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Evaluation of Empowerment Levels of the Cleveland Clinic Nurse

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2015

Abstract

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by

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BSN, Bowling Green University 1983

MSN, Regis University, 2010

MBA, Cleveland State University, 1991

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Nurses' perceptions of their work environment and empowerment in relationship to patient satisfaction are well explored in the literature. Empowerment has been linked to improved job satisfaction and improving the elements of empowerment cam improve overall patient satisfaction. This project examined 2 nursing units, 1 with lower patient satisfaction scores (Unit A) and 1 with higher patient satisfaction scores (Unit B), in order to compare their structural empowerment scores as measured by the Conditions of Work Effectiveness Questionnaire II (CWEQ-II). A total of 29 nurses who worked full-time, part-time, or-per diem on 1 of the 2 units were recruited to participate in the project (11 from Unit A and 18 from Unit B). Using Kanter's theory as a framework, the nurses were asked to complete the CWEQ-II and overall scores as well as subscale scores were calculated. Scores were estimated using a Mann-Whitney U test given the lack of normality and linearity of the data. Both units had a moderate overall empowerment level (Unit A: 19.55; Unit B: 21.47). Unit A had a significant difference in Access to Resources: Acquiring Temporary Help ($z = -2.07$, $p < 0.05$) as compared to Unit B. In comparing nurses with a Bachelor's and higher nursing degree to nurses with less than a Bachelor's degree, there was a significant difference in Access to Resources: Acquiring Temporary Help ($z = -3.115$, $p < 0.05$) and overall Resource Subscale ($z = -2.157$, $p < 0.05$). The project demonstrates the need for organizations to create a workplace that promotes empowerment among nurses as a strategy to improve patient and organizational outcomes. A work environment that promotes a nurse's control over his or her practice and decision-making ability may lead to higher patient satisfaction and may become the role model of a nursing practice environment as a result.

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Table of Content

Section One: Overview of the Evidence-Based Project 1

Introduction 1

Purpose Statement and Project Objectives 4

Project Questions 5

Significance/Relevance to Practice 5

Evidence-based Significance of the Project 6

Implications for Social Change in Project 7

Definition of Terms 9

Assumptions and Limitations 10

Summary 11

Section Two: Review of Scholarly Evidence 13

Literature Review 13

Job Satisfaction 14

Patient Satisfaction 15

Magnet and Shared Governance 16

Theoretical Framework 17

Section Three: Approach 19

Population and Sampling 19

Demographic Data 20

Instruments 20

Study Procedures 22

Protection of Human Rights 23

Data Analysis 23

Project Evaluation Plan 24

Summary 24

Section Four: Scholarly Product 25

Summary of Finding 25

Demographic Data……..…….…...…..25

Data from Conditions of Work Effectiveness Questionnaire…….…….…...…..25

Project Question #1……..……..…….……...26

Project Question #2……..……..…….……...26

Project Question #3……..……..…….……...28

Additional Findings ……..…….……..29

Discussion of Finding in Context of literature…….……..…….……...30

Implications ……..……..…….……...…...32

Project Strength and Limitations……...……..……..…….……...34

Recommendation for Remediation ……....…..35

Analysis of Self …….……...…….....…....35

Summary…….……...…….....…....38

Chapter Five: Executive Summary 40

Appendix A: Demographic Data **47**

Appendix B: Conditions of Work Effectiveness Questionnaire II **48**

Appendix C: Sample Consent **51**

Table One: Descriptive Statistics **52**

Table Two: Differences in Unit A and Unit B **53**

Table Three: Descriptive Statistics for CWEQ II **54**

Table Four: Differences in Empowerment Levels by Educational Status **56**

Section One: Overview of the Evidence-Based Project

Introduction

High quality patient care is a result of a fully competent and committed workforce that functions in an environment that empowers nurses to practice within their role. (Manojilovich, 2007). The word empower is defined as "to invest with authority" (empower, Merriam-Webster's Online Dictionary, 2014, para 1) and became a trend as a result of the self-help and political awareness movements in the 1960s and 1970s (Ryles, 1999). Chandler as (as cited in Monojlovich, 2007) was the first to describe empowerment in nursing by stating that empowerment enables one to act, where as power is about control and domination.

