008) asserted that successful IEN integration is a challenge not related to the IEN's lack of knowledge or lack of clinical proficiency, but rather resultant from sociocultural difference. The Hospital of the University of Pennsylvania's (HUP) program, Transitioning Internationally Educated Nurses for Success (TIENS), is presented as a model that can be used to assist organizations in developing curricula to improve the transition of IENs (Adeniran et al., 2008, A Model Transition Program, para. 1). The TIENS program at HUP encourages a supportive environment, which includes the provision of resources to bridge practice differences (Adeniran et al., 2008). Adeniran et al. asserted that *change* is a constant variable in a globalizing world, and consequently it is the core experience of the TIENS program. The TIENS program at HUP consists of four phases (Adeniran et al., 2008, Phases of the TIENS Program, para. 1).

1. Phase 1 is prearrival. The IEN receives the employment offer including helpful information to settle into the new environment; staff members meet the IEN at the airport and take a limousine ride to a finished apartment; apartments are no less than 15 minutes from the hospital by public

transportation; apartments are located in safe neighborhoods with proximity to shopping; and rent is prepaid for 2 months.

2. Phase 2 is onboarding. All stakeholder efforts focus on equipping the IEN with the information necessary for survival in the United States. Staff members assist the IEN in orienting to the community; familiarizing with food stores and food items; opening a bank account; completing paperwork for the employer and the government; and assigning of a buddy or support person that will follow the IEN through the transition program.
3. Phase 3 is formal classes. The IEN receives formal education about the U.S. health care system and clinical practices. The goal of the formal education sessions is to raise the IEN's awareness of key players in the U.S. health care system and to reveal differences that exist in nursing practice.
4. Phase 4 is clinical orientation. The IEN is assigned a clinical preceptor who is sensitive to the orientation and transition needs of the IEN. The IEN's clinical orientation has clear and measurable goals.

Adeniran et al. (2008) reported advocacy for the development of a national policy to standardize transition programs for IENs employed in the United States. Scholars have maintained that the recruiting country has a responsibility to confirm that resources are available to support the IEN transition (Adeniran et al., 2008; Goode, 2009). Although the literature does not indicate whether the TIENS program has influenced job satisfaction, scholars agree that proactive measures are effective at reducing the potential negative effects of transitioning IENs (Adreniran et al., 2008; Xu, 2010a).

Profile of IEN nurses. The 2008 RN population data indicated there were 170,235 IENs licensed as RNs in the United States (HRSA, 2010, p. 5). Hence, IENs represented 5.6% of the total RN population in 2008 (HRSA, 2010, p. 5). The most commonly noted countries of origin for IENs in 2008 were: (a) Philippines, (b) Canada, (c) India, (d) United Kingdom, (e) U.S. Territories, (f) Korea, (g) Nigeria, and (h) other. The percentages of IENs represented by countries of origin are presented in Figure 6. The IOM (2011) highlighted that the migration of IENs is unpredictably shaped by complex and dynamic, international forces. The profile of IENs in the United States is changing, and although the Philippines continue to provide the majority, India, Canada, and the Republic of Korea are among the top countries that provide RNs to the U.S. workforce (IOM, 2011).

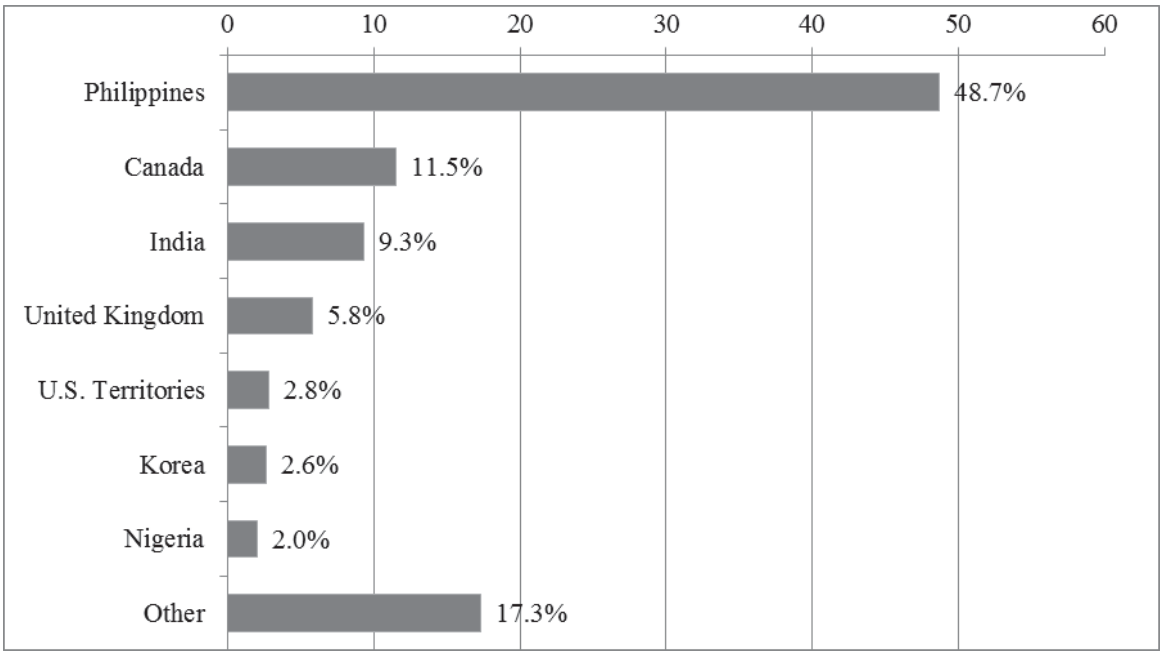

Figure 6. Countries of origin for the IEN population in the United States, 2008. Adapted from "Country of non-U.S. initial nursing education for the U.S. registered nurse population, 2008," U.S. Department of Health Resources and Services Administration, 2010, *The registered nurse population: Initial findings from the 2008 national sample survey of registered nurses.* Retrieved from a public domain: http://bhpr.hrsa.gov/healthworkforce/rnsurveys/rnsurveyinitial2008.pdf

Future directions. Researchers have highlighted the need for organizations to develop evidence-based programs to transition IENs into the workforces in the United States (Adeniran et al., 2008; Xu, 2010a). Xu (2010a) cited that broad categories exist in successfully transitioning the IEN. Language and communication are primary challenges as these skills are fundamental to providing safe and effective nursing care (Xu, 2010a). Another challenge is the variance in nursing practice including the role and expectation of the nurse in the U.S. health care system (Xu, 2010a). Other factors to consider are marginalization, discrimination, and racism (Xu, 2010a, p. 204). Because of bias, IENs

may encounter unfair treatment, stereotyping, and rejection by peer or patient. Xu (2010a) asserted that discrimination may be an outright injustice such as bullying or passing the IEN over for promotion. Additionally, cultural adjustments can be difficult for IENs as differences likely exist in one's values, norms, and expectations. *Acculturation* is the process of adjusting to the behaviors and attitudes of another group (IOM, 2011). According to the IOM (2011), acculturation of IENs can be divided into four phases: (a) acquaintance, (b) indignation, (c) conflict resolution, and (d) integration (p. 588). The integration phase of the acculturation process to transition IENs into practice takes approximately twelve months (Nichols, Davis, & Richardson, 2010). Preceptors should be available during the entire time. After approximately twelve months, it is expected that IENs will feel confident in their abilities and that IENs will have reconciled their differences between native and host culture (Nichols et al., 2010).

Xu (2010b) confirmed that globalization is a mega trend in nursing that will continue to accelerate the use of IENs. Xu (2010b) recommended that core competencies of an evidence-based IEN transition program be identified to promote an international policy. Xu (2010b) forecasted that regulatory agencies in the United States will likely require transition programs for all IENs deploying positions. The United Kingdom and Australia have IEN transition regulation policies in place (Xu, 2010b). Organizational leaders benefit from taking proactive measures to reduce the potential negative effects of transitioning IENs (Nichols et al., 2010; Xu, 2010a).

Cultural competence. Purnell et al. (2011) asserted that cultural competence requires collaborative efforts in the health care system. There are four elements

necessary in developing a culturally competent organization: (a) administration and governance, (b) orientation and education, (c) language, and (d) staff competencies (Purnell et al., 2011, p. 7). The administration and governing boards of an organization hold ultimate responsibility for ensuring that cultural competence occurs (Purnell et al., 2011). When selecting individuals for posts, the ethnic diversity of the community served should be represented (Purnell et al., 2011). Second, administrators must be confident in differentiating rules. Policies to ensure cultural competence are different from policies to ensure patient or staff member safety (Purnell et al., 2011). Another essential consideration is the creation of an ethics committee, which should include representative members of the community, those with the same race or the same ethnicity. Furthermore, a diversity committee is crucial and should include staff members, managers, chaplains, and representative members of the community (Purnell et al., 2011).

Human and fiscal resources should be allocated to diversity training. According to Purnell et al. (2011), administrators can quickly evaluate whether the ethno-cultural groups are being represented by considering the following questions: (a) are the organization's programs and activities advertised in the community, and in a language the community understands; (b) do pictures and posters represent the employees and the populations served; and (c) are translation services readily available? Furthermore, questions that are specific to the human resources department: (a) do the hiring activities reflect the diversity of the community; (b) do performance evaluations reflect cultural competence; (c) are conflict and grievance procedures written in multiple languages; (d)

are job satisfaction surveys written in multiple languages; (e) do mentoring and orientation programs exist for diverse staff populations; (f) does the IEN receive training on the diversity of professions within U.S. health care systems; (g) does the IEN receive training on insurance reimbursement systems, nursing practices or standards of care including the practices of defensive charting in the United States; and (h) are English as a second language classes available for staff members?

Purnell et al. (2011) cited language as a fundamental necessity to providing quality care. When organizations hire employees who find English difficult, they have an obligation to provide training to enhance communication skills (Purnell et al., 2011). Another component of cultural competence is the staff member competencies. Although staff members cannot be expected to learn all of the cultures of the world, direct care staff members must understand the cultural framework for the assessment of patients to whom they provide care (Purnell et al., 2011). Staff members must avoid stereotyping, although staff members must concurrently utilize knowledge of practice to promote health and well-being, comfort death and dying, and provide an appropriate response to rituals that vary across culture and religion (Purnell et al., 2011).

IEN studies. Xu, Zaikina-Montgomery et al. (2010) examined a 2004 national sample of RNs to discern characteristics of the IEN population. There were nonsignificant differences in factors of age and gender between the IEN population and the RN population in the United States (Xu, Zaikina-Montgomery et al., 2010). Significant differences were discovered in basic nursing education, employment status, position title, patient responsibility, and job satisfaction (Xu, Zaikina-Montgomery et al.,

2010). Significantly higher proportions of the U.S. nurse population (41.6%), as compared to IEN nurse population (8.7%), held an associate's degree (Xu, Zaikina-Montgomery et al., 2010, p. 21). Furthermore, significantly higher proportions of the IEN population were employed full-time, and worked significantly more hours per week, than the U.S. nurse population. The primary position titles and patient responsibilities for the IEN population were significantly different from the U.S. nurse population. The IEN workforces were more likely to hold staff nurse positions or direct patient care positions than they were to hold management positions. Significant differences in job satisfaction were discovered with the U.S. nurse population reporting extreme job satisfaction, more often than the IEN population (Xu, Zaikina-Montgomery et al., 2010). Whether the job satisfaction differences are related to IEN language barriers or frustrations, work behaviors or cultural norms, or unique challenges, the explanation has yet to be discovered (Xu, Zaikina-Montgomery et al., 2010). Because IENs play a vital role in caring for citizens of the United States, researchers should direct future studies to understanding the IEN population.

Seeking to understand the relationship between IEN job satisfaction and acculturation, Ea, Griffin, L'Eplattenier and Fitzpatrick (2008) surveyed a sample of Filipino RNs working in the United States ($N = 96$). All of the participants had received their entry level nursing education in the Philippines. Descriptive analysis indicated that the average length of residency in the United States was 15.5 years (Ea et al., 2008, p. 49). Mean acculturation scores indicated that participant acculturation was closer to American culture than Filipino culture. Job satisfaction was positively correlated to the

level of acculturation. Age, length of residency in the United States, and level of acculturation significantly predicted perceptions of RN job satisfaction. Although a convenience sample of 96 participants was used, and the researchers recommended comparative studies be completed, their findings have provided a broader understanding of the influence of acculturation (Ea et al., 2008). The implications for professional practice include support for the development of acculturation programs, directed at assisting the transition of IENs into the United States, the health care system, and the mainstream society (Ea et al., 2008).

Kim-Godwin, Baek, and Wynd (2010) acknowledged there is limited research conducted on the growing number of IENs employed in the United States. Using a sample population of Korean American nurses (N = 221), Kim-Godwin et al. (2010) sought to fill the gap in literature by measuring and examining factors associated with professionalism. *Professionalism* was described as the degree of loyalty an individual exhibits to the principles and characteristics of a specific professional identity. Five attributes of professionalism were cited: (a) support for professional organization, (b) belief in public service, (c) belief in self-regulation, (d) a sense of calling to the field, and (e) practicing autonomy (Kim-Godwin et al., 2010). Using the Professionalism Inventory Scale (HPI), Kim-Godwin et al. discovered membership to a professional organization correlated with higher total scores on the HPI. Furthermore, Korean American nurses who did not advance their nursing education in the United States had the lowest scores on the HPI. In addition, Korean American nurses who attended and graduated from American universities presented with significantly higher scores on the HPI than did

those nurses who completed their final degrees in Korea. The implications for professional practice are important considerations. When hiring IENs, recognize and value the education and experience these professionals bring to the U.S. workforce. Moreover, develop orientation programs that are tailored to promote a smooth transition, encourage and support continuing education in the United States, and provide the communication coursework necessary for the IEN to interact as an important part of the interdisciplinary team (Kim-Godwin et al., 2010).

Ryan (2010) sought to understand the experiences of IENs and thereby conducted qualitative naturalistic inquires of IENs working in America. The purposeful sample ($N = 12$) included nurses educated in Ghana, India, Ireland, Nigeria, Philippines, Poland, Romania, and Taiwan. Five major themes emerged during the interviews conducted: (a) *reflection* on the transition, dialog about the push versus pull phenomenon; (b) *struggling* to understand the personal and professional differences, dialog about adjusting, communicating, and practicing as a nurse; (c) *connecting* to others, dialog about family and friends at home, colleagues from their origin countries, and American nurses or American friends; (d) *prayer* and having faith, dialog about the importance of support from faith-based communities; and (e) feeling *devalued*, dialog about unfriendly behaviors, racism, and prejudice attitudes. The implications for professional practice are an endorsement for formal transition programs, which include mentoring, assistance with resolving communication difficulties, and training on the use of U.S. health care technology (Ryan, 2010). Moreover, IEN transition may be improved if American nurses were educated about the experiences of IENs working in America (Ryan, 2010).

Affirming that there has been little research conducted so far, Ryan suggested that researchers seek to examine factors that surround the IEN's experience in America.

In summary, scholars have documented the migration of health care workers worldwide for many years, and it appears that the migration of nurses is not a new phenomenon. The literature review has revealed that researchers agree that the IEN workforce will continue to play a vital role in the 21st-century. Efforts should focus broadly on improving the IEN's transition into the U.S. health care system. Increasing diversity in the nursing workforce is universally strategic to providing culturally relevant care to an increasingly diverse population of citizens in the United States. Next is the literature review of factors associated with aspects of RN job satisfaction.

Aspects of RN Job Satisfaction

The section on aspects of RN job satisfaction includes literature relevant to the research question: To what extent do personal satisfaction scores and satisfaction with workload scores correlate with global satisfaction scores? With respect to aspects of job satisfaction, as measured by the MJS instrument, the first heading of this section is personal satisfaction. Personal satisfaction includes subsections of: (a) shared governance, (b) autonomy, (c) stress resilience, (d) job burnout, and (e) job turnover. Literature that is relevant to other elements considered on the MJS instrument is presented thereafter: (a) satisfaction with workload, which contains a subsection on environmental factors; (b) satisfaction with professional support; (c) satisfaction with pay; and (d) satisfaction with standards of care.

According to Toode, Routasalo, and Suominen (2011), researchers have yet to discern the work motivation of contemporary staff nurses. Toode et al. (2011) conducted a literature review to examine published research on the work motivation of nurses. The researchers retrieved and assessed 1,783 citations, many of which were omitted from final review because the research was dated before 1990 or unrelated to conditions of the working staff nurse. Of the studies reviewed in the final paper (N = 24), few researchers had clearly defined the concept of nurses' work motivation (Toode et al., 2011). Toode et al. (2011) concluded that universal definitions of work motivation are lacking in nursing research, and the absence of such has hindered the ability to generalize research conducted to date. When exploring the work motivation of nurses, researchers should diligently consider job satisfaction and emotional exhaustion as these factors are essential in understanding motivational theory (Toode et al., 2011).

Hong Lu et al. (2011) conducted a literature review to examine job satisfaction (N = 100) and concluded that job satisfaction is closely related to the working environment of nurses. Role conflict, ambiguity, perception, and content negatively affect job stress, and organizational and professional commitment (Hong Lu et al., 2011). Hong Lu et al. (2011) emphasized that more research is necessary to understand the relative importance of the multidimensional constructs that affect the job satisfaction of nurses. The absence of a robust, comprehensive, and causal model of job satisfaction is undermining the discovery of workforce solutions directed at improving the job satisfaction of nurses employed in hospitals (Hong Lu et al., 2011).

Personal satisfaction. The personal satisfaction of a RN is a multidimensional construct (McGlynn, Griffin, Donahue, & Fitzpatrick, 2012) with a theoretical base on the meaningfulness of the professional role and the quality of the relationships established (Hill, 2011). Although Nightingale's distinguished work fits the description of a nursing theory and thereby forms a theoretical base, the development of nursing theory is a relatively newer construct with the most published work occurring in the 1960s, 1970s, and later (Rundio & Wilson, 2010). Nursing theory distinguishes the focus of nursing from other health care professions (Dickson & Wright, 2010). Nursing theory is a systematic guide that promotes critical thinking, and thereby contributes to professional autonomy, by clarifying values and assumptions, and by guiding practice, education, and research decisions within the profession (Dickson & Wright, 2010). Some researchers have considered the views surrounding nursing theory and asserted that models of nursing may be ineffectual in connecting nursing theory with contemporary nursing practice (McCrae, 2012).

***Shared governance*.** The empowerment of RNs through professional practice models of shared governance is well-documented (Barden, Quinn-Griffin, Donahue, & Fitzpatrick, 2011). The concept of shared governance was introduced to the nursing profession in the 1980s through the work of Porter-O'Grady (Porter-O'Grady, Hawkins, & Parker, 1997). Porter-O'Grady et al. (1997) asserted that the principles of shared governance, partnership, equity, accountability, and ownership, must occur at the point of service (Porter-O'Grady et al., 1997). Shared governance provides an opportunity for nurses to exercise control over their practice (Barden et al., 2011). Barden et al. sought to

reaffirm the relationship between the perception of shared governance and the perception of empowerment among nurses. Using a sample of RNs employed in a U.S. hospital (N = 158), Barden et al. administered the Index of Professional Nursing Governance (IPNG) and the Conditions of Work Effectiveness II Questionnaire (CWEQ-II). Barden et al. found that the Pearson correlation coefficient (r) on the sum of the IPNG and the sum of the CWEQ-II indicated a significant relationship between the variables. A significantly positive relationship was discovered between a nurse's perception of shared governance and a nurse's perception of empowerment (Barden et al., 2011). The implications for professional practice are organizational efforts to deploy models of shared governance. At an early stage of project implementation, approximately six to twelve months after shared governance principles were enacted, nurse participants perceived themselves to be moderately empowered (Barden et al., 2011).

The structural empowerment of nurses is a fundamental component of the Magnet Recognition Program (American Nurses Credentialing Center [ANCC], 2011). In the 1980s, the American Academy of Nursing (AAN) commissioned researchers to explore hospital workplaces and discover factors that affected RN vacancy rates and RN turnover rates (Drenkard, 2010; Sovie, 1984). The AAN nurse researchers discovered themes, which were later described as forces of magnetism (Drenkard, 2010; Sovie, 1984). This original AAN research serves as the foundation of the Magnet Recognition Program (Drenkard, 2010).

The ANCC described the Magnet model as comprised of five essential components: transformational leadership; structural empowerment; exemplary

professional nursing practice; new knowledge, innovations, and improvements; and empirical quality outcomes (ANCC, 2011, A New Vision for Magnet, para. 1). The journey to Magnet excellence is seen as a strategic force toward global improvement (Drenkard, 2010). From a business perspective, the Magnet model reportedly engages staff in the operational functions of the organization and consequently has significant capacity to improve efficiency and effectiveness at the point of service (Drenkard, 2010). The Magnet model reportedly reduces business costs through increased nurse satisfaction, increased patient satisfaction, and superior clinical outcomes (Drenkard, 2010). Hospitals that incorporate features of the Magnet model are associated with better nurse and patient outcomes (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Faller, Gates, Georges, & Connelly, 2011).

Autonomy. In Greece, seeking to understand the relationship between professional autonomy and job satisfaction, Ilopoulou and While (2010) conducted research on a sample of critical care RNs (N = 431). Researchers discovered that a RN's appointment level, category of critical care unit, and association with a professional organization were independently associated with autonomy (Ilopoulou & While, 2010). In addition, a moderate association existed between autonomy, job satisfaction, role conflict, and role ambiguity, but no relationship existed between job satisfaction and role conflict or role ambiguity (Ilopoulou & While, 2010, p. 2520). The majority of nurses in this study reported moderate overall autonomy. Female nurses reported higher levels of autonomy, and younger nurses reported statistically significant lower levels of autonomy (Ilopoulou & While, 2010, p. 2520). The implications for professional practice include

measures to educate, enhance, and encourage RNs to achieve maximum autonomy; doing so may increase job satisfaction and staff retention efforts (Ilopoulou & While, 2010).