Research has demonstrated that empowerment is an important predictor of organizational commitment in staff nurses and is associated with less nurse burnout, improved job satisfaction, and patient satisfaction (Laschinger, Almost & Tuer-Hodes, 2003). For example, higher empowerment levels are linked to higher job satisfaction, autonomy, trust and respect and these tenets are related to the ability to shape nursing practice to improve patient satisfaction (Laschinger, et al., 2003). Further, high levels of empowerment are related to organizations that have strong shared-governance models and Magnet designation (Laschinger, et al., 2003). Organizations having these elements also have shown to have higher patient satisfaction scores.

Patient satisfaction is an important element in healthcare as it is associated with improved patient outcomes. High patient satisfaction scores are important in a competitive environment where consumers may choose to return to a specific hospital for future care. Research has demonstrated that higher patient satisfaction rates are associated with improved patient outcomes (Glickman, et al., 2001). Healthcare is now focusing on patient centered care, which includes dignity and respect, information sharing, participation and collaboration in healthcare decisions

(Boev, 2012). The Center of Medicare and Medicaid Services (CMS) now requires participation in The Hospital Consumer Assessments of Healthcare Providers and Systems (HCAHPS) to assess patient satisfaction on hospital care (Hospital Consumer Assessments of Healthcare Providers and Systems, n.d.) Patient satisfaction scores are increasingly important to consumers and healthcare providers as patient satisfaction scores are posted publically and are now linked to reimbursement. Thus, creating a work environment that empowers nurses is an important element in changing healthcare environment, so that improved patient satisfaction rates occur.

Future of Nursing: Leading Change, Advancing Health (Institute of Medicine, 2010) recommends that nurses should practice to their full extent of their education and training, contributing to an empowered nursing workforce. Nurses practicing at the full extent of their licensure leads to control of nursing practice and has been identified as an essential element to a work environment that is productive and satisfying (American Association of Colleges of Nursing, 2014). An exchange of information by nurses that affect the practice of nursing can lead to changes in standards of care, patient care processes, and polices that ultimately improves patient outcomes (Kramer et al., 2008). An environment that supports the practice of nursing improves nursing satisfaction with the work thus creating quality care and improved patient satisfaction.

Manojlovich (2007) posited that nurses need to have opportunities, information, resources, and support to be a collaborative partner to improve patient outcomes and these attributes are the elements of empowerment. Nursing leaders need to support evidenced-based approaches to create a supportive work environment that provide high-quality care and high patient satisfaction scores. Organizations that create shared governance models have shown an improvement in the quality of care, nursing satisfaction scores, and patient outcomes (Kramer et

al, 2008). Shared governance models provide an environment where nurses feel a sense of authority, power, and influence. Individual power has been associated with quality care and is the essence of empowerment thus can be linked to higher patient outcomes and patient satisfaction scores (Manojlovich, 2007). Magnet hospitals have demonstrated better work environments that have created cultures that stimulate positive behaviors that improve quality outcomes (American Nurses Credentialing Center, 2013).

It is important to create a work environment that supports the practice of nursing. The American Association of Colleges of Nursing (2014) describes a professional nursing practice environment as having characteristics where clinical care emphasizes quality, safety, collaborative practice, and professional accountability where nurses have input into policy development, performance improvement initiatives, and accountability for their own practice.

The Cleveland Clinic- main campus facility is a physician-led organization where less than ten years ago, nursing power in the organization was minimized by a physician-led infrastructure (Cleveland Clinic, 2014). As nursing leaders became positioned to be decision-making representatives in the organization, along with pursuit of the Magnet Accreditation, the environment at the Cleveland Clinic changed to empower nurses to practice collaboratively with physicians in order to improve patient outcomes (Cleveland Clinic, 2014). Research has concluded nurses practicing at Magnet designated hospitals have higher empowerment levels because nurses have a greater access to the elements of an empowered work structure (Laschinger, et al., 2003). Nurses, who are empowered, tend to work to the fullest extent of their education and training, which results in higher patient satisfaction scores. Thus, organizations need to provide an environment where nurses are empowered to enhance the patient satisfaction scores (Laschinger, et al., 2003). The measurement of empowerment has not been determined at

the Cleveland Clinic nor has there been an association of higher patient satisfaction levels with higher empowerment levels in this Magnet designated hospital. This project will attempt to link the empowerment of the nursing work environment and patient satisfaction scores of the Cleveland Clinic. Magnet designation currently does not require measurement of empowerment but suggests that nurses participate in shared decision making.

Purpose Statement

The purpose of this project was to determine if bedside medical-surgical nurses on units with higher levels of patient satisfaction levels have higher empowerment scores as compared to bedside medical-surgical nurses on the unit with lower patient satisfaction scores.

Project Objectives

The following project's measurable objectives were explored:

1. To compare the structural empowerment scores as measured by CWEQ II between two nursing units, one with higher patient satisfaction scores and one with the lower patient satisfaction scores.
2. To compare the presence of structures that predict structural empowerment as measured by the subscales of the CWEQ II (access to opportunity; access to resources; access to information; and access to support) between two nursing units, one with higher patient satisfaction scores and one with the lower patient satisfaction scores.
3. To compare the presence of structures that enhance structural empowerment as measured by the subscales of the CWEQ II (formal power and informal power)

between two nursing units, one with higher patient satisfaction scores and one with the lower patient satisfaction scores.

Project Questions

Several project questions were as follows:

1. Does the one medical-surgical unit with higher patient satisfaction scores have a higher presence of structures that predict structural empowerment as compared to the medical-surgical unit with lower patient satisfaction scores?
2. Does the medical-surgical unit with higher patient satisfaction scores have a higher presence of structures that enhance structural empowerment as compared to the medical surgical unit with lower patient satisfaction scores?
3. Does the medical-surgical unit with higher patient satisfaction scores have higher formal and informal power subscale scores than the unit with lower patient satisfaction scores?

Significance/Relevance to Practice

Empowerment is essential to providing safe patient care and will be explored. Empowered nurses are able to motivate others and control their practice and ultimately improve patient outcomes (Manoilovich, 2007). The concept of empowerment in relationships has significant implications to the practice of nursing as the complexity of patient care and healthcare environments continue to emerge. The profession of nursing has increased interactions intraprofessionally and organizationally, which is needed to improve patient outcomes. Nurses need to have opportunities, information, resources, and support to be a collaborative partner to improve patient outcomes and these attributes are the elements that lead to empowerment.

Nursing leaders must create work environments that support the bedside nurse in participatory decision-making. Creation of such work environment solidifies the relationship between empowered work environments and patient outcomes. Nursing leaders should create and sustain an environment that is trusting, improves job satisfaction, and provides a shared governance model for decision-making. Nurses want work activities that are challenging, learning opportunities, acquisition of technical knowledge and skills, growth opportunities and autonomy to practice (Manojlovich, 2007). It is important to look at the elements of empowerment to determine which elements continue to shape nursing empowerment, which ultimately affects patient satisfaction.

Evidence-based Significance of the Project

Nursing empowerment has been linked to the overall quality of performance and patient care. There was a significant relationship between structural empowerment and nurse-driven quality care including a decreased number of falls thus resulting in better patient outcomes (Purdy, Laschninger, Finegan, Kerr, & Olivera, 2010). The authors concluded that empowering workplaces have positive effects on nurse-driven quality indicators. The work conditions support positive patient outcomes by removing the conditions that enables dependency and powerlessness in the environment. Nurses, who have high empowerment, are autonomous, self-efficacious, and find their work meaningful, which in turn increases job satisfaction. Creating environments that support nurses to have higher psychological empowerment will in turn improve job satisfaction and quality patient outcomes (Purdy, Laschninger, Finegan, Kerr, & Olivera, 2010).

Another study suggests that nurses who have access to empowerment structures and a supportive environment influences the climate of safety for patients, which ultimately improves patient outcomes. Overall empowerment was related to nurses participating in hospital decisions, collaborative relationships and resulted in the provision of care according to professional standards of care (Armstrong, Laschinger, & Wong, 2009). Formal power is based on the role of the person within the organization and informal power is provided through relationship within the work environment (Laschinger, et al., 2010). When there is an increase in both formal and informal power, the employee will have access to resources that will enable them to work effectively. Laschinger, et al. (2010) surmised that nursing leadership would connect the creation of an effective work environment that will increase the empowerment of the nursing staff, which will ultimately increase patient outcomes and satisfaction. The article further discusses strategies to assure nurses' participate in clinical decision-making, which will create an empowered work environment. The strategies discussed were allowing nurses to participate in system-wide committees, developing peer review processes for patient safety errors, and implementing nursing driven protocols. Improving the work environment will improve patient satisfaction scores, which will allow hospitals to stay competitive in a changing healthcare environment (American Association of Colleges of Nursing, 2014).