Malliarou, Sarafis, Moustaka, and Constantinidis (2010) explored RN job satisfaction, work related stress, job turnover, and patient satisfaction using a sample of Greek army and civilian nurses (N = 117). Registered nurses who had the greatest sense of job satisfaction practiced with autonomy, used independent judgment, and applied critical thinking skills in practice (Malliarou et al., 2010). Additionally, lack of coworker support and lack of professional recognition was related to job dissatisfaction in civilian nurses (Malliarou et al., 2010). Moreover, 89.9% of civilian RNs wanted their profession modified so to be an independent health professional, while only 35.9% of the civilian RNs felt professionally equal to other health professionals (Malliarou et al., 2010, p. 49). Malliarou et al. speculated that because Greek hospitals are doctor-centered, interdisciplinary collaboration is hindered, and as a result, civilian RN job satisfaction was significantly less than army RN job satisfaction. The implications for professional practice include initiatives to identify strategies to increase interdisciplinary teamwork, and in doing so, clarify Greek civilian nursing roles. Implementing innovative programs, which address the effect of low morale and high stress, may enhance RN job satisfaction (Malliarou et al., 2010).

DeMilt, Fitzpatrick, and McNulty (2011) conducted research to understand job satisfaction among a national sample of nurse practitioners (NPs) in the United States (N = 254). DeMilt et al. (2011) examined differences in NP job satisfaction based on anticipated job turnover. The Misener NP Job Satisfaction Scale (MNPJSS) was used to

measure NP job satisfaction, whereas the Anticipated Turnover Scale (ATS) was used to provide an estimation of voluntarily terminating the current job (DeMilt et al., 2011). DeMilt et al. discovered that NPs were most satisfied with practice partnership and collegiality, and least satisfied with benefits. In the MNPJSS subscale, NPs ranked aspects of job satisfaction, from highest to lowest, respectively: challenging work; autonomous practice; professional, social, and community interaction; opportunity for professional growth; and time constraints (DeMilt et al., 2011, p. 46). The most common reason for a NPs intention to leave his or her current position was perceived little control over practice, and limited opportunities for career advancement (DeMilt et al., 2011). The implications for professional practice are important considerations to NP recruitment and retention efforts; to the extent possible, employers should seek to provide NPs with a stimulating work environment that promotes autonomy (DeMilt et al., 2011).

Stress resilience. While exploring elements of RN job satisfaction, Larrabee et al. (2010) affirmed the influence of stress resiliency. Under a model of psychological empowerment, stress resiliency is deemed the outcome of adaptable interpretive styles (Larrabee et al., 2010). Interpretive styles are fundamental in determining how individuals empower or disempower themselves (Larrabee et al., 2010). When faced with the same situation, persons derive conclusions based on differences in their interpretive styles. Stated differently, Larrabee et al. asserted that interpretive styles affect a person's ability to judge subjective data, verify reality, and enhance meaning using objective facts. Larrabee et al. defined stress resiliency as the ability to (a) logically envision future tasks or events while concurrently focusing attention on

solutions, opportunities, and enjoyment of accomplishments; (b) choose freely among options and cope proficiently with obstacles; and (c) appreciate the talents, strengths, and weaknesses of one's own abilities, as well as the talents, strengths, and weaknesses of members of the team.

An example of an interpretive style is *deficiency focusing*. Deficiency focusing is evidenced by persistently blaming oneself for failures, overstating the obstacles, or ineffectively coping with the obstacles (Larrabee et al., 2010). Deficiency focusing influences work motivation negatively, and this is contrary to *skill recognition*. Skill recognition is an interpretive style of appreciating one's probability of successfully achieving a task (Larrabee et al., 2010). Persons high in skill recognition tend to appreciate success as it correlates directly to appreciation for one's own abilities. Another interpretive style is *necessitating,* which is an ability to judge or prioritize tasks assigned. Necessitating is a mental process, involving the will, impulse, or desire to view tasks as imperative demands versus desirable actions (Larrabee et al., 2010). In a sample of RNs (N = 464) employed in acute care hospitals, in West Virginia, stress resiliency was determined to be a predictor of emotional empowerment, conditional stress, and job satisfaction (Larrabee et al., 2010, p. 82). The implications for professional practice include the advantages of enhancing RN stress resiliency, which are: (a) increased psychological empowerment; (b) reduced situational stress; (c) increased job satisfaction; and (d) and predictably, an increased intent to stay (Larrabee et al., 2010).

In an effort to retain nursing staff, Matos, Neushotz, Quinn-Griffin, and Fitzpatrick (2010) affirmed that researchers should seek to discover factors that influence

job satisfaction. Matos et al. (2010) examined the relationship between stress resilience and job satisfaction. The Resilience Scale was used to measure the degree of individual resilience, defined as an ability to adapt to stress in the workplace (Matos et al., 2010, p. 308). High levels of resilience correlated to high levels of job satisfaction (Matos et al., 2010). Moreover, in examining the job satisfaction subscales, it was discovered that professional status had the highest mean rating while physician-nurse interaction had the lowest mean rating (Matos et al., 2010, p. 311). Although limited by a small sample size (N = 32) and a single collection site, the implications for professional practice are threefold: (a) education directed at teaching stress resilience may prove beneficial; (b) professional status is important, nurses who feel positive about their status are more satisfied; and (c) interpersonal relationship and effective communication are vital components of RN job satisfaction (Matos et al., 2010).

Job burnout. Burnout is described as a phenomenon that is reaching epidemic proportions in North America (Maslach & Leiter, 1997). Maslach and Leiter (1997) asserted that job burnout and personal stress may be an inevitable consequence of modern-day employment, as organizations are increasingly operating in highly competitive global markets (Maslach & Leiter, 1997). When organizations are built on foundations of debt, fiscal obligations take precedence and organizational leaders often endure relentless pressure to generate steady cash flow. Consequently, the long-term objective to create excellent products or offer excellent services may become irrelevant in the frantic pace to secure short-term fiscal performance (Maslach & Leiter, 1997). Particularly destructive to the workplace community is that, as organization leaders

perfunctorily cash out on the intrinsic worth of the company, the employees are deprived of their fundamental right to achieving intrinsic job satisfaction. Rather than extending employees an opportunity to earn a living and achieve personal satisfaction, employees begin to feel that they have sacrificed their livelihoods, and their ambitions, for the good of the corporation. The failing corporate citizenship that erodes the values, dignities, and spirits of employees is not sustainable. Burnout is thriving and according to Maslach and Leiter, burnout is not a problem caused by any single individual, but rather it is a problem caused by the social environment in which individuals work. When organizational leaders fail to recognize the human component of the employee, the risk of employee burnout increases, as does the price organizations must pay for burnout, which is the economic hardship of employing a workforce that is no longer dedicated, engaged, creative, nor productive (Maslach & Leiter, 1997).

Bentley (2010) discussed the nursing work environment for the consequence it has on nurse burnout and nurse retention. Nurse burnout was described as an emotional response that results in exhaustion, depersonalization, cynicism, ineffectiveness, and decreased personal accomplishment (Maslach & Leiter, 1997). Nurse burnout is a global nursing problem (Bentley, 2010). Occupational hazards in the work environment lead to nurse burnout. Stress can lead to *compassion fatigue* and *moral distress*, which can damage the reputation of the nursing profession and intensify the issue of nurse burnout (Bentley, 2010). Compassion fatigue is an accumulation of stress and strain resultant from providing care to those patients who have suffered (Bentley, 2010). Moral distress occurs when a nurse knows the ethically appropriate action to take but is unable to act

upon it, and consequently, he or she is forced to act in manner conflicting with his or her personal and professional values (Bentley, 2010). Moral distress has the capacity to undermine the integrity and authenticity of a nurse. Managers often view nurse burnout as an individual's problem, which is contrary from the truth as nurse burnout is an organization's problem (Bentley, 2010). Nurse executives should carefully consider the burnout problem in entirety as those at risk seem to be the most talented and educated professionals (Bentley, 2010). A healthy work environment occurs when a nurse feels the opposite of burnout, which is energized rather than exhausted, engaged rather than depersonalized, and efficient rather than inefficient (Bentley, 2010).

In China, Su, Wang, Bian, and Peng (2010) sought to understand factors that affect professional nurses' job burnout. Nurses were selected to participate from six private facilities, various hospital units were represented ($N = 267$). Su et al. (2010) administered a survey instrument, which measured three dimensions of job burnout: emotional exhaustion, depersonalization, and personal achievement. Job burnout was prevalent among the entire population although the reported level of job burnout in male nurses was less than female nurses. Pediatric unit nurses had the highest degree of job burnout. Emergency room nurses had the lowest degree of personal achievement. As the sum of patients directly under a RN's care increased, so did the incidence and degree of burnout. However, as RN satisfaction with wages increased, the degree of burnout decreased. The implications for professional practice include initiatives aimed at decreasing nurse burnout, which include provisions for ancillary and other support necessary to improve the working conditions of nurses in hospitals (Su et al., 2010).

In Canada, Leiter and Maslach (2009) sought to discover whether nurse burnout could predict nurse turnover. Nurses completed a survey instrument ($N = 667$) to disclose views on areas of work life, burnout, and turnover intentions. Researchers discovered cynicism was a key factor in predicting nurse turnover (Leiter & Maslach, 2009). Cynicism played a pivotal role in turning experiences into action plans. The psychological withdrawal from work was found to be a predictor of innermost intentions to withdraw completely. The implications for professional practice include initiatives to distribute workloads fairly so that they are manageable. Workplace enthusiasm may improve if nurse executives promote a model that increases nurses' perceived fairness of organizational values. Furthermore, recognizing and acknowledging employee contributions in a fair and meaningful way is important in organizational efforts to reduce cynicism (Leiter & Maslach, 2009).

In the United States, Cimiotti, Aiken, Sloane, and Wu (2012) examined the effects of nurse burnout and the association to hospital acquired infection rates. Using multivariate analyses, researchers concluded that nurse burnout was positively associated with urinary tract infections and surgical site infections (Cimiotti et al., 2012). Urinary tract infections and surgical site infections are two of the most commonly reported hospital acquired infections. The researchers have surmised that staff members exhibit cognitive detachment when they experience burnout, and consequently have lapses in hand hygiene and other infection control routines. Projecting the effects of reducing staff member burnout by 10%, the researchers cited an approximate annual reduction of 4,160 infections, which equated to an approximate annual cost savings of $41 million (Cimiotti

et al., 2012, p. 488). This research study is the first to evidence that nurse burnout is positively associated with higher infection rates in hospitals. The implications for professional practice are initiatives to improve the work environment of nurses and thereby reduce the incidence of nurse burnout and the incidence of hospital acquired infections.

Job turnover. Nurse turnover is challenging health care organizations by multiple measures. Jones (2008) examined the costs associated with nurse turnover and explained the methodology. Cost calculations for nurse turnover are customarily divided into two categories: prehire costs and posthire costs (Jones, 2008). Prehire subcategorical budgets included the cost of advertising, the cost of hiring, and the cost of vacancy (Jones, 2008). Vacancy costs can be significant considering the immediate cost of inadequate staffing: the cost of temporary staff, the cost of overtime, and the cost of closed beds or patient deferrals (Jones, 2008). Posthire subcategorical budgets included the cost of terminating the prior employee, the cost of new employee orientation and training, and the cost of productivity loss related to a delay in achieving a preturnover productivity level (Jones, 2008). Jones affirmed that organizations may encounter additional costs associated with nurse turnover. The additional costs are complex and may compound, and include: (a) gaps in continuity of care; (b) slow discharge planning that can result in increased patient lengths of stay; (c) inconsistent use of company policies and procedures; (d) communication difficulties; (e) nurse fatigue, burnout, or errors; and (f) the diversion of leadership attention and resource away from core business initiatives (Jones, 2009). The

cost of RN turnover is not only detrimental to an organization's performance, but it is also potentially detrimental to the patient and the staff safety (Jones, 2009).

The reported cost of nurse turnover in 2002 was examined and adjusted to represent an approximate 2007 cost (Jones, 2010). The fiscal year 2007 cost of turnover per RN ranged from an approximate $82,000 to an approximate $88,000 (Jones, 2010, p. 15). The lesser cost would be expected if the new hire were experienced (Jones, 2010). The higher cost would be expected if the new hire were inexperienced (Jones, 2010). The limitations of the estimated costs were disclosed as an assumption that baseline year 2002 figures and calculations remained relatively unchanged into year 2007 (Jones, 2010). On a macrolevel, knowledge of the cost associated with nurse turnover plays a pivotal role in understanding quality of care (Jones, 2010). On a microlevel, nurse retention efforts should be an organizational priority as chronic shortage exacerbates more turnovers and hinders the attraction of new nurses to the profession (Jones, 2010). On a societal level, nurse turnover impedes society's access to primary nursing services as high patient-to-nurse ratios limit a health care organization's ability to provide essential services (Jones, 2010).

To comprehend factors associated with unacceptable rates of nurse turnover, Webster, Flint, and Courtney (2009) conducted in-depth exit interviews ($N = 13$). According to Webster et al. (2009), the nurses who participated in this research had resigned from a 942-bed acute care teaching hospital in Australia. The researchers sought to understand the factors associated with a nurse's decision to resign. Resultant from their in-depth interviews, Webster et al. discovered that five themes surrounded two

domains of a satisfactory work practice environment. According to Webster et al. the two domains were work life and personal life. Themes that emerged under the domain of work life were safe or unsafe, valued or devalued, and an ability or inability to accomplish tasks. Themes that emerged under the domain of personal life were an opportunity or no opportunity for professional growth, and organizational flexibility or inflexibility. The exit interviewees disclosed innermost opinions of the work practice environment that fostered the researcher's ability to develop thematic subcategories. Some of the disclosed key words or phrases were powerlessness, disrespect, negative culture, workplace violence, reward for effort, support, collegiality, failure to listen, sink or swim, communication, management issues, nursing duties, professional advancement, barriers to learning, scheduling, and work-family balances (Webster et al., 2009, p. 42). Webster et al. concluded exit interviews are useful in identifying strategies for nurse retention.

In discussing the association between RN job turnover and RN job satisfaction, Wisotzkey (2011) cited that nurses encounter job dissatisfaction when they perceive they are assigned to the wrong position. Unclear responsibility, poor communication, and sheer boredom are examples of reasons that nurses perceive they are in the wrong position (Wisotzkey, 2011). Nurse managers should set individualized employee goals to increase productivity and to reduce job turnover. Goals should be validated between management and employee, and be specific and reasonable to ensure success (Wisotzkey, 2011). Furthermore, managers should teach nurses strategies to increase productivity. As an example, the 80/20 rule may facilitate setting priorities and meeting deadlines

(Wisotzkey, 2011). Managers should focus resources on tasks that must be completed, while simultaneously focusing attention on simplifying assigned tasks wherever possible (Wisotzkey, 2011).

Satisfaction with workload. Hoi, Ismail, Ong, and Kang (2010) considered time honored patient acuity measurement models that are commonly used to determine the RN staffing needs on a unit per shift or per day, essentially determining the nurse-to-patient ratio. The validity of outdated patient acuity measurement models was challenged. An improved prototype was proposed to measure the intensity of a nurse's workload, labeled the Nursing Workload Intensity Measurement System (WIMS). According to Hoi et al., all nursing units of a 1,500 bed acute care hospital in Singapore participated in an observatory period of 7 days ($N = 25$). Critical indicators of nurses' workload were measured by survey instrument and direct observation. Researchers discovered significant increases in nursing time required for low-acuity units, from an estimated 90.5 to actual 177.1 hours per day (Hoi et al., 2010, p. 44). The increase in nursing hours per patient per day (HPPD) reflects the emerging responsibilities of the 21st-century nurse. Nurses are increasingly involved a wide range of activities that are fundamentally vital to patient care, which include communicating and coordinating with the interdisciplinary team. Workload measurement systems should be systematically reviewed as nurses are functioning in a rapidly changing work environment. Moreover, nurse managers must dissociate the workload prediction from patient acuity, as Hoi et al. (2010) has evidenced that patient dependency and acuity status does not correlate with the nurses' workload.

Environmental factors. Applebaum, Fowler, Fiedler, Osinubi, and Robson (2010) used a correlational research design to investigate nursing stress, job satisfaction, and turnover intent. Applebaum et al. (2010) considered another variable in the equation, the environmental factor. Environmental factors in health care facilities have increasingly been recognized for their adverse effects on RN satisfaction (Applebaum et al., 2010). Air quality, temperature, humidity, noise, lighting, and aesthetics are vital considerations of perceived nurse stress (Applebaum et al., 2010). Using a sample of RNs from a large acute care hospital in New Jersey (N = 116), researchers discovered that a significant relationship existed between: (a) noise and perceived stress, (b) perceived stress and job satisfaction, (c) job satisfaction and turnover intention, and (d) perceived stress and turnover intention (Applebaum et al., 2010, p. 323). The implications for professional practice include support for efforts to mitigate negative environmental factors in health care facilities (Applebaum et al., 2010). Actions to diminish environmental factors are worthy investments that have the potential to reduce RN perceived stress and enhance RN job satisfaction (Applebaum et al., 2010).

Trinkoff et al. (2011) examined factors of the work environment and the effect it has on patient outcomes. The nursing work environment was described as an umbrella that covers factors such as staffing, work schedule, job demands, and practice environment (Trinkoff et al., 2011). Balance theory was proposed as the conceptual framework in the research to consider the job demands placed on the nurse (Trinkoff et al., 2011). Job demands were theorized to have two dimensions: psychological and physical. Interruptions were cited as psychological demands while heavy lifting was

cited as physical demands (Trinkoff et al., 2011). An increase in demand for the nurse adversely increased the workload and consequently adversely affected job performance. Furthermore, and in contrast, a reduced demand on the nurse favorably decreased the workload and consequently favorably affected job performance. Using a cross-sectional secondary data analysis of hospitals in North Carolina and Illinois (N = 71), Trinkoff et al. concluded that increased psychological demands negatively affected select patient outcomes. The work environment had a limited moderating effect on select outcome relationships in this study (Trinkoff et al., 2011). The implications for professional practice are for nurse executives to consider all of the dimensions of a nurse's job demand, including his or her work schedule, as these factors are considered modifiable work conditions that significantly influence patient outcomes (Trinkoff et al., 2011).

In Finland, Elovainio, Kuusio, Aalto, Sinervo, and Heponiemi (2010) examined factors associated with a nurse's work environment. Elovainio et al. (2010) sought to discover whether temporary work contracts and shift work were associated with indicators of a nurse's well-being. Indicators of well-being were described as intensities of psychological distress, job involvement, and work ability. Psychological distress was defined by psychosocial factors such as job demand, job control, and organizational justice (Elovainio et al., 2010, p. 1082). A sample of RNs was drawn from the database of Finnish nurses (N = 2,152). With linear regression analysis, Elovainio et al. concluded that temporary work contracts were negatively associated with a nurse's work ability and job involvement. Furthermore, shift work was negatively related to job involvement and to work ability, and shift workers reported increased levels of psychological distress. The

researchers discovered no significant variation in the health behavior of nurses who participated in this study.

Elovainio et al. (2010) asserted support for the allocation of resources necessary to improve the environmental factors and the psychosocial factors associated with a RN's job. An increase in workload and a reduction in job control are factors detrimental to a nurse's work environment. Heightened attention to the work environment of contract workers and shift workers is warranted. A nurse's trust in the fairness of management is crucial when nurses feel uncertain in situations that are unfamiliar. Due diligence in building trust between managers and staff is necessary for the positive effects it has on a nurse's psychosocial factors. The cost associated with building trust or enacting forms of justice is minimal in comparison to other initiatives in health care. Trust can be built by simply expressing concern for employees, or being available for them when they are most vulnerable. For example, clinical support is essential when excessive workloads exist, or stressful situations occur (Elovainio et al., 2010).

According to Kramer and Schmalenberg (2008), the description of what constitutes a healthy work environment for RNs is controversial. The attributes cited by professional organizations and nurse executives are considerably different from the attributes cited by staff nurses (Kramer & Schmalenberg, 2008). Leadership is the single attribute that all parties agree is essential to a healthy work environment (Kramer & Schmalenberg, 2008). For the staff nurse, a healthy work environment is productive. Staff nurses focus their efforts on meeting the patient needs. Hence, at the end of the shift, staff nurses want to feel satisfied that they have provided quality care (Kramer &

Schmalenberg, 2008). There are eight essential attributes of a healthy work environment, from a staff nurse's perspective: (a) work with other nurses who are clinically competent, (b) collegial and collaborative interdisciplinary relationships, (c) autonomy in clinical decision making, (d) supportive nurse manager, (e) control of nursing practice, (f) support for education, (g) perception that staffing patterns are adequate, and (h) organizational culture in which concern for the patient is paramount (Kramer & Schmalenberg, 2008, p. 57).

Moreover, a healthy work environment is imperative for society as the health care industry has structurally empowered staff nurses as the *gatekeepers* (Kramer & Schmalenberg, 2008). The notion of gatekeeper is crucial, as it signifies the central control staff nurses have over access to a patient's status (Kramer & Schmalenberg, 2008). For example, as advocates and guardians of safety, staff nurses are surveillance officers empowered to observe, and devoted to transmitting, patient data to the team. Staff nurses communicate and coordinate interdisciplinary care, which provides seamless patient transfers from one professional to another (Kramer & Schmalenberg, 2008). Health care administrators must consider the staff nurses' perspective when evaluating organizational structure, process, and outcome (Kramer & Schmalenberg, 2008).