Implications for Social Change in Project

The Institute of Medicine's 2010 report on nursing education is another pivotal change, which recommends the nurses, practice at the full scope of their licensure and improved new graduate education through residency in order to deliver safe and effective nursing care. All of these strategies have created the environment to change nursing practice in order to deliver safe

quality of care in an environment that nurse's feel empowered and engaged. This report promotes the provision for nurses to practice at the full extent of their licensure, which provides more opportunities for nurses in healthcare, which leads to greater empowerment of nurses to provide improved patient outcomes. Creating a workplace that promotes empowerment and determining if this type of work environment promotes higher patient satisfaction scores will provide a stronger understanding of the relationship between these components. A work environment that promotes nurse's control over their practice and decision-making ability leading to higher patient satisfaction can become the role model of a nursing practice environment through higher empowerment levels. The implications of this change may lead to better leadership training at the to improve the work environment which will lead to empowerment of the nursing staff. These changes in the work environment have led to social changes in nursing.

Another social change in healthcare is the transparency and mandatory reporting of patient outcomes, such as Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and core measures reporting. This social change has created changes in nursing and healthcare practices with the transparency of these measures, which include patient satisfaction scores. The nursing work environment is closely analyzed during the American Nurse Credentialing Center's (ANCC) Magnet certification to explore the promotion of quality in the environment that supports professional pro-activeness, the identification of delivery of excellence in nursing services to patients, and best practice in nursing practice (American Nurse Credentialing Center, 2013).

Definition of Terms

Formal Power: Pertains to the authority inherent in the job position (Kanter, 1977, 1993)**.** Derived from specific job characteristics such as: flexibility, adaptability, creativity associated with discretionary decision-making, visibility, and centrality to organizational purpose and goals (Laschinger, 2014).

Informal Power: Derived from social connections, and the development of communication and information channels with sponsors, peers, subordinates, and cross-functional groups (Laschinger, 2014).

Information: Refers to having the formal and informal knowledge that is necessary to be effective in the workplace (technical knowledge and expertise require to accomplish the job and an understanding of organizational policies and decisions) (Laschinger, 2014).

Magnet: Recognition of healthcare organizations for quality patient care, nursing excellence and innovations in professional nurse practice (American Nurses Credentialing Center, 2013).

Opportunity: Refers to the possibility for growth and movement within the organization as well as the chance to increase knowledge and skills (Laschinger, 2014).

Patient Satisfaction Scores: Patient satisfaction scores are measured using Gallup Survey and combines HCAHPS questions as well as customer engagement questions. Patient satisfaction with nursing care includes the measurement of frequency that nurses treat the patient with

dignity and respect, listens carefully to the patient, explain things to the patient, and provide a timely response to call button (Press Ganey, 2013a).

Power: The ability to mobilize information, resource, and support to get things done in an organization (Laschinger, 2014).

RedCap: Research **E**lectronic **D**ata **Cap**ture is a free, secure web-based application for the electronic collection and management of research and clinical study data (Partners Healthcare, 2013).

Resources: Relates to one's ability to acquire the financial means, material, time and supplies required to do the work (Laschinger, 2014).

Structural empowerment: The extent to which employees feel they have access to information, resources, and support to get things done in the organization (Laschinger, 2014).

Support: Involves receiving feedback and guidance from subordinates, peers, and superiors (Laschinger, 2014).

Assumptions and Limitations

Assumptions. The assumptions are that nurse's value having the knowledge, resource opportunities, and support to do their job. Nurses want to have the ability to function and work to their highest level of their licensure. The Magnet components of transformational leadership,

structural empowerment, exemplary professional practice, new knowledge, innovation and improvements and empirical quality results continue to be emphasized after the recent re-designation. Staff participation at all levels of the organization will continue to be examined. The Nurses who completed the survey looked at their overall perceptions about empowerment.

Limitations. The limitations of this project were related to the cross-sectional design. The number of variables is also be a weakness because looking at patient satisfaction related to the elements of empowerment eliminates other possible influences of the issue of empowerment on the unit. Other influences such as the qualities of leadership, complexity of care, staffing levels may impact empowerment and will not be examined. The comparison to other hospitals or even within hospitals at the Cleveland Clinic may not be applicable as only one other hospital has Magnet status, so findings could not be generalized. The use of an online survey may bias the sample because the survey is taken independently without supervision.

Summary

Recent literature from the Institute of Medicine's reports provides nursing the pivotal framework for changing the practice of nursing. So as a profession, the opportunity is ours to empower the bedside nurse in decision-making and assuring nurses are practicing at the full extent of their education, training, and experience. In order to empower the bedside nurse, the opportunity, resources, information, and support must be readily available so nurses may participate in shared-decisions about their practice, which will ultimately improve job satisfaction and patient satisfaction.

The literature has supported that the elements of empowerment do correlate with patient satisfaction and has even been linked to improving patient outcomes. The purpose of the project is to look at empowerment levels of the Cleveland Clinic bedside medical-surgical nurses to determine their empowerment levels in correlation to patient satisfaction. There is literature that indicates a significant relationship between structural empowerment and nurse-driven quality of care, which also is indicative in magnet hospitals with higher patient satisfaction scores. The next section of the paper will provide a detail scholarly review of the evidence in the literature.

Section Two: Review of Scholarly Evidence

The nursing practice environment can affect job satisfaction and patient satisfaction. Nursing leadership that supports an empowered work environment is positively correlated with nurse's job satisfaction. The following literature review will examine supporting evidence for this project starting with the literature on the empowerment, job satisfaction, and patient satisfaction, theoretical framework that is a strong conceptual component of this project and is rich in the make up of Kanter's Structural Empowerment theory.

Search Strategy

The review of the literature covered ranges from Kanter's Theory of 1977 to 2014. A number of bibliographic reference databases were utilized to retrieve sources for the literature review including MEDLINE and CINAHL. The search utilized terms such as empowerment, of work effectiveness, power, job satisfaction, patient satisfaction, and nursing. Reviewing the reference lists of the articles retrieved extended the literature search. All articles utilized were scholarly journals including the purchase of Kanter's original work, which was the guiding framework for the project.

Literature Review

The literature supports that connection between nursing perception of empowerment and job satisfaction supporting the need to create an environment where high job satisfaction occurs. The literature explores the elements of nurse manager's ability, intent to stay, collaborative practice and a supportive work environment as having positive effects on empowerment and job satisfaction, which can ultimately be linked to higher patient satisfaction. Patrick and Laschinger

(2005) posited that there is a link between organizational support and empowerment. Structural empowerment was positively associated with manager's perception of organizational support. The retention of quality nursing managers is important in a changing the healthcare arena. The concept found that empowerment and perceived organizational support were significant contributions to nurse manager's satisfaction (Patrick & Laschinger, 2005). An organizational structure that supports nursing manager's involvement in decision-making improves job satisfaction.

Job satisfaction

Similarly, there is a positive correlation to empowerment variables with intent to stay, thus correlating empowerment with intent to stay in the job (Ned, 2006). The nurses responded that they had greatest access to opportunity in their position followed by support, information, and resources, which led to higher empowerment scores. The higher intent to stay was correlated to higher empowerment levels and higher job satisfaction levels. Keeping experienced nurses in the organization is important to improving quality of care, thus creating an environment where nurses intend to stay is important for improving patient satisfaction scores. Laschinger (2008) found the elements of a practice environment that caused 20% of the variances of job satisfaction and these elements were related to the creation of an environment that supported quality of care, nurse manager's ability to provide leadership and support to nurses, adequate staffing and resources, and positive nurse-physician relationship. Creating a nursing work environment that is empowered creates higher nursing job satisfaction.