Satisfaction with professional support. Porter, Kolcaba, McNulty, and Fitzpatrick (2010) explained that unionized work environments present challenges, which may be perceived as difficulties in managing and motivating employees. Porter et al. (2010) investigated the influence of a nursing labor management partnership (NLMP) on RN turnover and RN job satisfaction. The research was conducted in a large northeastern

U.S. medical center, which employed more than 2,100 staff nurses under labor contact agreements. The hospital was unique in having achieved Magnet recognition under a unionized nursing workforce, the combination of which was cited in less than 0.7% of all U.S. hospitals (Porter et al., 2010, p. 210). Porter et al. sought to identify methods to facilitate a collaborative partnership between nursing management and the labor organization. The following stages were essential in the development of the NLMP: (a) identifying a mutually perceived need or goal, (b) conducting a bipartisan assessment of the risk and the benefit, (c) realizing a mutually agreed upon commitment to assume the risk, (d) founding the NLMP relationship on a perceived positive outcome that enticed momentum for partnership, and (e) establishing a performance expectation that was clearly defined and mutually agreed upon (Porter et al., 2010). Porter et al. used a survey instrument administered before and after the NLMP were implemented and discovered that the RN turnover rates decreased while the RN job satisfaction scores increased. The implications for professional practice are important for nurse executives to consider in supporting NLMPs, which collaboratively were successful in boosting RN retention and improving RN job satisfaction (Porter et al., 2010).

Tsai and Wu (2010) sought to understand the relationship between organizational citizenship behavior, job satisfaction, and turnover intention. Tsai and Wu (2010) cited high nurse turnover rates and consequential high cost of human capital as the impetus for their research study. *Organizational citizenship behavior* (OCB) was defined as professional conduct that inspires staff to venture voluntarily to advance organizational operations, without pushing for personal rewards, fiscal gains, or other remunerates (Tsai

& Wu, 2010, p. 3564). For their research, Tsai and Wu recruited nurses from 11 hospitals in Taiwan (N = 237). Tsai and Wu discovered that RN job satisfaction had a significantly positive correlation with OCB, and a negative correlation with job turnover intention. The implications for professional practice include support for efforts aimed at reducing turnover intention by promoting comprehensive opportunities for OCB (Tsai & Wu, 2010). Furthermore, as a cost containment effort, health care leaders should focus on attracting and retaining nurses who are capable of exhibiting positive OCB (Tsai & Wu, 2010). Doing so has the potential to improve nurse job satisfaction and decrease turnover intention (Tsai & Wu, 2010).

Tsai (2011) considered the role of organizational culture and leadership behavior, and sought to understand the effects of each on RN job satisfaction. Using a sample of RNs in Taiwan (N = 200), Tsai used a survey instrument to ascertain nurses' beliefs on factors of management. Through regression analysis, researchers discovered that organizational culture was positively associated with leadership behavior (Tsai, 2011, p. 12). Furthermore, organizational culture was positively related to nurse job satisfaction (Tsai, 2011, p. 12). The implications for professional practice include the importance of organizational culture as a measurement of whether the establishment is a healthy and happy place to work (Tsai, 2011). Positive interdisciplinary interaction contributes to team communication and team collaboration, which in turn enhances RN job satisfaction (Tsai, 2011).

As a fundamental component for redefining management practice, Cortese, Colombo, and Ghislieri (2010) examined RN job satisfaction in an Italian acute care

hospital (N = 299). The researchers aimed to advance a model that illustrated the relationship between factors that affect job satisfaction. The model theorized that social support reduced work to family conflict (WFC), job demand, and emotional charge, while concurrently increasing job satisfaction (Cortese et al., 2010). Researchers discovered that supportive management and supportive coworkers not only decreased WFC, emotional charge, and job demand but also directly increased job satisfaction (Cortese et al., 2010). The implications for professional practice include support for the allocation of resources aimed at reducing WFC, job demand, and emotional charge (Cortese et al., 2010). This may be accomplished by improving front line support through the use of nursing coordinators, modified organizational work models, advanced family friendly policies, and extended individual counseling programs (Cortese et al., 2010). Moreover, European entities must consider WFC factors without delay as new legislation seeks to safeguard the psychological well-being of employees by requiring the evaluation of all psychosocial risks in the workplace (Cortese et al., 2010). It appears an improved work-family balance is not only exemplary practice, but it has become a European business mandate (Cortese et al., 2010).

The importance of perceived front line support, or perceived organizational support for front line staff, should be recognized and respected. A nursing practice environment that is perceived supportive has repeatedly shown to affect positively nurse job satisfaction and nurse job retention (Cortese et al., 2010; Choi, Flynn, & Aiken, 2011; Gutierrez, Candela, & Carver, 2012; Tyler et al., 2012). The positive implications of a supportive environment have been documented for staff nurses employed in hospitals

(Cortese et al., 2010), staff nurses employed in long-term care settings (Choi et al., 2011), as well as, nurses employed as nursing faculty (Gutierrez et al., 2012). The importance of providing new graduates with a supportive, confident preceptor, who serves as a mentor, is documented, as well (Tyler et al., 2012). Support can occur laterally, at the front line, peer-to-peer. Unit-level leadership can be effective in fostering the structural empowerment of nurses and assisting in creating healthy work environments, which positively affect well-being (Spence-Laschinger, Finegan, & Wilk, 2011).

Satisfaction with pay. Seeking to understand motives for premature departure from the nursing profession, Camerino et al. (2008) collected longitudinal data for the Nurses' Early Exit Study (NEXT study). According to Camerino et al., participants were staff nurses employed in the European hospitals of Belgium, Germany, France, Italy, Netherlands, Poland, and Slovakia (2004, N = 18,726; 2006, N = 7,516). Management nurses were excluded from this study. Using multivariate analyses, Camerino et al. reported nurses' satisfaction with sleep and working time gradually decreased when comparing day shift workers to night shift workers. In addition, permanent night shift workers had the highest scores in measures of work involvement, motivation, and satisfaction with pay. Moreover, rotating shift workers had the lowest scores in measures of work involvement, motivation, and satisfaction with pay. Camerino et al. speculated that the permanent night shift workers may have received incentives to work night shift, whereas rotating shift workers may have sensed a lack of voluntary choice and consequently felt less rewarded for the most atypical work pattern. The implications for professional practice include support for labor approaches that seek to protect the health

and well-being of workers by ensuring an adequate balance between human resources and work commitments (Camerino et al., 2008). Organizational leaders should seek to implement processes aimed at supporting nurses to continue employment until pension age (Camerino et al., 2008). Dynamic, continuous, and pertinent changes are necessary to improve the work conditions of nurses, thereby guaranteeing a balance between the demands and the resources (Camerino et al., 2008). Organizational leaders should carefully consider viable solutions to the following challenges associated with staff nursing: restorative sleep, job alternative, career reward, satisfactory pay, and personal recognition (Camerino et al., 2008).

Seago, Spetz, Ash, Herrera, and Keane (2011) examined nurses' job satisfaction using longitudinal data of a nationally representative sample of RNs employed in the United States (2004, N = 10,648; 2008, N =10,291). Seago et al. (2011) sought to understand if a unionized work environment affected job satisfaction. Union representation correlated negatively with job satisfaction in both 2004 and 2008 (Seago et al., 2011). However, in 2008, the relationship was not significant. In 2004 and 2008, income was a statistically significant predictor of job satisfaction (Seago et al., 2011). The implications for professional practice are mixed. It is possible that nurses seek union representation when they are not satisfied; however, it is also possible that unionized nurses speak freer about their dissatisfaction (Seago et al., 2011). Second, the economic environment in the nation declined between 2004 and 2008, and it is possible that nurses were less inclined to express dissatisfaction in the latter year (Seago et al., 2011). Last, with regard to pay, income was a significant predictor of job satisfaction although the

fiscal effect on the organization was relatively small (Seago et al., 2011). For example, a $1,000 increase in a nurse's annual income correlated to a 0.1% increase in job satisfaction (Seago et al., 2011, p. 113). Therefore, the projected 2004 figure to increase job satisfaction equal to 4% would be associated with a mere estimated organizational cost of $40,000 (Seago et al., 2011, p. 113). Organizational leaders should fully consider all factors relating to pay. Nurse executives generate value for unionized organizations when they effectively communicate with stakeholders (Seago et al., 2011).

Satisfaction with standards of care. In Israel, Goldman and Tabak (2010) examined factors that affect a nurse's job satisfaction and considered the independent variables: perceived actual and perceived ideal ethical climate. The sample of nurses included practical and registered nurses working in six internal medicine wards ($N = 95$). Goldman and Tabak stated the Ethical Climate Questionnaire was used to measure ethical situation concept dimensions of ethical criterion and locus of analysis. Researchers discovered demographic factors such as gender, job tenure, and level of education partially influenced a nurse's perception of ethical climate (Goldman & Tabak, 2010, p. 233). Incongruence or mixed feelings in a nurse's perception of whether adequate care was being provided negatively influenced nurse job satisfaction (Goldman & Tabak, 2010). Conversely, robust feelings in a nurse's perception of actual caring and actual service provided positively influenced all aspects of nurse job satisfaction (Goldman & Tabak, 2010). The implications for professional practice include support for the development of education programs, and practice guidelines, aimed at assisting nurses in clarifying ethical frameworks to apply to ethical dilemmas (Goldman & Tabak, 2010).

Summary and Transition

Registered nurse job dissatisfaction is a well-documented business problem that affects health care organizations worldwide. The literature review has revealed that scholars believe the nursing profession is changing. The workload is becoming more complex, and the workforce is becoming more diverse. Broad demographic considerations are worthy of examination as it appears a diverse workforce is universally strategic to providing cost-effective, quality care that is relevant. The independent variables in this study are generation, gender, and origin of training. The dependent variables are personal satisfaction and satisfaction with workload, as measured by scoring on the MJS instrument. I selected the research variables, after review of the literature, as the most presumed to advance knowledge of factors that might affect RN job satisfaction.

To align this research study with the objectives of the D.B.A. curricula, and the aims of scholar practitioners in the field, I have concentrated on applied theory. At the conclusion of this study, I will not generate new theories on job satisfaction but instead determine whether Herzberg's motivational theory can be confirmed or disconfirmed in a representative sample of RN participants in the United States. Based on Herzberg's theory, I expected to confirm that personal satisfaction scores would correlate higher with global satisfaction scores than satisfaction with workload scores. Evidence-based knowledge of whether Herzberg's theory is applicable to the 21st-century RN workforce, employed in the United States, might support nurse executive decisions to allocate resources to the development and implementation of sustainable solutions, aimed at improving job satisfaction.

In Section 1, I have presented multifaceted issues that nurse executives encounter in identifying and implementing strategies to enhance job satisfaction in a diverse association of stakeholders. The foundation of the study has been presented, as well as the research problem and the purpose statement. In addition, the research questions, hypotheses, theoretical framework, and implications for social change have been presented. The assumptions, limitations, and delimitations of this research study have been acknowledged. The comprehensive review of literature has substantiated the significance of the problem statement. In Section 2, I will present the research method and design, the sample, and the data collecting instrument used to conduct this research study.

Section 2: The Project

In Section 2, I have identified the factors, elements, and considerations necessary to planning a research study. The research project is presented. The purpose statement, the role of the researcher, and details pertaining to the participants are specified. The research method, the research design, and details pertaining to the population and the sampling procedure are disclosed. Ethical research considerations are recognized. The data collection processes are specified. Details relating to the Measure of Job Satisfaction (MJS) instrument are presented, as well as details on collection and organization techniques. A data analysis plan is specified and itemized followed by the discussion of reliability and validity. Section 2 concludes after I present the components relevant and necessary to conducting a research study.

Purpose Statement

The purpose of this quantitative study was to advance knowledge of factors that might affect RN job satisfaction. I conducted the research in the United States via an online survey design. Approximately 127,000 RNs from across the nation received a virtual invitation to participate via e-mail. The electronic database of RN contact information was retained by U.S. Data Corporation. Representative sampling has increased the validity of the research, so that I may generalize the results to the target population (Cooper & Schindler, 2006; Creswell, 2009). Power analyses by G*Power (Faul et al., 2007) indicated an a priori minimum sample size of $N = 158$.

I used the MJS survey instrument to collect empirical data, which I examined thereafter using multivariate statistical analyses to ascertain the relationships between

variables. I examined the independent variables of generation, gender, and origin of training, across the dependent variables of personal satisfaction and satisfaction with workload. Global job satisfaction was measured and analyzed, as well. I used multiple linear regression analyses to confirm or disconfirm theory.

The nursing profession has an opportunity to advance the transformation of health care systems nationwide. Job dissatisfaction could impede change management initiatives. I may promote social change by raising the nurse executives' understanding of factors that affect RN job satisfaction, and thereby strengthening patient advocacy through improved business practice.

Role of the Researcher

According to Creswell (2009), formal inquiry often begins with the researcher's broad assumption about a topic. Based on assumptions, the researcher begins to make decisions in planning a study. The researcher decides on a design that is most aligned to answer the research question or explore the research topic. The researcher's design choice is commonly founded on the researcher's worldview assumptions and his or her predictions about: (a) strategies of inquiry, (b) data collecting methods, (c) analysis, and (d) interpretation. The researcher's personal experiences may also influence design decisions. For example, a researcher trained in statistics may choose a quantitative design and conversely, a researcher who enjoys conducting personal interviews may choose a qualitative design. As well, the researcher's intended audience may influence the researcher's design decisions.

Researchers conducting quantitative studies use a review of the literature to help substantiate the problem and develop a research hypothesis (Creswell, 2009). The literature review helps to identify and align a theory as a plausible explanation of the research problem (Creswell, 2009). Researchers should identify the sample population and closely consider ethical concerns that may arise. The selection of a valid and reliable survey instrument is the researcher's responsibility, as is management of the entire data collection process. Researchers should mitigate threats to internal and external validity. Finally, quantitative researchers impart statistical analysis to test hypotheses before concluding an interpretation of the study results (Creswell, 2009).

To disclose my interest or my bias for the research topic, I am an actively licensed RN employed in the United States. I achieved RN status in 1987 after graduating from a nursing program and successfully passing the NCLEX-RN examination. As the sole researcher in this study, I was responsible for the entire data collection process.

Participants

In 2008, the RN population comprised the largest health care occupation in the United States (U.S. Department of Labor, 2010). The most common employment setting for nurses is hospitals. In 2008, 62.2% of the RN population in the United States reported working for a hospital (HRSA, 2010, p. 13). The most common job title for nurses is a staff nurse. In 2008, 66.3% of the RN population in the United States reported a job title of staff nurse (HRSA, 2010, p. 16). The national average earnings for a RN working full time in the United States, in 2008, was reported as $66,973 (HRSA, 2010, p. 17).

The population of interest in this study consisted of RNs in the United States. A sample of 126,691 RNs in the United States was selected to receive a virtual invitation to participate, sent via e-mail, and those 126,691 individuals represent the sampling pool in this research study. The sampling pool was computer-generated from an electronic database retained by U.S. Data Corporation. According to the company, the electronic database of nurses was created from public records, licensing boards, and associations or organizations providing opt-in marketing lists. A directory of the specialty lists that U.S. Data Corporation used in generating the master database is contained in Appendix E. The master database originally included approximately 700,000 nurse contacts. The master database was filtered to exclude all nurses except verified RNs. Next, the master database was filtered to exclude all contacts except those with verified e-mail addresses. The filters were applied to the master database, at my request, to target a population relevant to the eligibility criteria of this research study.

After filtering the database, U.S. Data Corporation determined there were approximately 165,000 contacts available as prospective participants for this research study. To conduct the research study, I requested that the company provide a computer-generated sample of 126,691 prospective participants, selected randomly from the approximate 165,000 contacts available in filtered database at the time of purchase. According to U.S. Data Corporation, the company deployed Oracle SQL software function RAND to select the 126,691 prospective participants randomly from the approximate 165,000 contacts available. Although I presumed that 126,691 contacts would exceed the anticipated volume needed to meet the minimum sample size for this

research study, 126,691 contacts were the lowest volume U.S. Data Corporation would supply for the base-cost investment. The 126,691 contacts were dispersed across the nation. To show the distribution by state of recipients who received a virtual invitation to participate, I have created Figure 7 as an illustration.

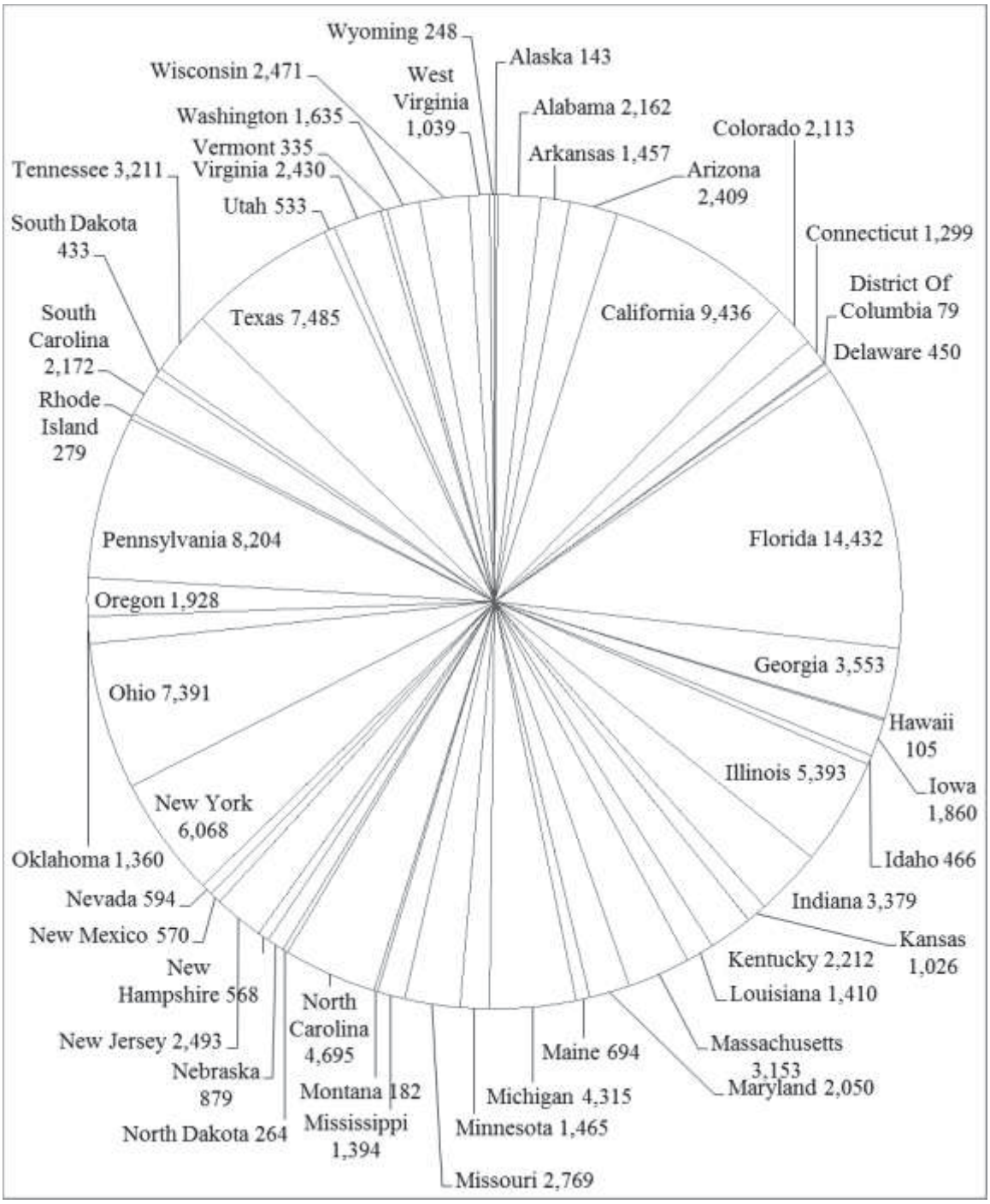

Figure 7. The distribution by state of the sample of prospective RN participants. The 126,691 prospective RN participants were approximately dispersed across the nation, with 50 states in the United States represented, plus the District of Columbia.

I was granted access to 126,691 prospective RN participants after I opened a U.S. Data Corporation account, and put final purchasing agreements in place. At no time did I have access to view the prospective participant contact information data. The e-mail broadcast was sent directly from the U.S. Data Corporation server to the 126,691 prospective participants. Sending the e-mail broadcast directly from the U.S. Data Corporation server was preferable, as the company's server was in compliance with U.S. federal laws relating to e-mail spam and e-mail broadcasts. Prospective participants received one e-mail. There was a contingency plan to send reminder e-mail broadcasts, should it have been necessary. With 126,691 e-mails circulated to a sample of prospective RN participants, I expected to meet the participatory quota needed to conduct this research study. Researchers have cited that one can anticipate electronic survey response rates to be approximately 4% (Singh et al., 2009, p. 202) to approximately 15% (Kaplowitz, Lupi, & Couper, 2012, p. 344), although other researchers have conducted literature reviews and concluded widely inconsistent data exists on the topic of electronic survey response rates (Shih & Fan, 2009).

It is important to note that the 126,691 RNs who represented the sampling pool in this research study were not construed as a random sample of the RN population in the United States. To generate a true random sample, which are rare in nonexperimental research (Tabachnick & Fidell, 2007; Vogt, 2007), all members of the RN population in the United States would have had to been included in the database. Consequently, all members of the RN population would have had an equal probability of being selected to participate, which is not the case. The only randomness that existed in the sampling pool

for this study was that U.S. Data Corporation selected randomly 126,691 prospective participants from the approximate 165,000 contacts available and those 126,691 RNs received an invitation to participate in this study. As acknowledged in Section 1 under Delimitations, not all RNs in the United States were included in the U.S. Data Corporation database. With other limitations disclosed in Section 1 under Limitations, an imperfect representative sample of the RN population in the United States is acknowledged. A representative sample provides the researcher an increased ability to generalize results to the target population (Cooper & Schindler, 2006; Creswell, 2009; Tabachnick & Fidell, 2007). The foremost objective of researchers deploying representative sampling is to increase the external validity of the research project (Vogt, 2007).

A representative sample is preferable for theory application when the researcher's goal is to confirm or disconfirm an existing model (Calder et al., 1981). When concluding the interpretation of the study results, rather than display point estimates of the variables, I examined the relationship between the variables. To confirm or disconfirm Herzberg's motivation-hygiene theory in the sample of RN participants, I examined the extent to which personal satisfaction scores and satisfaction with workload scores correlated with global satisfaction scores.

I considered the ethical protections of participants in this study. Researchers who deploy survey instruments may invade a participant's right to privacy by asking questions about innermost experiences or personal beliefs (Cooper & Schindler, 2006; Neuman, 2003). Participants who took part in this study were anonymous. Participant responses

were confidential. I recognized the participant's right to informed consent, as well as the participant's right to refuse participation. Another relevant ethical consideration is the use of an appropriately suited survey instrument. Researchers who deploy carelessly designed survey instruments waste human resources, which can become a source of human hardship (Neuman, 2003). Furthermore, the researcher should be sufficiently prepared to conduct rigorous, quantitative analysis that imparts meaningful data while concurrently recognizing the study's limitations (Neuman, 2003). The study's limitations should be candidly revealed, and the investigator's recommendations should not exceed the scope of the study (Cooper & Schindler, 2006).

In conducting this research study, I implemented the following strategies to minimize ethical concerns:

- I completed the National Institutes of Health (NIH) Office of Extramural Research training course titled Protecting Human Research Participants.
- I broadcast a virtual invitation to participate in this research via e-mail; the online survey approach offered prospective participants a discreet opportunity to decline the invitation by closing the Web site browser and effectively ending the research inquiry.
- I disabled any survey software option that tracked the Internet Protocol (IP) address thereby confirming participant responses remained anonymous.
- I used an opening survey question, requiring that participants answer affirmatively to the acknowledgment of informed consent to participate.

- I sought and attained Walden University Institutional Review Board (IRB) permission to conduct research.
- I utilized a valid and reliable survey instrument.
- I applied a data retention process that will securely archive participant responses for a period of 5 years.

The NIH certificate completion document is contained in Appendix F. The virtual invitation to participate in contained in Appendix G. The informed consent to participate document is contained in Appendix H. The Walden University IRB approval to conduct research document is contained in Appendix I. Details on the MJS instrument are provided in Section 2 under Instruments.

In order to determine the required sample size for this study, I conducted statistical power analyses using the G*Power software program (Faul et al., 2007). For the power analysis, two-tailed tests, an alpha level of .05, desired power of .80, and medium effect sizes were specified. The statistical techniques that I used to test the null hypotheses of this study consisted of factorial ANOVAs and multiple linear regression analyses. Factorial ANOVAs were used to answer the first two research questions, and there were three independent variables: generational cohort (with three levels), gender (with two levels), and origin of training (with two levels). Therefore, there were a total of 12 groups (3 x 2 x 2). Each main effect had either 2 degrees of freedom (for the generational cohort effect) or 1 degree of freedom (for the gender and origin of training effects). With a medium effect size estimate of $f = .25$, G*Power indicated that 128 participants would be required to detect the 1 degree of freedom effects and 158

participants would be required to detect the 2 degrees of freedom effect. Figure J1 and Figure J2 are contained in Appendix J and reveal results of the G*Power analyses for the factorial ANOVAs.

For the third research question, I performed a multiple linear regression analyses with personal satisfaction scores and satisfaction with workload scores as predictors of global satisfaction scores. With a medium effect size estimate of $f^2 = .15$, G*Power indicated that 68 participants would be required to achieve power of .80, as shown in Figure J3, which is contained in Appendix J. Based on these power analyses, the minimum required sample size for this study was set at 158, necessary in order to ensure statistical power of .80 for all statistical tests.

Research Method and Design

There are three types of research methods: (a) quantitative, (b) qualitative, and (c) mixed methods approach (Creswell, 2009). The researcher determines the appropriate research method based on factors that surround the information needed to answer the research question (Cooper & Schindler, 2006). For this research study, I selected a quantitative research method, in conjunction with an online survey research design.

Method

Quantitative researchers embrace positivist philosophical assumptions, which imply that the examination of relationships between and among variables is central to answering the research question (Creswell, 2009). Quantitative researchers use statistical procedures to examine the relationships between variables, as measured precisely through statistical means (Cooper & Schindler, 2006; Creswell, 2009; Neuman, 2003; Vogt,

2007). In business, quantitative researchers can examine and reveal factors relating to stakeholder behaviors, opinions, knowledge, or attitudes. Quantitative methods can uncover information relating to quantities, frequencies, individualities, and tallies (Cooper & Schindler, 2006). Although quantitative methods primarily use mathematical formulas to draw conclusions, quantitative researchers must also be proficient in applying knowledge of the subject, selecting instruments to collect evidence, and pointing logic to the equation (Vogt, 2007).

In conducting this multivariate study, I used factorial ANOVA (Grice & Iwasaki, 2008; Tabachnick & Fidell, 2007) to examine combinations of quantitative variables. I selected factorial ANOVA because it would reveal if population mean differences existed on the dependent variable, personal satisfaction, across the demographic factors of the independent variables: generational cohort, gender, and origin of training. I repeated factorial ANOVA to reveal if population mean differences existed on the dependent variable, satisfaction with workload, across the demographic factors of the independent variables: generational cohort, gender, and origin of training. In addition to factorial ANOVAs, I conducted multiple linear regression analyses with personal satisfaction scores and satisfaction with workload scores as predictors of global satisfaction scores. When scoring the MJS instrument, a larger correlation between personal satisfaction and global satisfaction, than between satisfaction with workload and global satisfaction, would suggest that participants value personal satisfaction more than satisfaction with workload (Traynor, n.d.).

The testing of hypotheses is distinctly characteristic of quantitative research methods (Cooper & Schindler, 2006; Creswell, 2009; Neuman, 2003; Vogt, 2007). Researchers formulate hypotheses based on theoretical frameworks and educated presumptions (Green & Salkind, 2011). Because quantitative researchers primarily focus on testing the hypotheses, it is essential that the hypotheses are formulated and substantiated by the overall business problem and consequential overall motivation for undertaking the research study (Green & Salkind, 2011). Careful formulations of hypotheses are essential to yielding accurate research results (Green & Salkind, 2011). I founded the hypotheses of this study on assumptions pertaining to: (a) diverse demographic employee considerations, (b) aspects of RN job satisfaction, (c) Herzberg's motivation-hygiene theory and, (d) the MJS survey instrument.

Researchers are increasingly recognizing that quantitative research methods do not endure all of the elements necessary to rendering smart business decisions (Cooper & Schindler, 2006). A hindrance to large quantitative studies is that the research quickly becomes common knowledge in the industry and thus may pose a threat to sprouting intellectual knowledge (Cooper & Schindler, 2006). Although the research results may not be readily available to competitors, once a large quantitative study launches, rivals can observe and extract insight alongside the sponsor (Cooper & Schindler, 2006). Furthermore, because quantitative researchers code, categorize, manipulate, and reduce participant responses to abstract numbers configured for statistical analysis (Neuman, 2003), critics charge that quantitative researchers reduce the participant to a number, as they are solely concerned with abstract laws or formulas distantly relevant to the genuine

opinions of actual people (Cooper & Schindler, 2006). Working solely with objective data, the quantitative researcher's potential to gain insight into an emerging problem or an emerging issue, may be limited.

In contrast, qualitative methods require that a researcher apply a different approach to scholarly inquiry (Creswell, 2009). Qualitative researchers often embrace a different worldview and a different philosophical assumption (Creswell, 2009). The qualitative researcher's strategy of inquiry, method of data collection, analysis, and interpretation would also be different from that of a quantitative researcher (Creswell, 2009). Qualitative data frequently derives from the transcript of a participant's detailed description of events, interactions, or situations (Cooper & Schindler, 2006; Rubin & Babbie, 2009). The subjective data often provides the researcher with new perspectives into an emerging problem or an emerging issue. Some researchers believe the richness of human behavior captured in qualitative research is not accessible through any other research method (Green & Salkind, 2011). With valuable and abundant insight into a participant's personal meanings, qualitative researchers can often generate new theories at the conclusion of their study (Cooper & Schindler, 2006).

While computer software is increasingly used to code and analyze reams of words found in the participant's transcript, the heart of qualitative research lies in the experience of the researcher (Cooper & Schindler, 2006). The researcher is the key instrument in a qualitative study, tending to collect data firsthand, in the field or the natural setting, where the problem or the issue occurs (Creswell, 2009). Employing inductive processes, qualitative researchers build patterns, categories, and themes from the ground up

(Creswell, 2009). Most importantly, qualitative researchers focus on learning the meanings that the participants hold, not the meanings of the writers of relevant literature (Creswell, 2009).

Beneficial and perhaps strategic under certain circumstances, qualitative research can be conducted in highly secure environments, out of the reach of competitor knowledge (Cooper & Schindler, 2006). Moreover, qualitative research can be conducted with small sample sizes, wherever individual interviewing or group interviewing is feasible (Creswell, 2009). The small sample size provides an opportunity for fast turnaround of findings, and although speed should not be a reason in choosing a methodology, qualitative studies may be useful to support low-risk business decisions that must be made quickly (Cooper & Schindler, 2006).

Although qualitative research methods have roots in a multitude of disciplines including sociology, psychology, economics, and semiotics, qualitative data remain far too subjective for many senior managers (Cooper & Schindler, 2006, p. 220). Hence, qualitative methods do not possess the unqualified endorsement of many senior managers, principally because of bias in data collection, and human error in interpretation (Cooper & Schindler, 2006). The qualitative research method approach was not chosen for this study, as the method is not best suited to answer the research questions.

Mixed methods approaches are perceived legitimate research procedures that have become popular in the social and human science fields (Creswell, 2009). Mixed methods approaches have evolved since the first comprehensive overview of the research strategy was published in 2003. Critics charge that attempts to combine quantitative and

qualitative research are not well advanced (Vogt, 2007). However, the combination of quantitative and qualitative methods has gained attractiveness with research teams seeking to employ diverse methodological interests and approaches (Cooper & Schindler, 2006; Creswell, 2009). Denzin (2010) described the term *triangulation* in the advantageous sense that researchers can combine quantitative and qualitative methods to triangulate results. Cooper and Schindler (2006) concurred that from a business perspective, triangulation may be helpful in increasing a senior manager's perception of the quality of research conducted, thereby endorsing qualitative research findings that have been substantiated or validated by quantitative research findings.

Cooper and Schindler (2006, p. 219) cited four strategies for combining research methodologies: (a) conduct qualitative and quantitative research simultaneously; (b) conduct longitudinal, qualitative research in concurrence with longitudinal, quantitative research; (c) conduct preceding qualitative research that is substantiated later with quantitative research; and (d) conduct preceding quantitative research that is substantiated later with qualitative research. According to Cooper and Schindler (2006), some researchers comprehend, acknowledge, and appreciate that qualitative research may counterbalance the weaknesses of quantitative research and vice versa. Researchers who allow the methodologies to complement rather than oppose each other create strategic business advantage (Cooper & Schindler, 2006).

The mixed methods approach, which encompasses the collection and analysis of both types of data, is resource intensive. I did not select the mixed methods approach for this research study, as the method is not best suited to answer the research questions.

After review of all research methods, I concluded that the research questions for this study were best answered with a quantitative research method.

Research Design

Vogt (2007, p.8) ranked seven types of research designs by the level of interaction that researchers have with the subjects or participants: document analysis, secondary analysis of data, naturalistic observation, surveys, interviews, experiments and quasi-experiments, and participant observation. Research designs can be further classified by the approach used to collect data: observation or communication (Cooper & Schindler, 2006). A researcher can observe conditions, behaviors, events, and processes (Cooper & Schindler, 2006, p. 244). In contrast, a researcher can communicate with people about topics, attitudes, motivations, intentions, and expectations (Cooper & Schindler, 2006, p. 244). Researchers determine the appropriate research design based on factors that surround the information needed to answer the research question (Cooper & Schindler, 2006).

I selected quantitative online survey for this research study because it has practical advantages and because it would efficiently answer the research questions. Online surveys pose an array of benefits. The decreasing cost of computer hardware and software fosters increasing Internet use, and consequently large segments of society access the Internet to communicate daily (Wright, 2005). Online surveys have the potential to attract a broader research participant pool, in many ways broader than conventional survey approaches (Cooper & Schindler, 2006). A broad demographic participant pool was necessary to test the constructs of the research study conducted.

The instant electronic storage of data collected online reduces the resources necessary to administer the survey and data entry the participant scores (Hart et al., 2009). Moreover, the swift turnaround of data collection fosters the swift analysis of participant scores (Cooper & Schindler, 2006; Neuman, 2003). Online participants may sense anonymity (Cooper & Schindler, 2006), and when sensitive topics are assessed, online participants are more likely to respond honestly and openly (Hart et al., 2009; Neuman, 2003). The statistical analysis of data collected online imparts meaningful interpretation, which can be easily replicated over time (Cooper & Schindler, 2006; Neuman, 2003).

Hart et al. (2009) and Singh et al. (2009) examined the response rates of online surveys and provided suggestions to increase online survey participation. Online surveys can be conducted via three methods: online forums, e-mails, and professional associations (Singh et al., 2009). According to Singh et al. (2009), messages that were posted to an online forum thread, with a request for and link to a survey, received the highest response rate across the three methods. The response rate for online forums was 11%, calculated over a 10-day period (Singh et al., 2009, p. 202). The response rate for an e-mail list was 4%, as compared to the response rate for a professional association, which was 2% (Singh et al., 2009, p. 202). The forum response rates were thought to be the highest because forum participants often share a strong sense of community (Singh et al., 2009). In addition, forum participants may be more comfortable with an online format, as compared to other respondents (Singh et al., 2009).

Incentives have been used historically to increase traditional survey response rates (Singh et al., 2009). Singh et al. (2009) cited that providing a nominal gift increased online survey participation while providing entry in a raffle equivocated to no incentive. Hart et al. (2009) and Kaplowitz et al. (2012) conducted research to examine whether personalized prenotification of an online survey increased response rates. Hart et al. (2009) found that prenotification did not make a difference in online survey response rates. Kaplowitz et al. (2012) found that prenotification increased the response rates for certain groups of respondents, particularly when the prenotification provided lengthy details of the research. Although it is not clear whether best practices influence the response rate of online surveys, best practices for online survey research are cited:

- Prenotification of a survey should occur no sooner than 3 days prior to the survey arrival (Hart et al., 2009).
- Avoid sending requests for online surveys during holiday seasons, income tax-time, and the start or end of academic semesters (Singh et al., 2009).
- The best day of the week to send out survey requests is Tuesday; the best day to send reminders is Thursday (Singh et al., 2009).
- Whenever possible, personalize the communication to all prospective participants (Hart et al., 2009).
- Use a recognizable sender name with an authoritative subject line (Kaplowitz et al., 2012).
- The virtual invitation should be complete and persuasive, and the survey URL should be near the bottom of the invitation (Kaplowitz et al., 2012).

A number of factors may dissuade researchers from employing online surveys. Cooper and Schindler (2006) asserted that online survey approaches are in early stages of development, and cautioned, what is known about online survey research has been learned from conventional mail surveys. However, as researchers increasingly utilize online survey methods, the strengths and weaknesses of contemporary self-administered survey methods will emerge and build on an existing body of knowledge (Cooper & Schindler, 2006). Another factor is uninvited online survey requests, which can be perceived as a discussion board spam and thus deleted from online community forums (Wright, 2005). In addition, uninvited online survey requests may induce *respondent anger*. Respondent anger is an emotion that occurs when people are inundated with unwelcome e-mail requests (Hart et al., 2009). Another concern is the management of online responses and the possibility of receiving multiple responses from the same participant. Although there are technical options to prevent multiple responses from the same computer, such as using cookies, tracking IP addresses, or using a unique URL for each survey request, the options raise privacy concerns, which warrant ethical consideration (Singh et al., 2009).

In comparing e-mail surveys to paper-based surveys, Singh et al. (2009) cited that the overwhelming majority of e-mail survey responses were returned before postal mail was inventoried. As Web-based research companies increase, in the same manner as computers and software programs have in the past, it is reasonable to expect that the majority of survey research conducted in the future, will be conducted online (Hart et al., 2009). According to Singh et al. (2009), others agree that the survey platform is trending

to online, in particular, for the academic researcher, who often conducts research on a very limited budget. As computer technology is increasingly integrated into the daily lives of societal members, the Internet sample may become more representative of the general population at large (Singh et al., 2009).

Leaders of organizations apply research methods and research designs to collect information that might be useful to solving business problems (Cooper & Schindler, 2006). Business research is the process of acquiring, analyzing, and disseminating relevant data to organizational leaders. Business research should be a systematic inquiry that serves to guide decisions made by organizational leaders (Cooper & Schindler, 2006). In effect, business research is a major contributor to evidence-based knowledge of factors inherent to maximizing business performance (Cooper & Schindler, 2006).

Population and Sampling

In 2008, the RN population comprised the largest health care occupation in the United States (U.S. Department of Labor, 2010). According to the U.S. Department of Health Resources and Services Administration (HRSA, 2010, p. 3), the total estimated population of RNs in 2008 was 3,063,163. By sheer volumes, the RN workforce has the potential to lead transformational change in health care systems nationwide (IOM, 2011). Job dissatisfaction could hinder change initiatives. The prospective participant population was chosen because of their relevance in understanding factors that might affect RN job satisfaction.

I selected the prospective participants for this research study from a computer-generated sample of RNs chronicled by U.S. Data Corporation. Bias is acknowledged for

the sample because not all RNs in the United States were included in the U.S. Data Corporation database of nurses. In addition, some RNs do not have Internet access or e-mail access and were also excluded from participating in this online survey. However, the Internet sample may become more characteristic of the general population at large, as societal members increasingly become comfortable with Internet technology (Singh et al., 2009).

With eligibility criteria, I specified that participant RNs must be (a) 18 years of age or older, (b) actively licensed as a RN to practice nursing, and (c) currently employed as a RN in the United States. Registered nurses who were retired, unemployed, or working in a setting outside the United States were excluded from participating in this online survey. The licensed practical nurse (LPN) or licensed vocational nurse (LVN) was excluded from participating in this online survey research. I selected the eligibility criteria to advance knowledge of factors that might affect RN job satisfaction. My goal in conducting this research study was to apply motivation theory, as it pertains to the 21st-century RN workforce employed in the United States.

I selected the sample pool of RNs for this study from an electronic database, which U.S. Data Corporation created from public records, licensing boards, and associations or organizations providing opt-in marketing lists. U.S. Data Corporation selected 126,691 prospective participants from the approximate 165,000 contacts available on the company's electronic database. Although I considered that 126,691 contacts were presumably more than the anticipated volume I needed to meet the minimum sample size for this research study, 126,691 contacts were the lowest volume

U.S. Data Corporation would supply me for the base-cost investment. Power analyses by G*Power (Faul, et al., 2007) indicated an a priori minimum sample size of $N = 158$, necessary to ensure statistical power of .80 for all statistical tests.

To reach prospective participants, U.S. Data Corporation broadcast an e-mail, which included a virtual invitation to participate in this study. Prospective participants could take part in this research by clicking on the hyperlink provided in the virtual invitation. Clicking on the hyperlink redirected the prospective participant to an electronic survey instrument hosted by SurveyMonkey. Prospective participants were required to indicate that they understood the provisions of informed consent. Prospective participants had an opportunity to print the informed consent document, if they choose. Prospective participants were required to answer subsequent eligibility criteria affirmatively. Prospective participants who did not answer the opening eligibility questions with an affirmative response were ineligible to take part in this research study and informed of such tactfully. Thereafter, eligible participants began answering questions on the MJS instrument. At any time during the study, participants could close the Web site browser and effectively relinquish participatory involvement. The MJS survey hyperlink remained open to collect data for 10 days.

There was a contingency plan to send additional e-mail broadcasts. If necessary to obtain a satisfactory response rate, a second e-mail broadcast would have been sent 10 days after the first, and the MJS survey hyperlink would have remained open to collect data for additional 10 days. If necessary to obtain a satisfactory response rate, a third and final e-mail broadcast would have been sent 10 days after the second, and the MJS survey

hyperlink would have remained open to collect data for additional 10 days. In any case, the same virtual invitation to participate would have been broadcast via e-mail, and the same 126,691 prospective participants would have been invited to participate again. The contingency plan was not utilized, as I achieved a satisfactory response rate from the first e-mail broadcast.

Ethical Research

I considered the ethical protections of the participants in this research study. I sought and attained Walden University IRB approval to conduct research. I collected no individual names. I collected no organizational names. All participants remained anonymous. All participant responses remained confidential.

The informed consent to participate in this research study is contained in Appendix H. The informed consent was scripted on the first Web page that opened when a prospective participant clicked on the survey invitation hyperlink provided in the e-mail exchange. A hyperlink to a printable version of the informed consent document was provided for participants who preferred to print the document. If a prospective participant agreed to take part in this research study, the electronic survey configuration prohibited proceeding with the survey, until he or she answered the following eligibility criteria questions.