There is a strong linkage to the elements of social empowerment to job satisfaction. Individuals that are viewed as professional in a multidisciplinary team showed higher job

satisfaction. Such elements include being recognized by the team and being listened to by the team for their expertise. Nurses perceived their work environment to be somewhat empowering with the highest elements of access to opportunities and information and the least to access to support, and resources (Casey, Saunders, & O'Hara, 2010). A supportive environment that develops collaborative practice increases the empowerment levels of nurses and improves job satisfaction.

The impact of structural empowerment, psychological empowerment, and workplace incivility on new graduate nurses showed a correlation to empowerment and job satisfaction (Laschinger, 2008). Access to opportunity was the most empowering factor with support and formal power as least empowering. Workplace and supervisor incivility was greater than in previous studies by Laschinger (2003) with 90.4% reporting some degree of co-worker incivility. Assuring the work environment is a supportive environment can improve job satisfaction.

Overall, the literature demonstrates a strong link to the opportunity elements of structural empowerment, which improves job satisfaction (Smith, Andrusyszyn, & Laschinger, 2010). Creating a workplace environment that supports nurses to have organizational support and resources increases job satisfaction. Increasing decision-making ability, access to information, and opportunity provides an environment that supports higher empowerment levels. The literature demonstrates the linkage of a work environment that can improve job satisfaction in nurses.

Patient Satisfaction

There is a linkage between empowerment and patient satisfaction. Nurses in a study by Donahue, Pizza, Griffin, Dykes, & Fitzpatrick (2008) had a moderate empowerment score

overall with a significant positive correlation between empowerment scores and patient satisfaction scores. This supports the premise of higher empowerment of nurses can be linked to higher patient satisfaction scores. There was a link made between the consequences of empowerment by relating a lack of nursing empowerment to poor patient outcomes (Rao, 2012). When work environments are not supportive this can negatively affects patient outcomes.

The characteristics of the nursing practice environment were examined as well as patient and family satisfaction in the intensive care environment (Boev, 2012). The characteristics that were examined between the two units were staffing, resources, perception of their nurse manager, and foundation for quality care. The nurse manager's leadership ability was the most significant linkages related to patient satisfaction. Overall, there is a strong linkage between empowerment and improved patient satisfaction scores in multiple studies. These studies support creating an environment that supports the practice of nursing by providing resources and leadership, which increases patient satisfaction.

Magnet and Shared Governance

Methods to create a supportive environment have been explored with connecting empowerment to hospitals with shared governance models. There is evidence to link empowerment to an integrated shared governance model (Kramer et al, 2008). Nurses that work at facilities with integrated shared governance models have a higher degree of empowerment and examples of power were evident during interview process. This links the bedside nurses' empowerment to shared governance models as being upwardly positive.

The linkage of the workplace environment to improve decision-making was correlated as a method to improve actualized power (Bogue, Joseph, & Sieloff, 2009). This study links the use

of nurse practice councils as way to improve nursing power and identified three personal characteristics that were associated with positive scores on the use of nursing practice councils. These personal characteristics included agreeableness, extroversion, and intellectual openness.

Empowerment allows for the nurse to act autonomously in a working environment that fosters the ability for the employee to have the tools to make decision and take actions that benefit the work environment facilitates this. The literature is rich in connecting empowerment to nurse satisfaction and patient satisfaction, which ultimately will improve patient care by creating a work environment that promotes the elements of empowerment.

Theoretical Framework

Kanter's Structural Empowerment is the theoretical framework for this study. Kanter's Structural Empowerment Theory is based on the fact that removing the conditions that foster dependence and powerlessness in the environment will result in positive employee practices and improve performance. The origins of Kanter's Structural Empowerment Theory was from the area of sociology and the business perspective as she wrote a theoretical description about job constraints and organizational change that would be needed to improve work life (Kanter, 1977, 1993). Kanter had five assumptions in her theory including: 1) The organization has a large effect on the employee's life, 2) Employees' act in an adaptive way, 3) Employees have free will despite the restriction of their position, 4) How an employee behaves at work is a result of the description and rank of their job, and 5) Employee's ability to demonstrate their skills is not the same in all positions (Kanter, 1977, 1993). Kanter's theory describes work empowerment as access to the following: information, resources, support, and opportunity (Kanter, 1977, 1993). Information is considered to be the data, technological knowledge, and expertise needed for

performance. Access to resources is considered the needed supplies, material, money, and staff to meet the organizational goals. Access to support includes guidance, feedback, and direction provided by supervisors, peers, subordinates. Access to opportunity includes growth, mobility, and the chance to build knowledge (Kanter, 1977, 1993).