1. I have read and understood the informed consent document and hence agree to participate in this research study voluntarily.
    - Yes

- No (If a person indicated no, the electronic survey was configured to end the inquiry, indicating ineligibility)

2. Are you 18 years of age or older?
   - Yes
   - No (If a person indicated no, the electronic survey was configured to end the inquiry, indicating ineligibility)
3. Are you an actively licensed registered nurse (RN)?
   - Yes
   - No (If a person indicated no, the electronic survey was configured to end the inquiry, indicating ineligibility)
4. Are you currently employed as a registered nurse (RN) in the United States?
   - Yes
   - No (If a person indicated no, the electronic survey was configured to end the inquiry, indicating ineligibility)
5. Participants are encouraged to submit their responses only one time. Have you completed this online survey before?
   - Yes (If a person indicated yes, the electronic survey was configured to end the inquiry, indicating ineligibility)
   - No

Participants had a right to decline participation in this research study. At any point during the survey, participants could withdraw from the research study by closing

the Web site browser and effectively ending the research inquiry. Participants received no incentive or reward to participate in this research study. The rights of the participants were protected by applying a data retention process. The securely archived electronic data was password protected and backed up on a thumb drive. Five years after the completion of this study, CyberShredder software will be used to erase the confidential files from the computer and the thumb drive permanently.

Data Collection

Instruments

The MJS instrument was designed to investigate nurse job satisfaction (Traynor & Wade, 1993; van Saane et al., 2003; Wade, 1993). The central question in the MJS instrument was, "How satisfied are you with this aspect of your job?" (Traynor & Wade, 1993, p. 129). Participants answered 44 multidimensional questions by indicating their response on a 5-point Likert-type scale, ranging from 1 (*very satisfied*) to 5 (*very dissatisfied*). The MJS instrument was formatted to collect online responses via SurveyMonkey Web-based solutions. Participants were instructed to click on the Likert-type scale indicating their level of satisfaction or dissatisfaction with various aspects of their job. Appendices A and B contain a copy of the MJS instrument and the MJS scoring key. Appendices C and D contain the e-mail correspondence requesting and receiving permission to use, and republish, the MJS instrument in this study.

The MJS instrument was developed to gauge the morale of community nurses in the United Kingdom (Traynor & Wade, 1993). Traynor and Wade (1993) conducted a pilot study using a sample of community nurses from the Royal College of Nursing

(N = 489). Applying principal component analysis with varimax rotation, Traynor and Wade (1993, p. 127) established that the MJS instrument appraised five dimensions of RN job satisfaction: personal satisfaction, satisfaction with workload, satisfaction with professional support, satisfaction with pay and prospects, and satisfaction with training.

According to Traynor (n.d.), an updated version of the MJS instrument was later developed and tested in a pilot study using a sample of community nurses (N = 650). The updated version reestablished the aforementioned five dimensions of RN job satisfaction and advanced two more dimensions: satisfaction with training, and satisfaction with standards of care (Traynor, n.d). Additionally, the updated version split the dimension satisfaction with pay and prospects into two distinct dimensions: satisfaction with pay, and satisfaction with prospects (Traynor, n.d.). Therefore, the updated version of the MJS instrument is comprised of seven subscales that may be summed to gauge an eighth subscale, which is overall job satisfaction (Traynor, 1991). The updated version of the MJS instrument was used for this research study, and is contained in Appendix A.

The MJS instrument was determined to be a valid and reliable tool with sufficient sensitivity to discriminate between various groups of nurses (Traynor & Wade, 1993, p. 136). The MJS instrument reliability was assessed for internal consistency. Cronbach alpha was computed for the original five subscales using the main sample population (N = 489) and a smaller sample population (N = 37), which were surveyed on two occasions with a 2-week interval between assessments (Traynor & Wade, 1993). The correlations and Cronbach alpha values on both occasions were almost identical, indicating an absence of test-retest effect (Traynor & Wade, 1993). The Cronbach alpha values that were computed

for the updated MJS instrument are indicated on the MJS scoring key, as contained in Appendix B.

Traynor and Wade (1993) examined another sample of nurses ($N = 33$) who completed the MJS instrument concurrently with a Price Waterhouse instrument. The Price Waterhouse instrument measured factors such as volume of work, standard of service, work relationships, recognition, career development, working hours, working environment, childcare facilities, and other aspects of job satisfaction (Traynor & Wade, 1993, p. 132). After adjustments for missing data on the MJS instrument, related to childcare facilities, a high correlation was computed for the Price Waterhouse instrument total score and the MJS instrument job satisfaction overall score (Traynor & Wade, 1993, p. 133). Consequently, the MJS instrument was determined to have concurrent validity.

Traynor and Wade (1993) established discriminate validity by computing mean scores and confidence intervals for each of the five original subscales and the overall job satisfaction dimension. Different groups of community nurses were considered: district nurses, school nurses, nurse managers, and others. Very small groups were excluded. The scores revealed and illustrated differences between the groups of nurses indicating that the MJS instrument has sufficient sensitivity to discriminate between various groups of nurses (Traynor & Wade, 1993).

In an effort to discover the reliability and validity of instruments used in measuring health care worker job satisfaction, van Saane et al. (2003) conducted a systematic review of available instruments. The researchers examined 29 instruments and concluded that although many different instruments exist, only a few meet criteria for

high reliability and construct validity (van Saane et al., 2003). The MJS instrument was one of seven instruments that contained the necessary quality criteria to classify as high reliability and high construct validity. Of those seven instruments, the MJS instrument additionally included most of the work factors necessary for good content validity (van Saane et al., 2003, p. 198). Furthermore, the 11 standard work factors were represented on the MJS instrument (van Saane et al., 2003).

Herzberg's (2003) motivation-hygiene theory avowed that intrinsic motivational factors are associated with employee: (a) growth, (b) advancement, (c) responsibility, (d) work itself, (e) recognition, and (f) achievement. For the purpose of this research study, I appraised a RN's intrinsic motivational factors by considering his or her score on the MJS personal satisfaction content. In appraising personal satisfaction, using the MJS instrument, the participant rated how satisfied he or she was with the following aspects of his or her job:

- The feeling of worthwhile accomplishment I get from my work.
- The amount of personal growth and development I get from my work.
- The extent to which my job is varied and interesting.
- The amount of independent thought and action I can exercise in my work.
- The extent to which I can use my skills.
- The amount of challenge in my job.

I conducted factorial ANOVA to examine the dependent variable of personal satisfaction, in conjunction with the independent variables of generation, gender, and origin of training.

Herzberg's (2003) motivation-hygiene theory avowed that hygiene factors are associated with employee: (a) security, (b) status, (c) relationship with subordinates, (d) personal life, (e) relationship with peers, (f) salary and work conditions, (g) relationship with supervisor, and (h) company policy and administration. For the purpose of this research study, I appraised a RN's hygiene factors by considering his or her score on the MJS satisfaction with workload content. In appraising satisfaction with workload, using the MJS instrument, the participant rated how satisfied he or she was with the following aspects of his or her job:

- The time available to get through my work.
- The amount of time spent on administration.
- My workload.
- Overall staffing levels.
- The amount of time available to finish everything that I have to do.
- What I have accomplished when I go home at the end of the day.
- The hours I work.
- The time available for patient or client care.

I conducted factorial ANOVA to examine the dependent variable of satisfaction with workload, in conjunction with the independent variables of generation, gender, and origin of training.

According to Traynor (n.d.), the global satisfaction score, designated as item 44 on the MJS instrument, can be used to rank the relative importance of different aspects of job satisfaction. For example, a larger correlation between personal satisfaction and

global satisfaction, than between satisfaction with workload and global satisfaction, would suggest that participants value personal satisfaction more than satisfaction with workload (Traynor, n.d.). To confirm or disconfirm Herzberg's (2003) motivation-hygiene theory, I conducted multiple regression analyses with personal satisfaction and satisfaction with workload as predictors of global satisfaction scores.

I have selected the appropriate statistical method to test the study's constructs, and to mitigate threats to statistical conclusion (Vogt, 2007). The assumptions of the statistical method were not violated. I mitigated the threats to construct validity by defining all operational terms relevant to the study's constructs (Vogt, 2007). Operational terms are found in Section 1 under Definition of Terms. I mitigated threats to test-retest reliability by selecting an appropriate survey instrument (Vogt, 2007). To mitigate threats to external validity, I have imparted trustworthy conclusions about the representative sample of RN participants (Vogt, 2007). In addition, I have mitigated threats to internal validity by avoiding any cause and effect conclusions (Vogt, 2007).

Researchers have deemed the MJS instrument to have high reliability and high construct validity (Traynor & Wade, 1993; van Saane et al., 2003). I made no adjustments or revisions to the MJS survey instrument. The raw data collected in this research study is available upon written request. The contact information for written requests is located at the end of this document, under the section titled Curriculum Vitae.

Data Collection Technique

The data collection technique that I used for this research study was an online survey design. I used SurveyMonkey Web-based solutions to prepare and format the

MJS instrument for online access. After I received IRB approval from Walden University, and the MJS instrument was ready for online access, the data collection process began. Prospective participants received an e-mail broadcast sent directly from the U.S. Data Corporation server and including a virtual invitation to participate in this research study. The online survey was launched by clicking on the hyperlink provided in the virtual invitation. The informed consent to participate in this research was scripted on the first Web page that opened when a prospective participant clicked on the hyperlink provided. If a prospective participant satisfied all of the research eligibility criteria, he or she was granted access to proceed with the MJS instrument. I did not conduct a pilot study as researchers had previously deemed the MJS instrument to have high reliability and high construct validity (Traynor & Wade, 1993; van Saane et al., 2003).

Data Organization Techniques

I used SurveyMonkey Web-based solutions to collect, organize, and classify the participant responses. The SurveyMonkey product was the gold level plan, which provided SPSS data integration. I analyzed the participant data using SPSS software Grad Pack 20.0. The data organization technique for this research provided seamless transfer of data from SurveyMonkey database to SPSS database, thereafter available for researcher computation. The securely archived electronic data was password protected. The securely archived electronic data was backed up on a thumb drive. Five years after the completion of this study, CyberShredder software will be used to erase the confidential files from the computer and the thumb drive permanently.

Data Analysis Technique

Participant responses to the MJS instrument were collected online via SurveyMonkey Web-based solutions. The SurveyMonkey, LLC entity is the world's leading provider of Web-based survey solutions (SurveyMonkey, 2011, About us, para. 1). TRUSTe certified, under the Privacy Seal program, that the SurveyMonkey LLC entity's policies comply with the EU-US Safe Harbor Framework for data protection related to the collection, use, and retention of data from the European Union.

I analyzed the participants' MJS data using SPSS software. The IBM Corporation completed the acquisition of the SPSS Corporation in 2009. According to the IBM Corporation, SPSS software provides organizational leaders with predictive analytics, which are essential in the discovery of unexpected patterns or unexpected associations. Organizational leaders who apply predictive analytics in developing solutions that guide front line interactions ultimately generate competitive and sustainable business advantage.

I performed inferential analyses to answer the research questions of this study. I used two-tailed tests and an alpha level of .05 for all inferential tests. The first research question of this study is: To what extent, if any, do the personal satisfaction scores of RNs vary as a function of generational cohort, gender, or origin of training?

The null hypotheses associated with this research question are:

$H1_0$: There is no difference in personal satisfaction scores as a function of generational cohort (Baby Boomers, Generation X, and Generation Y).

$H3_0$: There is no difference in personal satisfaction scores as a function of gender (female and male).

$H5_0$: There is no difference in personal satisfaction scores as a function of origin of training (United States or international).

In order to test these three null hypotheses, I performed a factorial ANOVA. There are three independent variables: generational cohort (with three levels), gender (with two levels), and origin of training (with two levels). Only the main effects of generational cohort, gender, and origin of training were of interest, and therefore, I only examined the main effects in this analysis.

The second research question of this study is: To what extent, if any, do the satisfaction with workload scores of RNs vary as a function of generational cohort, gender, or origin of training? The null hypotheses associated with this research question are:

$H2_0$: There is no difference in satisfaction in workload scores as a function of generational cohort (Baby Boomers, Generation X, and Generation Y).

$H4_0$: There is no difference in satisfaction in workload scores as a function of gender (female and male).

$H6_0$: There is no difference in satisfaction in workload scores as a function of origin of training (United States or international).

As with the first research question, I performed a factorial ANOVA to test these three null hypotheses. The same three independent variables were examined: generational cohort, gender, and origin of training. The dependent variable was satisfaction in

workload scores. I only examined the main effects in this analysis, as was the case for the first research question.

The third and final research question of this study is: To what extent do personal satisfaction scores and satisfaction with workload scores correlate with global satisfaction scores? The corresponding null hypothesis is:

$H7_0$: Personal satisfaction scores do not correlate higher with global satisfaction scores than satisfaction with workload scores.

In order to test this null hypothesis, I performed a multiple linear regression analyses with personal satisfaction and satisfaction with workload as predictors of global satisfaction scores.

The data analysis plan for the research I completed is contained in Table 1. I coded the data elements as presented in Table 1 under the columns labeled. As shown, each variable was represented numerically. I conducted factorial ANOVAs for the first two research questions, and then performed a multiple linear regression analyses for the third research question. To control for Type I error, I only examined main effects and did not examine interactions in the factorial ANOVAs (Tabachnick & Fidell, 2007).

Table 1

Data Analysis Plan for the Research Study

Research Question	Related Null Hypothesis	Data Elements: Independent Variables: Nominal or nonmetric data	Data Elements: Dependent Variables: Interval or metric data	Statistical Approach
To what extent, if any, do the personal satisfaction scores of RNs vary as a function of generational cohort, gender, or origin of training?	$H1_o$: There is no difference in personal job satisfaction scores as a function of generational cohort (Baby Boomers, Generation X, and Generation Y). $H3_o$: There is no difference in personal job satisfaction scores as a function of gender (female and male). $H5_o$: There is no difference in personal job satisfaction scores as a function of origin of training (United States or international).	(a) Generational cohort (Baby Boomer, Generation X, or Generation Y), (b) Gender (female or male), and (c) Origin of training (U.S. or international).	MJS instrument personal satisfaction score.	Factorial analysis of variance (ANOVA) with main effects only.
To what extent, if any, do the satisfaction with workload scores of RNs vary as a function of generational cohort, gender, or origin of training?	$H2_o$: There is no difference in satisfaction with workload scores as a function of generational cohort (Baby Boomers, Generation X, and Generation Y). $H4_o$: There is no difference in satisfaction with workload scores as a function of gender (female and male). $H6_o$: There is no difference in satisfaction in workload scores as a function of origin of training (United States or international).	(a) Generational cohort (Baby Boomer, Generation X, or Generation Y), (b) Gender (female or male), and (c) Origin of training (U.S. or international).	MJS instrument satisfaction with workload score.	Factorial analysis of variance (ANOVA) with main effects only.
To what extent do personal satisfaction scores and satisfaction with workload scores correlate with global satisfaction scores?	$H7_0$: Personal satisfaction scores will not correlate higher with global satisfaction scores than satisfaction with workload scores.	(a) MJS personal satisfaction scores (predictor), (b) MJS satisfaction with workload scores (predictor), and (c) MJS global satisfaction scores (criterion).		Multiple linear regression analyses.

Reliability and Validity

Reliability

The reliability and validity of a research instrument is interrelated yet distinctly different (Vogt, 2007). An instrument is deemed reliable to the degree that it measures consistent results (Cooper & Schindler, 2006). While it is true that an unreliable instrument will reveal inconsistencies each time it is utilized, researchers should consider that mere reliability does not ensure validity (Vogt, 2007). For example, no matter how reliable an aptitude test is, it is not a valid measure of achievement (Vogt, 2007). In effect, if an instrument is not valid, it hardly matters if it is reliable (Cooper & Schindler, 2006). Reliability pertains to the researcher's degree of confidence that an instrument is free of random or unpredictable error (Cooper & Schindler, 2006). Moreover, reliable instruments are robust and consistent, providing dependable results on different occasions under different conditions (Cooper & Schindler, 2006).

The designer of the MJS instrument appraised reliability in two ways. Internal consistency was calculated for each of the job satisfaction subscales, as well as overall job satisfaction (Traynor & Wade, 1993). Cronbach's alpha is the most widely reported reliability statistic, typically used to determine whether several items measure the same thing, thus determining whether several items are correlated (Vogt, 2007). Calculated Cronbach's alpha scores are presented on each of the MJS instrument subscales, and those calculations are contained in Appendix B, on the document titled MJS instrument scoring key (Traynor, n.d.).

Second, the designer of the MJS instrument appraised reliability by having participants complete the MJS instrument on two different occasions, reportedly with a 2-week interval between assessments (Traynor & Wade, 1993). The participant scores on both occasions were almost identical thereby suggesting an absence of test-retest effect (Traynor & Wade, 1993). After careful consideration of multiple instruments used to appraise health care worker job satisfaction, van Saane et al. (2003) deemed that the MJS instrument had a high level of reliability.

Validity

There are two types of research validity: internal and external. Internal validity pertains to the researcher's degree of confidence in the robustness of an instrument (Creswell, 2009). In other words, to understand internal validity, researchers should consider if the instrument precisely measures what its designer claims it measures (Cooper & Schindler, 2006, p. 318). There are three widely accepted forms of validity: content validity, criterion-related validity, and construct validity (Cooper & Schindler, 2006; van Saane et al., 2003; Vogt, 2007).

- Content validity pertains to whether the instrument will measure what it is supposed to measure (Vogt, 2007). Researchers upheld that the MJS instrument had content validity for five measures of work factors: personnel satisfaction, workload, professional support, salary, and prospects and training (Traynor & Wade, 1993; van Saane et al., 2003, p. 195).
- Criterion-related validity pertains to how closely the instrument relates to another instrument previously assumed to have validity (Vogt, 2007). For

example, researchers discovered that the MJS instrument scores highly correlated with Price Waterhouse instrument scores, which measured factors such as volume of work, standards of service, work relationships, recognition, career development, working hours, working environment, childcare facilities, and other aspects of job satisfaction (Traynor & Wade, 1993, p. 132). Consequently, the MJS instrument exhibited concurrent validity, which is a form of criterion-related validity (Traynor & Wade, 1993; van Saane et al., 2003, Vogt, 2007).

- Construct validity pertains to how closely an instrument measures concepts or constructs of interest (Vogt, 2007). Researchers asserted that the MJS instrument had construct validity by demonstrating discriminate validity, which is a form of construct validity (Vogt, 2007). The MJS instrument was found to have discriminate validity when researchers discovered scores revealed differences between the groups of nurses indicating sufficient sensitivity to discriminate between various groups of nurses (Traynor & Wade, 1993).

External validity is the degree to which the researcher's findings can be generalized across populations, environments, and periods of time or eras (Cooper & Schindler, 2006). When considering external validity, the researcher must determine to what degree the information about the sample provides information about the population (Vogt, 2007). By using a representative sample of RN participants, I have increased the external validity of the study I conducted (Creswell, 2009). The representative sample

has enabled precise predictions, thereby enhancing the statistical-conclusion validity and hence providing a rigorous test of the theory (Calder et al., 1981). Calder et al. (1981) emphasized that theories that continually endure precise attempts to falsification are acknowledged as a scientific explanation and are accordingly contenders for application (p. 198). Scientific theories typically evolve to gain universal acceptance and thus can be used to explain any relevant phenomenon within the domains considered (Calder et al., 1981, p. 198).

Summary and Transition

Seeking to advance knowledge of factors that might affect RN job satisfaction, I have investigated a representative sample of actively licensed RNs employed in the United States. I selected the participants from an electronic database retained by U.S. Data Corporation. By way of e-mail, approximately 127,000 prospective RN participants received a virtual invitation to participate. Representative sampling has increased the validity of generalizing results to the target population (Cooper & Schindler, 2006; Creswell, 2009).

I conducted factorial ANOVAs to examine whether the population means of the dependent variables, personal satisfaction and satisfaction with workload, differed across the demographic factors of the independent variables: generational cohort, gender, and origin of training (Green & Salkind, 2011). In addition, I conducted multiple linear regression analyses to examine the relative importance of job factors in order to determine the extent to which motivational theory is a useful framework for understanding RN job satisfaction. Nurse executives might benefit from evidence-based

knowledge of whether Herzberg's motivational theory is applicable to the 21st-century RN workforce, employed in the United States. Evidence-based knowledge of factors that affect RN job satisfaction may provide the catalyst for 21st-century workforce solutions.

In Section 2, I presented the factors, elements, and considerations necessary in planning a research study. The research study that has been conducted has been shown. The purpose statement, role of the researcher, and details on the participants were specified. The research method, research design, and details on the participants and sampling procedures were disclosed. Ethical research considerations were recognized. The data collection processes were specified. Details on the MJS instrument were presented, as well as details on the collection and organization techniques. A data analysis plan was specified with considerations to reliability and validity.

In Section 3, I begin with an overview of the research study before I present the research findings and discuss the applications to professional practice. The implications for social change are reviewed, as well as, recommendations for action and recommendations for further study. Finally, in Section 3, I will close this research study by offering some personal reflections, a summary, and a conclusion.

Section 3: Application to Professional Practice and Implications for Change

An overview of the research study conducted is contained in Section 3, as well as evidence to substantiate the conclusions yielded. The implications for professional practice are specified and denote how the findings are relevant to promoting social change by strengthening patient advocacy through improved business practice. The recommendations for action are plainly described. The recommendations pertain to measures that could be deployed to enhance the job satisfaction of nurses. There are recommendations for future researchers, which I impart before closing with reflections on the research conducted, and a summary of my conclusions.

Overview of Study

The general business problem was a forecast nursing shortage that could be compounded by job dissatisfaction, job burnout, discontent with the work environment, and a high level of job turnover (Aiken et al., 2011; Jones, 2008; McHugh et al., 2011). In acknowledging the compelling organizational pressure to enhance workforce diversity (IOM, 2011)—strategic to providing culturally relevant service—I identified the specific business problem as insufficient, evidence-based knowledge as to whether aspects of RN job satisfaction differ across the factors of generational cohort, gender, and origin of training. Consequently, the purpose of this quantitative research was to advance knowledge of factors that might affect RN job satisfaction.

I conducted the quantitative online survey research in the United States using a computer-generated sample of RNs selected from an electronic database retained by U.S. Data Corporation. By way of e-mail, approximately 127,000 prospective RN participants

received a virtual invitation to participate. I collected empirical data through participant scores on the Measure of Job Satisfaction (MJS) survey instrument. The sample size for this research study was $N = 272$. Although the sampling pool of prospective participants included RNs from 50 states across the nation, plus the District of Columbia, I only received a survey response from RNs in 45 states, and approximately 70% of them indicated that their primary employers were located in California, New York, Texas, Florida, Illinois, Pennsylvania, Massachusetts, Ohio, or Michigan.

I developed the first two research questions in order to determine if differences exist on two reported aspects of RN job satisfaction. The dependent variables were identified as personal satisfaction and satisfaction with workload. I examined the dependent variables across the factors of the independent variables of generational cohort, gender, and origin of training. I conducted factorial ANOVAs to determine the relationships between the variables and to answer the first two research questions. The first research question was:

1. To what extent, if any, do the personal satisfaction scores of RNs vary as a function of generational cohort, gender, or origin of training?

The corresponding null hypotheses were:

$H1_0$: There is no difference in personal satisfaction scores as a function of generational cohort (Baby Boomers, Generation X, and Generation Y).

$H3_0$: There is no difference in personal satisfaction scores as a function of gender (female and male).

$H5_0$: There is no difference in personal satisfaction scores as a function of origin of training (United States or international).

The second research question was:

2. To what extent, if any, do the satisfaction with workload scores of RNs vary as a function of generational cohort, gender, or origin of training?

The corresponding null hypotheses were:

$H2_0$: There is no difference in satisfaction with workload scores as a function of generational cohort (Baby Boomers, Generation X, and Generation Y).

$H4_0$: There is no difference in satisfaction with workload scores as a function of gender (female and male).

$H6_0$: There is no difference in satisfaction with workload scores as a function of origin of training (United States or international).

I developed the third research question as a test of Herzberg's motivational theory in order to determine the extent to which theory is a useful framework for understanding RN job satisfaction. I analyzed personal satisfaction scores and satisfaction with workload scores as predictors of global satisfaction scores, by conducting multiple regression analyses to examine the relative importance of job factors.

The third research question was:

3. To what extent do personal satisfaction scores and satisfaction with workload scores correlate with global satisfaction scores?

The corresponding null hypothesis was:

$H7_0$: Personal satisfaction scores do not correlate higher with global satisfaction scores than satisfaction with workload scores.

By surveying a representative sample of RNs employed in the United States, I have concluded that no differences exist in personal satisfaction scores or satisfaction with workload scores, as a function of generational cohort (Baby Boomers, Generation X, and Generation Y), gender (female and male), or origin of training (United States or international). In addition, I have demonstrated that personal satisfaction scores are positively correlated with global satisfaction scores, as are satisfaction with workload scores. However, the higher standardized regression coefficient for satisfaction with workload indicates that it is a better predictor of global satisfaction than is personal satisfaction. Hence, it has emerged that Herzberg's motivational theory is not supported in the representative sample of RN participants in this research study.

Presentation of the Findings

The virtual invitation to participate, contained in Appendix G, was broadcast on Tuesday July 7, 2012, and indicated to participants that the survey would remain open for 10 days. An influx of participate responses were noted descriptively as follows: day 1 (n = 95, 34.3%), day 2 (n = 78, 28.2 %), day 3 (n = 61, 22.0%), day 4 (n = 14, 5.1%), day 5 (n = 12, 4.3%), day 6 (n = 12, 4.3%), day 7 (n = 5, 1.8%), day 8 (n = 0), day 9 (n = 0), day 10 (n = 0). The response rate for this research study was 0.22%, which was calculated by dividing the total number of participants who completed the MJS survey (277) by the total number of virtual invitations that were broadcast (126,691). Although the response rate appears very low by conventional calculations, the e-mail broadcast

tracking report indicated that only 1,658 prospective participants opened the e-mail and clicked-on the link to participate. Considering those who completed the MJS survey (277), divided by those who opened the e-mail and clicked-on the link to participate (1,658), the response rate equated to 16.7%. Since there was an insufficient response rate from the generational cohort Veterans (n = 5), and to control for Type I and Type II error, I omitted the outlier generational cohort Veterans from the multivariate analyses that I conducted. Consequently, the absolute sample size for this research study was N = 272.

In completing the eligibility criteria, all of the participants indicated that (a) they had read and understood the informed consent statement, (b) they were 18 years old or older, (c) they were actively licensed RNs, (d) they were currently employed in the United States, and (e) they had not previously completed the survey. More participants indicated that they were Baby Boomers (n = 134, 49.3%) than nurses in Generation X (n = 99, 36.4%) or Generation Y (n = 39, 14.3%). Most of the participants were females (n = 244, 89.7%) who had trained in the United States (n = 251, 92.3%) and had attained a bachelor's degree (n = 125, 46.0%) or an associate's degree (n = 83, 30.5%).

The most common range of years that participants indicated they were licensed were between 15 and 22 years (n = 100, 36.8%), followed by 9 to 14 years (n = 79, 29.0%), and 3 to 8 years (n = 48, 17.6%). Most of the participants indicated that they were staff nurses (n = 236, 86.8%), and the majority indicated that they worked in hospitals (n = 182, 66.9%). The participants indicated that their primary employers were most commonly located in the states of California (n = 36, 13.2%), New York (n = 30, 11.0%), Texas (n = 29, 10.7%), Florida (n = 27, 9.9%), Illinois (n = 21, 7.7%),

Pennsylvania (n = 19, 7.0%), Massachusetts (n = 14, 5.1%), Ohio (n = 8, 2.9%), or Michigan (n = 6, 2.2%). Table 2 contains descriptive statistics for the demographic characteristics of the sample population of RN participants (N = 272). Table 3 contains descriptive statistics for the background characteristics of the sample population of RN participants (N = 272).

Table 2

Descriptive Statistics for Demographic Characteristics

Variable	*n*	%
Generational cohort		
Baby Boomer	134	49.3
Generation X	99	36.4
Generation Y	39	14.3
Gender		
Female	244	89.7
Male	28	10.3
Country of training		
United States	251	92.3
Philippines	6	2.2
Canada	1	.4
India	7	2.6
Korea	6	2.2
Nigeria	1	.4

Table 3

Descriptive Statistics for Background Characteristics

Variable	*n*	%
Highest degree attained		
Diploma	34	12.5
Associate's	83	30.5
Bachelor's	125	46.0
Master's	22	8.1
Doctorate	8	2.9
Years licensed		
0 to 2	11	4.0
3 to 8	48	17.6
9 to 14	79	29.0
15 to 22	100	36.8
23 or more	34	12.5
Job title		
Staff nurse	236	86.8
Manager, supervisor, clinical coordinator, or administrator	16	5.9
Advanced practice nurse, nurse practitioner, clinical nurse specialist, nurse anesthetist, or nurse midwife	8	2.9
Nurse educator or nurse researcher	12	4.4
Other	1	.4
Setting		
Hospital	182	66.9
Nursing home, long-term care, or an extended care facility	61	22.4
Home health care, community health, or school nursing	22	8.1
Academia, education, or research	6	2.2

The descriptive statistics for the three key dependent variables in this study, personal satisfaction scores, workload satisfaction scores, and global satisfaction scores ($N = 272$), are shown in Table 4. I computed personal satisfaction scores as the mean item score across the six items on this scale. These scores ranged from 1.25 to 4.50 with a mean of 2.61 ($SD = .89$) and a Cronbach's alpha reliability coefficient of .93. I computed satisfaction with workload scores as the mean item score across the eight items corresponding to this scale. These scores ranged from 1.50 to 5.00 with a mean of 3.19 ($SD = .99$) and a Cronbach's alpha reliability coefficient of .92. Global satisfaction scores were based on a single survey item and ranged from 1.00 to 5.00 with a mean of 3.03 ($SD = .86$).

Table 4

Descriptive Statistics for Dependent Variables

Variable	Items	Min.	Max.	*M*	*SD*	α
Personal Satisfaction	6	1.25	4.50	2.61	.89	.93
Workload Satisfaction	8	1.50	5.00	3.19	.99	.92
Global Satisfaction	1	1.00	5.00	3.03	.86	-

The first research question of this study was: To what extent, if any, do the personal satisfaction scores of RNs vary as a function of generational cohort, gender, or origin of training? The null hypotheses associated with this research question were:

$H1_0$: There is no difference in personal satisfaction scores as a function of generational cohort (Baby Boomers, Generation X, and Generation Y).

$H3_0$: There is no difference in personal satisfaction scores as a function of gender (female and male).

$H5_0$: There is no difference in personal satisfaction scores as a function of origin of training (United States or international).

In order to test these three null hypotheses, I performed a factorial ANOVA. There were three independent variables: generational cohort (with three levels), gender (with two levels), and origin of training (with two levels). Only the main effects of generational cohort, gender, and origin of training were of interest, and therefore, I only examined the main effects in this analysis. Table 5 shows the personal satisfaction scale means as a function of the three independent variables ($N = 272$). Table 6 contains the results from the factorial ANOVA ($N = 272$). As can be seen in Table 5, personal satisfaction scores are similar across the three generational cohorts with means for the Baby Boomers of 3.14 ($SD = 1.05$), for Generation X of 3.22 ($SD = .95$), and for Generation Y of 3.29 ($SD = .88$). Males ($M = 3.13$, $SD = 1.07$) and females ($M = 3.20$, $SD = .98$) also have similar means, as do those trained in the United States ($M = 3.19$,

SD = .99) and those trained internationally (*M* = 3.17, *SD* = .93). The factorial ANOVA results confirm that there are no statistically significant differences in personal satisfaction scores based on generational cohort, $F(2, 267) = .50$, $p = .605$, gender, $F(1, 267) = .19$, $p = .667$, or origin of training, $F(1, 267) = .01$, $p = .912$. Therefore, the first, third, and fifth null hypotheses of this study are not rejected, and it is concluded that there are no differences in personal satisfaction scores as a function of generational cohort (Baby Boomers, Generation X, and Generation Y), gender (female and male), or origin of training (United States or international).

Table 5

Descriptive Statistics for Personal Satisfaction Scores

Independent Variable	*M*	*SD*
Generational cohort		
Baby Boomer	3.14	1.05
Generation X	3.22	.95
Generation Y	3.29	.88
Gender		
Female	3.20	.98
Male	3.13	1.07
Country of training		
United States	3.19	.99
Other	3.17	.93

Table 6

Results from Factorial ANOVA for Personal Satisfaction Scores

Effect	Sum of Squares	*df*	Mean Squares	*F*	*p*
Generational cohort	.99	2	.50	.50	.605
Gender	.18	1	.18	.19	.667
Origin of training	.01	1	.01	.01	.912
Error	263.39	267	.99		
Total	264.50	271			

The second research question of this study was: To what extent, if any, do the satisfaction with workload scores of RNs vary as a function of generational cohort, gender, or origin of training? The null hypotheses associated with this research question were:

$H2_0$: There is no difference in satisfaction in workload scores as a function of generational cohort (Baby Boomers, Generation X, and Generation Y).

$H4_0$: There is no difference in satisfaction in workload scores as a function of gender (female and male).

$H6_0$: There is no difference in satisfaction in workload scores as a function of origin of training (United States or international).

As with the first research question, I performed a factorial ANOVA to test these three null hypotheses. The same three independent variables were included: generational

cohort, gender, and origin of training. The dependent variable was satisfaction with workload scores. I examined only main effects in this analysis. Table 7 shows the mean satisfaction with workload scores as a function of the independent demographic variables ($N = 272$). Table 8 contains the results from the factorial ANOVA ($N = 272$). Scores on the satisfaction with workload scale are similar for the three generational cohorts with means of 2.60 ($SD = .93$) for the Baby Boomers, 2.57 ($SD = .86$) for Generation X, and 2.71 ($SD = .83$) for Generation Y. Scores are also similar for males ($M = 2.57$, $SD = .91$) and females ($M = 2.61$, $SD = .89$), and for those trained in the United States ($M = 2.62$, $SD = .91$) and those trained internationally ($M = 2.49$, $SD = .70$). The factorial ANOVA results confirm that there are no statistically significant differences in workload satisfaction scores based on generational cohort, $F(2, 267) = .25$, $p = .776$, gender, $F(1, 267) = .08$, $p = .779$, or origin of training, $F(1, 267) = .25$, $p = .621$. Therefore, the second, fourth, and sixth null hypotheses of this study are not rejected. It is concluded that no differences exist in satisfaction with workload scores as a function of generational cohort (Baby Boomers, Generation X, and Generation Y), gender (female and male), or origin of training (United States or international).

Table 7

Descriptive Statistics for Workload Satisfaction Scores

Independent Variable	*M*	*SD*
Generational cohort		
Baby Boomer	2.60	.93
Generation X	2.57	.86
Generation Y	2.71	.83
Gender		
Female	2.61	.89
Male	2.57	.91
Country of training		
United States	2.62	.91
Other	2.49	.70

Table 8

Results from Factorial ANOVA for Workload Satisfaction Scores

Effect	Sum of Squares	*df*	Mean Squares	*F*	*p*
Generational cohort	.41	2	.20	.25	.776
Gender	.06	1	.06	.08	.779
Origin of training	.20	1	.20	.25	.621
Error	214.10	267	.80		
Total	214.85	271			

The third and final research question of this study was: To what extent do personal satisfaction scores and satisfaction with workload scores correlate with global satisfaction scores? The corresponding null hypothesis was:

$H7_0$: Personal satisfaction scores do not correlate higher with global satisfaction scores than satisfaction with workload scores.

I conducted multiple linear regression analyses and discovered that personal satisfaction scores are positively correlated with global satisfaction scores ($r = .67$, $p < .001$), as are satisfaction with workload scores ($r = .75$, $p < .001$). The regression model is statistically significant, $F(2, 269) = 189.07$, $p < .001$. The R^2 coefficient of .58 indicates that 58% of the variance in global satisfaction scores is explained by personal satisfaction and satisfaction with workload scores. Individually, both personal satisfaction scores ($\beta = .22$, $p = .001$) and satisfaction with workload scores

($\beta = .58$, $p < .001$) are statistically significant. However, the higher standardized regression coefficient for satisfaction with workload indicates that it is a better predictor of global satisfaction than is personal satisfaction. Table 9 shows the results from the multiple linear regression analyses with personal satisfaction and satisfaction with workload as predictors of global satisfaction scores ($N = 272$).

Table 9

Results from Regression Analyses

Predictor	*B*	SE_B	β	*t*	*p*
Constant	.95	.12		8.09	<.001
Personal Satisfaction	.19	.05	.22	3.50	.001
Workload Satisfaction	.57	.06	.58	9.46	<.001

Notes. $R^2 = .58$, adjusted $R^2 = .58$, $F(2, 269) = 189.07$, $p < .001$.

The findings of this study complement a substantial body of literature on the topic of RN job satisfaction. Although researchers (Kramer, 2010; Wieck et al., 2009; Wilson et al., 2008) have asserted that generational differences exist in workforce characteristics central to RN job satisfaction, I have evidenced that no differences exist between generational cohorts, and their personal satisfaction and workload satisfaction scores. While Croson and Gneezy (2009) have asserted that gender differences exist in risk preferences, social preferences, and attitudes toward competition, and Rochlen et al. (2009) have asserted that gender theory influences the career choices of men, I have addressed a gap in literature and evidenced that no differences exist between genders, and

their personal satisfaction and workload satisfaction scores. Although it is not known whether acculturation (Ea et al., 2008) may have influenced the responses of the IEN participants in this study, I have addressed a gap in literature and evidenced that no differences exist between RNs trained in the United States and RNs trained internationally, and their personal satisfaction and workload satisfaction scores.

The findings of this study also relate to a substantial body of literature on the topic of motivational theory. The theoretical framework was Herzberg's motivation-hygiene theory (Herzberg et al., 1959/2010). Herzberg (2003) professed that intrinsic motivational factors are the foundation for understanding employee behavior, having asserted that employees are most motivated by stimulating work, engaging challenge, and appreciable responsibility (p. 87). Although personal satisfaction scores are positively correlated with global satisfaction scores, as are the satisfaction with workload scores, the higher standardized regression coefficient for satisfaction with workload indicates that it is a better predictor of global satisfaction than is personal satisfaction. Hence, it has emerged that Herzberg's motivational theory is not supported in the representative sample of RN participants in this research study.

Applications to Professional Practice

The applications to professional practice are important. Using a representative sample of RNs employed in the Unites States, I have evidenced that there are no differences in personal satisfaction scores or satisfaction with workload scores, as a function of generational cohort, gender, or origin of training. By examining diverse demographic factors, and concluding that no differences exist in aspects of job

satisfaction, nurse executives may feel confidence knowing that the evidence supports their decisions to dedicate the resources necessary to implementing solutions, aimed at enhancing the job satisfaction of all nurses. The evidence-based knowledge that has emerged is that workforce solutions may be broadly categorized and that solutions distinctly aimed towards any specific demographic factor are not necessary.

Although I have concluded that Herzberg's motivational theory is not supported, it is important to recognize that I have evidenced that 58% of the variance in global satisfaction is explained by personal satisfaction and satisfaction with workload scores. This discovery is worthy to reflect in applications to professional practice, considering the many factors that could have a greater or lesser effect on the global satisfaction of nurses. Moreover, I have demonstrated that satisfaction with workload is a better predictor of global satisfaction than is personal satisfaction. Hence, the evidence-based knowledge that has emerged is that the work environment of nurses is a crucial factor in understanding global RN job satisfaction. My discovery aligns with the conclusion of many other researchers (Aiken et al., 2011; Applebaum et al., 2010; Choi et al., 2011; Cortese et al., 2010; Elovainio et al., 2010; Gutierrez et al., 2012; Kramer & Schmalenberg, 2008; Maslach & Leiter, 1997; Porter et al., 2010; Trinkoff et al., 2011; Tyler et al., 2012; Wieck et al., 2009). By examining motivational theory and concluding that workload satisfaction is a better predictor of global satisfaction, nurse executives may feel confidence knowing that the evidence supports their decisions to dedicate the resources necessary to addressing the problems associated with the work environment of nurses. Nurse executives who dedicate the resources necessary to incorporating best

practice models, such as the Magnet Recognition Program (ANCC, 2011; Kramer, Maguire, & Brewer, 2011), may substantially improve the work environment of nurses, and thereby generate competitive and sustainable business advantage.

Implications for Social Change

The implications for social change are twofold. As provisions of the Patient Protection and Affordable Care Act (Public Law 111-148) are enacted, opportunities for the United States to transform its health care system will become practicalities (IOM, 2011). To achieve transformation, many facets of the U.S. health care system will need to be amended. The nursing professions' response to transformation is pivotal to attaining the goals of the Act, as the nursing workforce represents the largest portion of the health care workers in America (U.S. Department of Labor, 2010). Nurses are advocates who have long been recognized for their commitment to patient safety (Mahlin, 2010). The role of patient advocate has become increasingly difficult with tasks ranging from championing duties of hand washing, to confirming that medications are reconciled across the continuum, to coordinating multidisciplinary teams, to contesting discharge plans when they are perceived as unsafe. The nature of the advocacy job, what nurses must do, and when, where, how, and why they do it, can become a source of emotional strain that negatively affects job satisfaction (Maslach & Leiter, 1997). The evidence-based knowledge that has emerged is that workforce solutions aimed at enhancing job satisfaction may be broadly applied and that solutions targeted towards any specific demographic factor are not necessary. Hence, I may promote social change by

raising the nurse executives' understanding of factors that affect RN job satisfaction, and thereby strengthening patient advocacy through improved business practice.

Next, I may promote social change as this research contributes to a substantial body of literature on the topic of motivational theory and I have evidenced that the work environment of nurses is a crucial factor that should be recognized when addressing the global job satisfaction of nurses. Although limited by its long-term effectiveness, individuals can deploy coping techniques to improve or modify their work environments. However, coping techniques deployed by individuals are not as powerful, persuasive, nor permanent as changes that can occur at the organizational level (Maslach & Leiter, 1997). By deploying organizational-wide initiatives to reduce the psychological stresses that health care employees face, organizations communally reaffirm the human connection between those who give help, and those who need help (Maslach & Leiter, 1997). Hence, nurse executives may feel confidence knowing that the evidence supports their decisions to dedicate the resources necessary to addressing the problems associated with the work environment of nurses. Doing so may create competitive and sustainable business advantage, while concurrently promoting social change within health care organizations nationwide.

Recommendations for Action

Using a representative sample of RNs, I have evidenced that no differences exist in aspects of job satisfaction, as a function of generational cohort, gender, or origin of training. In addition, I have demonstrated that the work environment of nurses is a better predictor of global satisfaction than is personal satisfaction. The work environment is a

crucial factor that should be considered when addressing the global job satisfaction of nurses. Leadership is the single attribute that all parties agree is essential to a healthy work environment (Kramer & Schmalenberg, 2008). The transformation of health care systems across the nation will require strong and effective leadership at the points of services (Porter-O'Grady & Malloch, 2009).