Kanter (1997, 1993) further describes work empowerment to be associated with informal and formal power that employees have in the organization. Formal power is derived from jobs that are important to the organization and allow for flexibility, adaptability, creativity associated with discretionary decision-making, visibility, and centrality to organizational purpose and goals. Informal power is derived from social connections, and the development of communication and information channels with sponsors, peers, subordinates, and cross-functional groups (Kanter, 1977, 1993).

Section Three: Approach

Project Design

This design project was a non-experimental survey design. The variables included the nurse empowerment elements identified through the CWEQ II and nurse and patient satisfaction levels through Gallup Survey results already obtained previously from the organization.

Population and Sampling

Patient satisfaction scores of the units at one of the Cleveland Clinic hospitals were reviewed to determine which two medical surgical units has the biggest gap between their patient satisfaction scores in order to identify one unit with low patient satisfaction scores as compared to a unit with high patient satisfaction scores. The overall patient satisfaction score was the determining factor using the most recent survey results available in August of 2014. Unit A was the lowest overall patient satisfaction scores in the 55th percentile and Unit B was the highest in the 85th percentile.

The use of a convenience sampling was conducted based on the population of interest, which are the registered nurses on the two identified medical surgical units. The inclusion criteria were medical surgical nurses working full-time, part-time or PRN on these two units. The exclusion criteria were float nurses. Using their work email, qualifying nurses received an email inviting them to participate in the survey. The email included a link to the survey. By clicking on the link, the nurses agreed to participate in the survey. Using a significance criterion of .05, power of .80, a sample effect size of .80 indicated a sample size of 26 in each group with a total sample size of 52 in order to demonstrate an effect size.

Demographic Data

The following demographic data was collected: age, gender, unit working, highest nursing degree earned, if currently pursuing a degree in nursing, certification status, years of experience, number of years in current job, and participation on unit or hospital-level shared governance.

Instruments

In order to measure patient satisfaction, the Hospital Consumer of Healthcare Providers and Systems (HCAHPS) scores were analyzed. HCAHPS scores, conducted by Press Ganey Associates, is the largest valid survey tool for patient satisfaction. This tool meets requirements for governmental reporting of patient satisfaction scores on Hospital Compare, a governmental reporting site of the Centers for Medicare and Medicaid Services (CMS). The scores used were the most recent known scores at the time of the CWEQ II launch.

HCAHPS scores are tabulated on a quarterly basis. The survey tool is a 32-question survey with 21 of the questions encompassing aspects of patient experience and 7 demographic items and 4 questions that allow patients to skip questions or direct them to the appropriate area of survey. The scores that were examined included overall satisfaction and likelihood to recommend scores. Patients are asked to rate the hospital on a scale of 0-10, 0 being the worst and 10 being the best to obtain the overall satisfaction score. The patent are then asked if they would recommend the hospital to friends and family using a scale of definitely yes, probably yes, probably no, and definitely no (Hospital Consumer Assessments of Healthcare Providers and Systems. (n.d.). The Cronbach's alpha values for each subscale are estimated to be 0.84 to 0.95, with the reliability value for the questionnaire at 0.98 (Press Ganey Association, 2002).

The CWEQ-II is a modification of the original tool developed by Chandler in 1986 and was developed by Laschinger, Finegan, Shamain and Wilk in 2001 to test Kanter's theory of structural empowerment in nursing. Kanter's theory of structural and work empowerment was first used to research empowerment in nursing by Chandler (1986). The Conditions of Work Effectiveness Questionnaire I (CWEQ I) measured the concepts of structural empowerment and was later revised by Laschinger, Finegan, Shamian, and Wilk (2001) to be shorter and more targeted tool for use in research studies. CWEQ-II has a construct validity given the section on global empowerment as empowered nurses use more effective work practices, which result in positive patient outcomes (Laschinger, Finegan, Shamian, and Wilk, 2001).