The recommendations for actions are directed to nurse executives who have the power to affect the multidimensional factors that influence the job satisfaction of nurses. Organizational changes are necessary to spur human renewal, and to build competitive business advantage. Nurse executives may be inspired to enact change by considering the historical development of management theory, which emerged in the 19th-century industrial age in retort to industry petitions for mass production (Rundio & Wilson, 2010). Contextually, management was distinguished to solve the problems of efficiency and scale. However, bureaucracy emerged as the solution, which enabled hierarchical structure and empowered precise role definitions, and thereby authorized elaborate rules and procedures (Hamel, 2009, p. 92). Thematically, it appears that the industrial age paradigm is collapsing amidst an age of rapid 21st-century change. For organizational sustainability, future leaders must embrace management practices that focus on the achievement of socially significant and noble goals (Hamel, 2009, p. 92).

Chaordic leadership is an art that fosters competitive business advantage (Hock, 2000). In chaordic leadership, genuine leadership transpires from the leadership of all employees. The influences of leadership occur inward, upward, outward, and downward throughout the organization. Hock (2000) predicted that dominator management styles

will collapse under 21st-century challenges, emphasizing that the industrial age styles fail to distinguish the human component and thereby fail to renew the human spirit. Rather than holding a traditional downward looking perspective on employees, Hock asserted that managers should first manage their own integrity, knowledge, ability, conduct, ethics, and wisdom. Second, managers should manage their boss by building respect, necessary to support their initiatives to manage their employees. Third, managers should manage their peers by setting an example for them, motivating them, exciting them, persuading them, influencing them, informing them, forgiving them, interesting them, disturbing them, and absolutely, leading their peers. Last, managers should manage their staff by hiring good people, teaching them the art of chaordic leadership, recognizing them and rewarding them, and getting out of their way (p. 23).

On a large scale, nurse executives may generate competitive and sustainable business advantage by dedicating the resources necessary to incorporating best practice models, such as the Magnet Recognition Program (ANCC, 2011), which promotes system-wide improvements. The Baldrige Performance Excellence Program is another best practice model that promotes system-wide improvements (Evans, Ford, Masterson, & Hertz, 2012). The Joint Commission (TJC, 2012) accreditation standards conceptually contain many of the categorical criteria found within the aforementioned best practice models. Organizations that incorporate components of all three best practice models may have the most robust advances in organizational improvement. Similarly, but on a smaller scale, managers can engage staff nurses by dedicating the resources necessary to incorporating another best practice model, the Beacon Award for Excellence (Ulrich et

al., 2007; Vollers, Hill, Roberts, Dambaugh, & Brenner, 2009), which promotes system-wide improvements at the unit level. I have identified the recommendations for actions. The recommendations for actions will be disseminated to nurse executives when this research is published in the ProQuest dissertations & thesis database.

Recommendations for Further Study

There are recommendations for further study. In the interest of upholding patient advocacy, promoting human gratification, and endorsing economic gain, I believe that resources should continue to be directed to exploring the relative importance of the multidimensional constructs that affect the job satisfaction of nurses. I have shown that 58% of the variance in global job satisfaction is explained by personal satisfaction and satisfaction with workload. Remarkably, over one-half of the variance in global satisfaction is explained by these two scales on the MJS instrument. Presumably, some of the unexplained 42% would be accounted for by examining the other five scales on the MJS instrument— satisfaction with professional support, satisfaction with training, satisfaction with pay, satisfaction with prospects, and satisfaction with standards— however, some variance would likely remain unexplained and could be related to completely different factors, perhaps, life satisfaction or personal expectations. To further advance knowledge of factors that might affect RN job satisfaction, future researchers should consider the allocation of resources necessary to examine the participant's MJS data collected in its entirety. In addition, future researchers should consider the allocation of resources necessary to explore unexplained variance in global job satisfaction.

Resources should be directed to understanding the effects of workforce solutions on the job satisfaction of nurses. Dedicated resources are necessary to conduct longitudinal studies to gain insight into the effectiveness of workforce solutions over time. The notion of creating genuinely human organizations (Hamel, 2009, p. 98) holds much promise, but research is necessary to understand logistically how such initiatives could be implemented system-wide in health care organizations. Research that is designed to explore or examine the effects of environmental factors in the workplace—such as leadership, teamwork, engagement, efficiency, burnout, work-family balance, electronic medical record, smart phone usage, and instant message support—is also warranted. Furthermore, acknowledging that qualitative research may counterbalance the weaknesses of quantitative research and vice versa, I recommend that future researchers allow the methodologies to complement each other, and in doing so, promote strategic business advantage.

Reflections

Conducting this research study has been a fantastic journey. I have gained knowledge and insight, and strengthened my enthusiasm to petition for change. I had fully expected to affirm that Herzberg's motivational theory was applicable to the 21st-century workforce employed in the United States. In retrospect, I acknowledge that I had not fully considered the complexity of issues that nurses encounter in performing their day-to-day assignments. In reflecting on the research conducted, I concur that a transformation is necessary and that nurses must proceed as full partners, with physicians and other health care professionals, to reclaim the health care systems in America.

Summary and Study Conclusions

As provisions of the Patient Protection and Affordable Care Act (Public Law 111-148) are enacted, the health care sector in the United States will undergo a transformation. To manage adjustments and attain national goals, strong and effective leadership will be necessary. Organizational leaders have an obligation to identify inefficiencies and inadequacies, and to develop and implement plans for improvement. Nurse executives can strengthen competitive and sustainable business advantage by working to address problems that affect the quality and cost of care across the health care continuum. By virtue of sheer numbers, adaptive abilities, and scientific understanding of care practices, RNs have the potential to propel comprehensive transformational change.

In acknowledging the compelling organizational pressure to enhance workforce diversity—strategic to providing culturally relevant service—I identified the business problem as insufficient, evidence-based knowledge as to whether aspects of RN job satisfaction differ between generational cohort, gender, and origin of training. To determine the extent to which motivational theory is a useful framework for understanding RN job satisfaction, I analyzed personal satisfaction scores and satisfaction with workload scores as predictors of global satisfaction scores. Consequently, the purpose of this quantitative research was to advance knowledge of factors that might affect RN job satisfaction.

Using a representative sample of RNs employed in the United States, I have confirmed that no differences exist in personal satisfaction scores or satisfaction with

workload scores, as a function of generational cohort, gender, or origin of training. Furthermore, I have demonstrated that a nurse's satisfaction with workload is a better predictor of global satisfaction than is a nurse's personal satisfaction, and thereby confirmed that Herzberg's motivational theory is not supported in the sample of RN participants. The evidence-based knowledge that has emerged is that workforce solutions aimed at enhancing job satisfaction may be broadly categorized and that solutions distinctly aimed towards any specific demographic factor are not necessary. Moreover, the work environment of nurses is a crucial factor that should be duly considered when addressing the global job satisfaction of nurses.

In conducting this research study, I have revealed the multifaceted issues that nurse executives encounter in identifying and implementing strategies to enhance job satisfaction in a diverse association of stakeholders. By deploying organizational-wide initiatives to address the factors that affect the job satisfaction of nurses, organizations reciprocally reaffirm the human connection between those who render help, and those who need help rendered. In the interest of upholding patient advocacy, promoting human gratification, and endorsing economic gain, I believe that resources should continue to be directed to exploring the relative importance of the multidimensional constructs that affect the job satisfaction of nurses.

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Appendix A: The Measure of Job Satisfaction (MJS) Instrument

Opening Questions: Eligibility Criteria

Instructions: If you are agreeable to participate in this research study, please answer the following eligibility criteria questions by clicking on the mark next to the response that best describes you, or is most applicable to your current employment.

1. Informed consent to participate: I have read and understood the informed consent document and hence agree to participate in this research study voluntarily.
    - Yes
    - No (If a person indicated no, the electronic survey was configured to end the inquiry, indicating ineligibility)
2. Are you 18 years of age or older?
    - Yes
    - No (If a person indicated no, the electronic survey was configured to end the inquiry, indicating ineligibility)
3. Are you an actively licensed registered nurse (RN)?
    - Yes
    - No (If a person indicated no, the electronic survey was configured to end the inquiry, indicating ineligibility)
4. Are you currently employed as a registered nurse (RN) in the United States?
    - Yes

- No (If a person indicated no, the electronic survey was configured to end the inquiry, indicating ineligibility)

5. Participants are encouraged to submit their responses only one time. Have you completed this online survey before?
    - Yes (If a person indicated yes, the electronic survey was configured to end the inquiry, indicating ineligibility)
    - No

Demographic Variables

Instructions: The collection of your demographic information is necessary for the researcher to test the hypotheses of this research study. Please answer the following questions by clicking on the mark next to the response that best describes you.

What is your age range?

1. I was born between 1922-1945
2. I was born between 1946-1964
3. I was born between 1965-1980
4. I was born between 1981-1994

What is your gender?

1. I am female
2. I am male

In what country did you receive your basic nursing education?

1. United States
2. Philippines

3. Canada
4. India
5. United Kingdom
6. U.S. Territories
7. Korea
8. Nigeria
9. Other: Please specify

What is the highest degree of nursing education you have achieved?

1. I have a diploma in nursing
2. I have an associate degree in nursing (ASN)
3. I have a bachelor's degree in nursing (BSN)
4. I have a master's degree in nursing (MSN)
5. I have a doctorate degree in nursing (Ph.D, DNP, Dr.NP, DNSc, or DNAP)

How many years have you been licensed as a registered nurse?

1. I have been a licensed RN for 0 to 2 years
2. I have been a licensed RN for 3 to 8 years
3. I have been a licensed RN for 9 to 14 years
4. I have been a licensed RN for 15 to 22 years
5. I have been a licensed RN for greater than 23 years

What is your primary job title?

1. I am a staff nurse providing direct patient care
2. I am a manager, supervisor, clinical coordinator, or administrator

3. I am a nurse practitioner, clinical nurse specialist, nurse anesthetist, or nurse midwife
4. I am a nurse educator
5. Other: Please specify

What setting is your primary job title?

1. I work in a hospital
2. I work in a nursing home, long-term care, or an extended care facility
3. I work in home health care, community health, or school nursing
4. I work in academia, education, or research
5. Other: Please specify

What is the geographical location of your primary employer?

1	Alabama	27	Montana
2	Alaska	28	Nebraska
3	Arizona	29	Nevada
4	Arkansas	30	New Hampshire
5	California	31	New Jersey
6	Colorado	32	New Mexico
7	Connecticut	33	New York
8	Delaware	34	North Carolina
9	District of Columbia	35	North Dakota
10	Florida	36	Ohio
11	Georgia	37	Oklahoma
12	Hawaii	38	Oregon
13	Idaho	39	Pennsylvania
14	Illinois	40	Rhode Island
15	Indiana	41	South Carolina
16	Iowa	42	South Dakota
17	Kansas	43	Tennessee
18	Kentucky	44	Texas
19	Louisiana	45	Utah
20	Maine	46	Vermont
21	Maryland	47	Virginia
22	Massachusetts	48	Washington

23	Michigan	49	West Virginia
24	Minnesota	50	Wisconsin
25	Mississippi	51	Wyoming
26	Missouri		

The MJS Survey Instrument

Instructions: The MJS instrument has been designed to assess how groups of nurses feel about different aspects of their job. Please rate how strongly you are satisfied or dissatisfied with different aspects of your job by clicking on the mark to indicate your level of satisfaction. You will rate your level of satisfaction on a 5-point scale, ranging from 1 (*very satisfied*) to 5 (*very dissatisfied*), with a neutral selection of 3 (*neither satisfied nor dissatisfied*). Please rate your level of satisfaction with all statements even though some statements may seem similar.

How satisfied are you with these aspects of your work?	1	2	3	4	5
1. Payment for the hours I work	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
2. The degree to which I feel part of a team	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
3. The opportunities I have to discuss my concerns	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
4. My salary/pay scale	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
5. Being funded for courses	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
6. The time available to get through my work	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied

7. The quality of work with patients/clients	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
8. The standard of care given to patients/clients	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
9. The degree to which I am fairly paid for what I contribute to this organization	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
10. The amount of support and guidance I receive	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
11. The way that patients/clients are cared for	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
12. My prospects for promotion	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
13. The people I talk to and work with	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
14. The amount of time spent on administration	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
15. My workload	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
16. My prospects for continued employment	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
17. The standard of care that I am currently able to give	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
18. The opportunities I have to advance my career	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
19. The extent to which I have adequate training for what I do	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
20. Overall staffing levels	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied

21. The feeling of worthwhile accomplishment I get from my work	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
22. The degree of respect and fair treatment I receive from my boss	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
23. The degree of time available to finish everything that I have to do	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
24. What I have accomplished when I go home at the end of the day	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
25. The amount of job security I have	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
26. Time off for in-service training	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
27. The amount of personal growth and development I get from my work	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
28. The extent to which my job is varied and interesting	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
29. The support available to me in my job	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
30. The amount of independent thought and action I can exercise in my work	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
31. The opportunity to attend courses	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
32. The possibilities for a career in my field	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
33. The general standard of care given in this unit	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
34. The outlook for any professional group/branch of nursing	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied

35. The overall quality of the supervision I receive in my work	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
36. The amount of pay I receive	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
37. The hours I work	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
38. The extent to which I can use my skills	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
39. The amount of challenge in my job	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
40. The time available for patient or client care	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
41. How secure things look for me in the future of this organization	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
42. The contact I have with colleagues	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
43. Patients are receiving the care that they need	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
44. Overall, how satisfied are you with your job?	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied

Appendix B: The MJS Scoring Key

THE DAPHNE HEALD RESEARCH UNIT

The Royal College of Nursing of the United Kingdom

Measure of Job Satisfaction (MJS)

Introduction

The MJS was developed from the responses of a random sample of more than 700 community nurse members of the Royal College of Nursing to an item bank derived from the literature and from talking to key informants.

The MJS is a group measure designed to monitor the morale of community nurses following changes in legislation and the delivery of health and social care in the U.K. Norms for different groups of U.K. nurses are enclosed. The MJS has also been designed for anonymous completion and takes approximately 10 minutes to complete.

Coding and Scoring Key

This updated version of the MJS was developed using a second sample of 650 community nursing staff. It comprises 7 subscales which may be combined to give a measure of 'Overall Job Satisfaction'. There are 43 items all of which are scored as follows:

Very satisfied	5
Satisfied	4
Neither satisfied nor dissatisfied	3
Dissatisfied	2
Very dissatisfied	1

Analysis

The MJS is sensitive to differences in satisfaction over time and to differences in level of satisfaction between different groups of staff. Therefore, it should be analyzed according to job title. The first 43 items form 7 subscales of job satisfaction. Item mean scores are calculated for each subscale by dividing the sum of item scores by the number of items comprising that scale. For example, the 'Satisfaction with Standards' scale consists of 6 items. The item mean score would be the sum of all items divided by 6. Similarly 'Overall Job Satisfaction' is the sum of the first 43 items divided by 43.

The last question, item 44, is included to give an indication of global satisfaction. With large samples it can be used to give an indication of the relative importance of different

aspects of job satisfaction. For example, a larger correlation between 'Personal Satisfaction' and item 44 than between 'Satisfaction with Pay' and item 44 would suggest that personal satisfaction may be more important than pay. Such relative importance may vary between different groups of staff and/or over time.

The Scales

'Personal Satisfaction' 6 items, Cronbach alpha=0.85

21. The feeling of worthwhile accomplishment I get from my work
27. The amount of personal growth and development I get from my work
28. The extent to which my job is varied and interesting
30. The amount of independent thought and action I can exercise in my work
38. The extent to which I can use my skills
39. The amount of challenge in my job

'Satisfaction with Workload' 8 items, Cronbach alpha=0.88

6. The time available to get through my work
14. The amount of time spent on administration
15. My workload
20. Overall staffing levels
23. The amount of time available to finish everything that I have to do
24. What I have accomplished when I go home at the end of the day
37. The hours I work
40. The time available for patient or client care

'Satisfaction with Professional Support' 8 items, Cronbach alpha=0.89

2. The degree to which I feel part of a team
3. The opportunities I have to discuss my concerns
10. The amount of support and guidance I receive
13. The people I talk to and work with
22. The degree of respect and fair treatment I receive from my boss
29. The support available to me in my job
35. The overall quality of the supervisions I receive in my work
42. The contact I have with colleagues

'Satisfaction with Training' 5 items, Cronbach alpha=0.85

5. Being funded for courses

18. The opportunities I have to advance my career
19. The extent to which I have adequate training for what I do
26. Time off for in-service training
31. The opportunity to attend courses

'Satisfaction with Pay' 4 items, Cronbach alpha=0.90

1. Payment for the hours I work
4. My salary/pay scale
9. The degree to which I am fairly paid for what I contribute to this organization
36. The amount of pay I receive

'Satisfaction with Prospects' 6 items, Cronbach alpha=0.88

12. My prospects for promotion
16. My prospects for continued employment
25. The amount of job security I have
32. The possibilities for a career in my field
34. The outlook for my professional group/branch of nursing
41. How secure things look for me in the future of this organization

'Satisfaction with Standards of Care' 6 items, Cronbach alpha=0.90

7. The quality of work with patients/clients
8. The standard of care given to patients/clients
11. The way that patients/clients are cared for
17. The standard of care that I am currently able to give
33. The general standard of care given in this unit
43. Patients are receiving the care that they need

'Overall Satisfaction' 43 items, Cronbach alpha=0.95

This scale is calculated using all the above items.

Appendix C: Permission to Use the MJS Instrument

You replied on 10/4/2011 5:14 PM.

From: Michael Traynor Sent: Tue 3/8/2011 4:28 AM

To: Ann Huffenberger

Cc:

Subject: Re: Use of the Measure of Job Satisfaction (MJS) Instrument

Attachments:

Dear Ann
I am happy for you to use the MJS in your study. You will find a copy of the measure and the scoring key and an account of its development on my space on academia.edu
Please can you acknowledge the development paper in Journal of Advanced Nursing and I would appreciate a copy of your findings once you have written up your work,
With best wishes
Michael

On 07/03/2011 22:23, "Huffenberger, Ann"
wrote:

> Greetings Dr. Traynor-
>
> As a student of Walden University's Doctoral Business Administration (DBA)
> program, I am beginning work on a final doctoral project. I would like to use
> the Measure of Job Satisfaction instrument in my research. Use of the tool
> will be for educational purposes only; I seek to evaluate Herzberg's
> Motivational- Hygiene Theory by surveying a group of professional nurses.
>
> What must I do to secure permission to use the Measure of Job Satisfaction in
> my research study? I appreciate your time in replying.
>
> Sincerely,
>
> Ann
>
> Ann Huffenberger, RN

Appendix D: Permission to Reprint the MJS Instrument

You replied on 10/5/2011 6:38 PM.

From: Michael Traynor Sent: Wed 10/5/2011 1:20 PM

To: Ann Huffenberger

Cc:

Subject: RE: Measure of Job Satisfaction (MJS) Instrument

Attachments:

Dear Ann,
it is fine to reproduce it. I've put it and the other material up on my Academic.edu webspace.
I'm loooking forward to hearing your results
best wishes
Michael
Michael Traynor

_____

Sent: 04 October 2011 22:20
From Ann Huffenberger
To: Michael Traynor
Subject: RE: Measure of Job Satisfaction (MJS) Instrument

Greetings, Dr. Traynor.

I am a Doctoral Business Administration (DBA) student at Walden University completing research on RN job satisfaction. Earlier this year we corresponded about using the Measure of Job Satisfaction (MJS) survey instrument. You may recall giving me permission to use the survey instrument for my doctoral study project. I agreed to acknowledge your development paper published in the Journal of Advanced Nursing (Traynor & Wade, 1993) and share my findings with you once written. In retrospect, I forgot to ask permission to reproduce the actual MJS survey instrument in my dissertation document.

What must I do to secure permission to not only use the MJS survey instrument, but also to reproduce the MJS survey instrument in my dissertation work?

I appreciate your time in replying.

Ann

Ann Huffenberger, RN

Appendix E: U.S. Data Corporation Database Information

The sample of RN participants for this research study originated from an electronic database, which U.S. Data Corporation created from public records, licensing boards, and associations or organizations providing opt-in marketing lists. The following associations or organizations provided U.S. Data Corporation with opt-in marketing lists.

- Advanced Practice Lists
- Clinical Nursing Specialist Lists
- Geriatric Care Lists
- Home Health Care Lists
- Home Health Assistant Lists
- Midwife Lists
- Medicine Assistant Lists
- Nurse Anesthetist Lists
- Nurse Practitioner Lists
- Prescriptive Authority Lists
- Acute Care Practitioner Lists
- Adult Care Lists
- Family Care Lists
- Neonatal Lists
- Pediatrics Lists
- Adult Psych Lists
- Women's Health Lists
- School Nurse Lists
- Medical/Surgical Lists
- Critical Care - Adults Lists
- Community Health Lists
- Child Psychiatric/Mental Health Lists
- Public Health Lists
- Ob/Gyn Lists
- AIDS Lists
- Cardiology Lists
- Dermatology Lists
- Dialysis Lists
- Drug/Alcohol Lists
- Eye, Ear, Nose & Throat Lists
- Emergency Care Lists
- Neurology Lists
- Occupational Health Lists
- Oncology Lists
- Orthopedics Lists
- Peri-operative Lists
- Rehabilitation Lists
- Transplants Lists
- Urology Lists
- Perinatal Lists
- IV Certification Lists
- Family Psychiatric Lists
- Maternal - Child CNS Lists
- Medication Aide Lists
- Geriatric Aide Lists
- Reproductive Health Professionals Lists
- Family Planning Lists
- Pediatric Oncology Lists

Appendix F: Certificate of NIH Training Completion

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Ann Marie Huffenberger** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 09/15/2010

Certification Number: 515852

Appendix G: Virtual Invitation to Participate in Research

Subject : RN job satisfaction survey: Participate in this national survey today!
Date : Tue, Jul 17, 2012 08:12 AM CDT
From : Ann Huffenberger, RN
To : Ann Marie Huffenberger at Walden University

Greetings Professional Nurse!

You are invited to participate in an online research study, where factors that affect RN job satisfaction will be examined. Participation is voluntary, responses are anonymous, and 10 minutes of your time are necessary. Your personal satisfaction, workload satisfaction, and global satisfaction with nursing will be investigated.

The benefits to participating in this research study are twofold: (1) You may be pleased to know your input will contribute to evidence-based knowledge of factors relevant to employing a diversely inspired 21st-century nursing workforce; and (2) You may promote social change by strengthening patient advocacy through improved business practice, by raising the nurse executives' understanding of sustainable 21st-century workforce solutions.

The title of the research study is *Factors Affecting Job Satisfaction of Registered Nurses Working in the United States*. I am the sole researcher and a student in the Walden University Doctor of Business Administration program. When completed, the research study will be published in the ProQuest dissertations & thesis database.

Please take a moment today, join your colleagues nationwide and participate in this research study! The survey will close in 10 days— please click on the Web link to participate
http://www.surveymonkey.com/s/RNjobsatisfaction

I appreciate your commitment to advancing knowledge of factors that affect RN job satisfaction. You may contact me if any questions arise.

Thank you!

Ann

Ann Marie Huffenberger, BSN, MBA, RN
Doctor of Business Administration Student
Walden University
100 Washington Street South, Suite 900
Minneapolis, MN 55401

One-hundred thousand RN colleagues across the nation have been selected to participate from an electronic database of RNs in the United States.

Appendix H: Informed Consent to Participate in Research

Greetings Professional Nurse!

You are invited to participate in a research study, where the researcher will examine factors that affect registered nurse (RN) job satisfaction. The online survey will take approximately 10 minutes to complete. To be eligible to participate you must be: (a) 18 years of age or older, (b) actively licensed to practice as a RN in the United States, and (c) currently employed as a RN in the United States.

The purpose of this study is to advance knowledge of factors that might affect RN job satisfaction including generational cohort, gender, and origin of training (U.S. or International). Your personal satisfaction, workload satisfaction, and global satisfaction with nursing will be investigated.

The Measure of Job Satisfaction (MJS) instrument was designed to investigate nurse job satisfaction. The central question is, "How satisfied are you with this aspect of your job?" You will be asked to consider 44 occupational factors by indicating your response on a 5-point scale, ranging from 1 (*very satisfied*) to 5 (*very dissatisfied*). You are encouraged to answer the survey questions to the best of your ability, honestly and openly.

The benefits to participating in this research study are twofold: (a) You may be pleased to know your input will contribute to evidence-based knowledge of factors relevant to employing a diversely inspired 21st-century nursing workforce; and (b) You may promote social change by strengthening patient advocacy through improved business practice, by raising the nurse executives' understanding of sustainable 21st-century workforce solutions. There are no identified risks to participating in this research study.

Your participation is entirely voluntary. You will receive no incentive or reward to participate in this research study. You have a right to decline participation, and can withdraw from participating, by closing the Web site browser and effectively ending the research inquiry. There is no penalty for declining to participate.

Your privacy is protected. All participants will remain anonymous. All information you provide will be anonymous. Your name, or anything else that could identify you, will not be collected. Five years after the completion of this study, CyberShredder software will be used to erase the confidential files from the researcher's computer permanently.

The Institutional Review Board (IRB) at Walden University has provided Ann Marie Huffenberger permission to conduct this research study titled Factors Affecting the Job Satisfaction of Registered Nurses in the United States. The approval number for this research study is 06-30-12-0178384. The approval expires on June 29, 2013.

Ann Marie Huffenberger, RN is the sole researcher and a doctoral student in the Walden University Doctor of Business Administration (DBA) program, and who can be reached by phone: xxx-xxx-xxxx

Dr. Leilani Endicott is a Walden University representative, who is also available to discuss your participatory rights, and who can be reached by phone: xxx-xxx-xxxx

Please save a copy of this informed consent. If you are agreeable to participate in this research study, kindly begin by answering the opening eligibility questions by clicking on the box below, labeled NEXT.

Appendix I: Walden University's IRB Permission to Conduct Research

Subject : IRB Materials Approved-Ann Marie Huffenberger

Date : Sat, Jun 30, 2012 10:49 AM CDT

From : IRB at Walden University

To : Ann Marie Huffenberger

Dear Ms. Huffenberger,

The Institutional Review Board (IRB) has approved your application for the study entitled, "Factors Affecting Job Satisfaction of Registered Nurses Working in the United States."

Your approval # is 06-30-12-0178384.

Your IRB approval expires on June 29, 2013.

Walden University
Office of Research Ethics and Compliance

Appendix J: G*Power Analyses

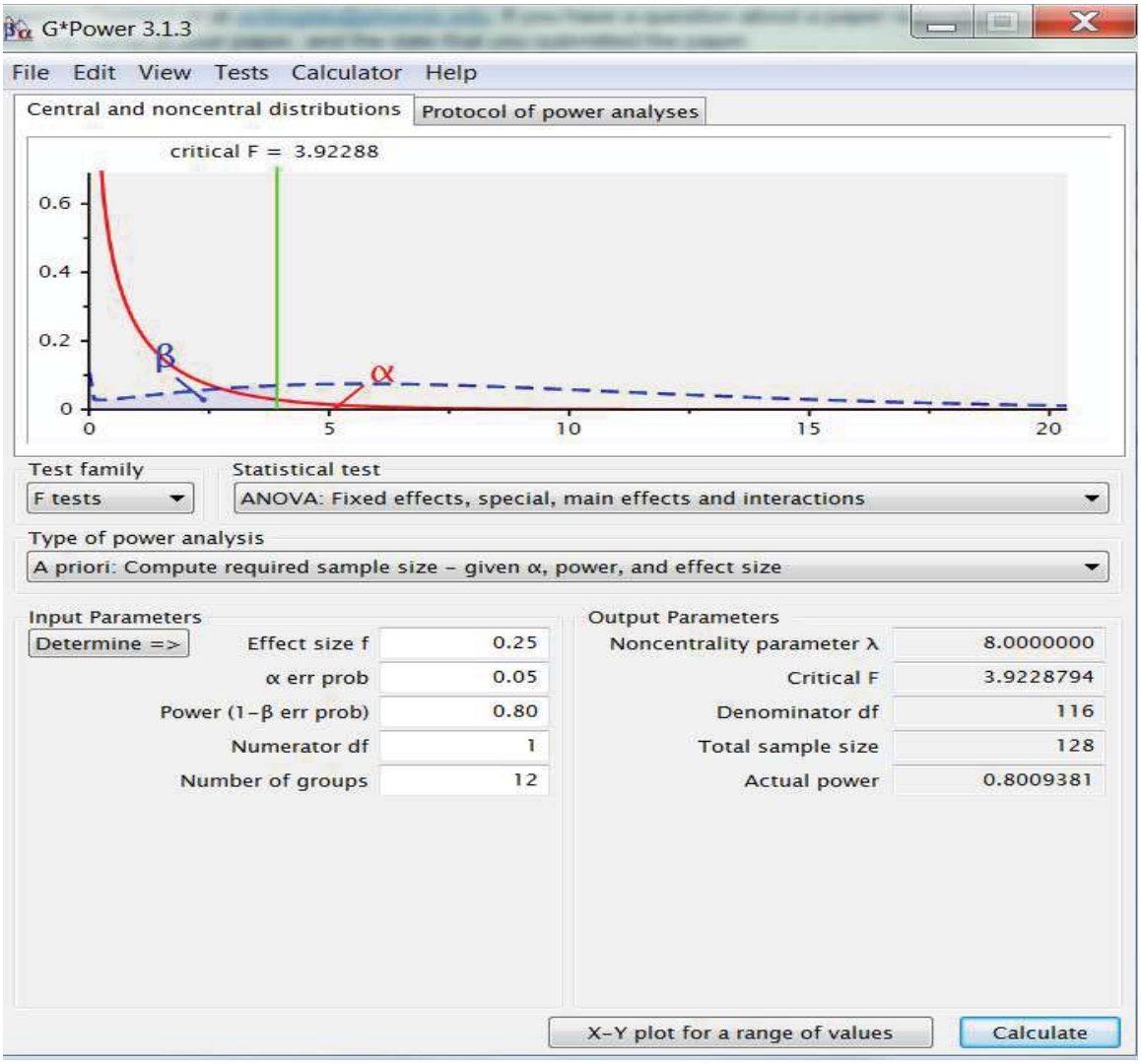

Figure J1. Results of G*Power analysis for factorial ANOVA 1 degree of freedom effects.

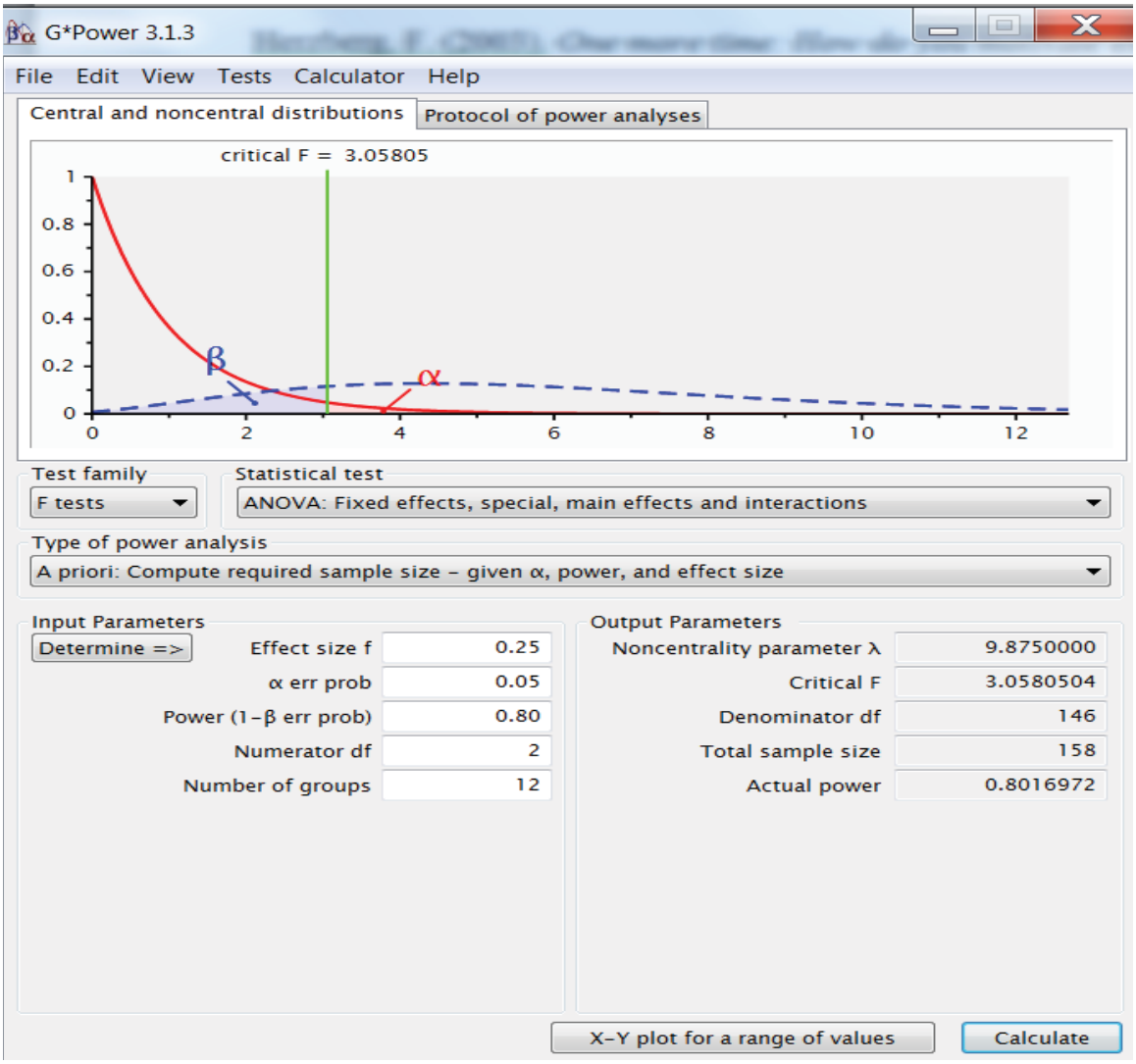

Figure J2. Results of G*Power analysis for factorial ANOVA 2 degree of freedom effects.

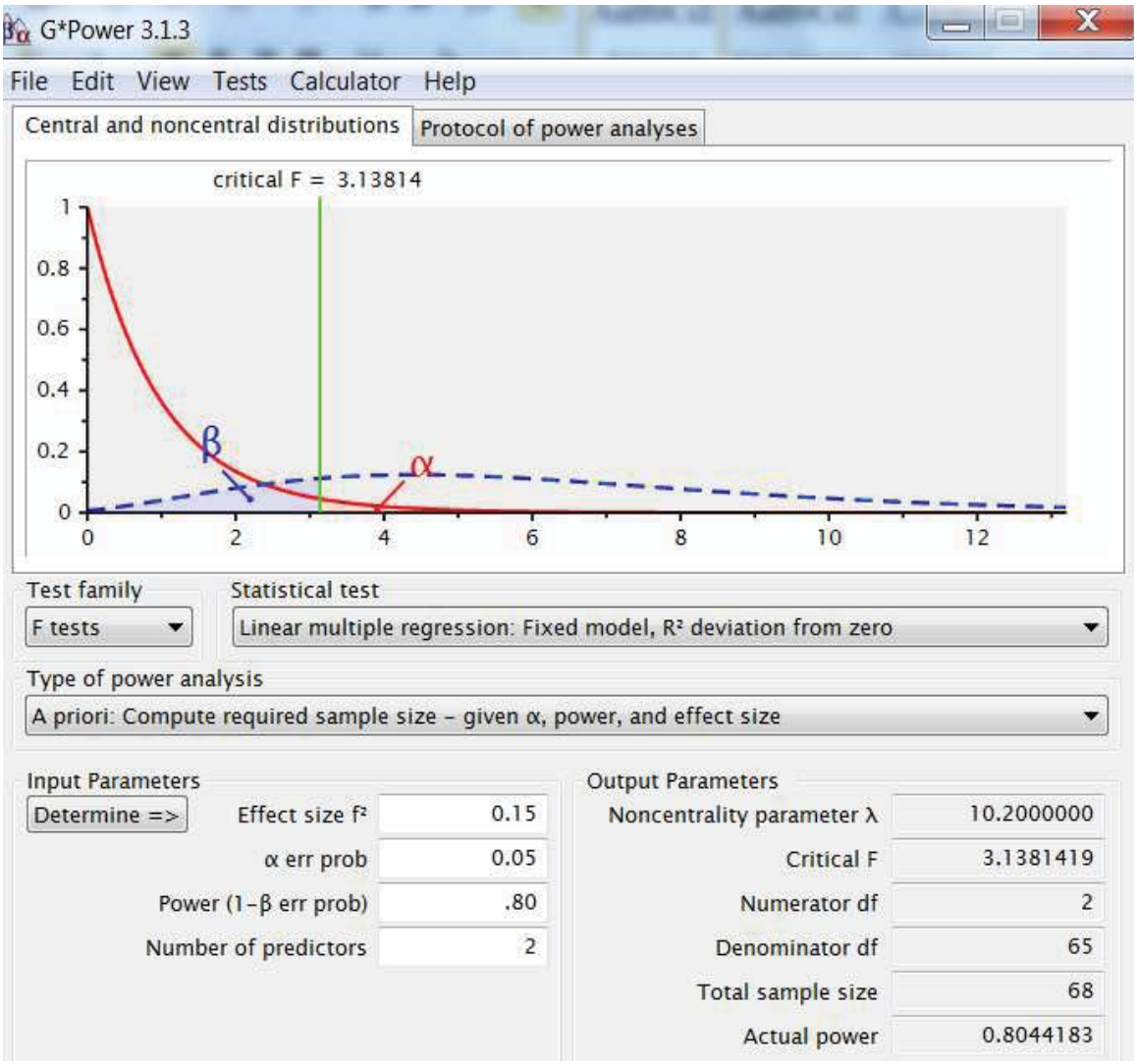

Figure J3. Results of G*Power analysis for multiple linear regression.

Appendix K: Reference Summary

	Recent references (dated 2008 or more recent)	Older references (dated 2007 or older)	Total
Books	7	8	15
Dissertations	1	0	1
Peer-reviewed articles	120	12	132
Other references	8	0	8
Total	136	20	156
Percentage of total	87%	13%	

Curriculum Vitae

Ann Marie Huffenberger

annmarie.huffenberger@gmail.com

Education

- Walden University (2009-2012). Doctor of Business Administration.
- University of Phoenix (2006-2008). Master of Business Administration.
- Gwynedd-Mercy College (1994-1995). Bachelor of Science in Nursing.
- Gwynedd-Mercy College (1985-1987). Associate of Science in Nursing.

Licensure

- Registered Nurse, State of Pennsylvania
- Registered Nurse, State of New York

Certification

- Nurse Executive Advanced- Board Certified (NEA-BC): (2010-Present)
- Critical Care Registered Nurse- Adult (CCRN): (1995-2004)

Honors and Awards

- 2012 World Business Forum, New York City. Leadership in action: A global meeting point for those inspired to build better people, better businesses, and a better world. Attendee selection based on academic performance, leadership experience, and quality of essay submitted.
- 2010 Quality & Safety Award, Penn Medicine at Rittenhouse. Operational award for designing and implementing an online solution to streamline the scheduling process for clinical staff members.

- 2010 Helen McClelland Award for Clinical Scholarship, University of Pennsylvania Health System. Nursing excellence award dedicated to those who have demonstrated a commitment to lifelong learning.

Professional Membership

- American Nurses Association (ANA)

Registered Nurse Experience

- 2008 – Current

Title: Registered Nurse, Clinical Coordinator

Organization: Good Shepherd Penn Partners. Philadelphia, PA 19146

Role: Clinical coordinator in a post-acute care hospital, responsible for all aspects of safe hospital operation in the absence of an administrator.

- 2007 – 2008

Title: Registered Nurse, Clinical Coordinator

Organization: Kindred Healthcare. Havertown, PA 19083

Role: Clinical coordinator in a post-acute care hospital, responsible for all aspects of safe hospital operation in the absence of an administrator.

- 2003 – 2007

Title: Registered Nurse, Nurse Administrator (NAI)

Organization: New York State Veterans' Home. Oxford, NY 13830

Role: Nursing supervisor in a long-term care facility, responsible for all aspects of safe operation in the absence of an administrator. NAI responsibilities included management of the Medicare office, case management of all beneficiaries.

- 1999 – 2003

Title: Registered Nurse

Organization: Crozer-Keystone Health System. Ridley Park, PA 19078

Role: Staff nurse assigned as needed to the hospital's intensive care unit, emergency room, telemetry unit, medical-surgical unit, and rehabilitation unit.

- 1987 – 2003

Title: Registered Nurse

Organization: Mercy Hospital of Philadelphia. Philadelphia, PA 19143

Role: Staff nurse assigned as needed to the hospital's intensive care unit, emergency room, telemetry unit, medical-surgical unit, interventional radiology (IR), and case management department.

Merchant Mariner Experience

Licensure: United States Coast Guard (USGC) Master of Sailing Vessels, 1600 ton, near coastal waterways, towing endorsement.

Experience: Sailed as a professional merchant mariner, discontinuously from 1989 to 1999. USGC license was rendered inactive in 2003.

Career Culminations:

- Captain of the barkentine *Gazela Primeiro*, a Class A tall ship. One of approximately 67 Class A tall ships in the world. Operated as a sail training program for volunteer crew members of all ages. Traveled throughout the coastal communities of the U.S. eastern seaboard, Gulf of Mexico, as well as Nova Scotia, Cape Breton, and Prince Edward Island, Canada.

- Captain of the schooner *New Way*. Operated by VisionQuest as a sail training program for adjudicated youth participating in the organization's OceanQuest program. Traveled throughout the coastal communities of the U.S. eastern seaboard.
- Captain of the schooner *William H. Albury*. Operated as a sail training program. Traveled throughout the coastal communities of the Abaco Islands, Bahamas.
- Chief mate of the schooner *Bill of Rights*. Operated by VisionQuest as a sail training program for adjudicated youth participating in the organization's OceanQuest program. Traveled throughout the coastal communities of the U.S. eastern seaboard.
- Chief mate of the schooner *Harvey Gamage*. Operated by the Ocean Classroom Foundation, dedicated to providing programs of education under sail to young people of the world. Traveled throughout the coastal communities of the U.S. eastern seaboard, as well as the coastal communities of the Caribbean Sea.
- Chief mate of the topsail schooner *ToleMour*. Operated by the Marimed Foundation, dedicated to Hawaiian high-risk adolescents participating in the organization's residential sailing program. Traveled throughout the coastal communities of the Hawaiian Islands, Hawaii.

Life aboard large traditional sailing ships has provided extraordinary insight into the organizational value of a visionary leader and an unconditionally cohesive team!

Research Interests:

Management: leadership, efficiency, teamwork, motivation, personal satisfaction.