Written permission with was obtained from Laschinger to use the tool. The tool consists of 19 items that measure the six components of structural empowerment and a two-item global empowerment scale, which is used for construct validation purposes. The six components include information, support, resources, opportunity, formal power and informal power and are rated on a 5-point Likert scale where 1 = none and 5 = a lot. Construct validity and Cronbach's alpha reliability coefficients of .72 and 0.82 and has been used in multiple studies conducted between 1996 and 2008 (Laschinger, 2008). The construct validity of the CWEQ-II was substantiated in a confirmatory factor analysis that revealed a good fit of the hypothesized factor structure ($Xc^2 = 279$, df = 129, CFI = .992, IFI = .992, RMSEA = .054) (Laschinger, 2001).

Study Procedures

Institutional Review Board approval was obtained from Walden University and Cleveland Clinic. Following IRB approval, the registered nurses on the two units were invited to participate via email. The link to the survey was distributed using REDcap Survey tool using the email lists of the two floors provided by unit managers after verification with the staffing office to determine the number of active full-time, part-time and PRN registered nurse staff on each of the two units. Two email lists were created for each of the two units in order to email the survey link to the participants. The survey was developed in REDCap by student for distribution developing the demographic data at the top of the survey with the CWEQ II survey at the bottom of the survey. The information about confidentiality and how it will be maintained was included in the email sent to the staff.

Instructions for the survey were described at the beginning of survey which included instructions how to complete the survey, consenting information, completion date which will be three weeks after distribution, as well as the need to complete the survey completely. The survey was sent via email to the two groups using a separate link and a reminder email was provided to complete the survey at the halfway point, which is the middle of the second week as well as two days before the deadline. The survey confidentiality on the survey select toolmaker was made through password protections and no names will be included on survey.

The consent process was sent in the email that describes the survey. The consent described the purpose of the study, who is eligible to participate and that participation is voluntary, the extent of the involvement including time, and how confidentiality is maintained. The last sentence of the consent stated that by completing the survey through the survey link you

are consenting to the process. See the sample consent that received IRB approval of the consenting process (Appendix C).

Protection of Human Rights

The study was submitted to Walden University Institutional Review Board (IRB) as well as the Cleveland Clinic's IRB with approval with no changes needed. The protection of human rights was accomplished through the handling of data through the survey. All information about the participant's completing the data was anonymous. The survey was emailed to eligible participants with an information sheet providing instructions about the questionnaire completion and the registered nurse chose to complete the survey or reject the survey, Surveys in REDcap are labeled automatically as survey one, two etc. and each group was divided separately. The completion of the survey was considered the consent to participate in the project and the instruction will be included first on the survey page. There are no risks for the participants and the data is reported at unit-based level in aggregate format. The confidentiality of the data was maintained on a password-protected computer in a locked office. Data for this project was placed on encrypted USB drive for analysis and was stored in a locked desk with access by project leader only.

Data Analysis

Descriptive statistics were used to describe the sample. The scores of the subscales were determined according to the directions provided for using the tool. The scores were summed and a mean score was determined. The scores range is between 1 and 5 with higher scores representing higher access to the opportunity, resources, information, and support, along with

formal and informal power. A total structural empowerment score can be calculated by summing the six subscales with a score range between 6 and 30 and obtaining a mean score. Total mean scores ranging from 6 to 13 are low levels of empowerment and 14 to 22 are moderate levels of empower and 23 to 30 as high levels of empowerment. A Mann-Whitney *U* test was used to estimate the difference between the units.

Project Evaluation Plan

The evaluation process was conducted using formative evaluation for the purpose of getting information about the empowerment of nurses at one of the Cleveland Clinic hospitals. The evaluation would examine the data in order to determine a set of recommendations to improve the elements of empowerment. Many strategies have been conducted to improve patient satisfaction as the organization, which has an overall goal to be in the 95th percentile on these measures since they are publically reported. Measuring empowerment levels of the nurse provides insight to the organization as correlation between patient satisfaction and empowerment was found in other studies. The measurement of empowerment levels has not been conducted at the Cleveland Clinic.

Summary

The use of the CWEQ II can determine the elements of empowerment of two medical-surgical floors at one Cleveland Clinic Hospital to create a discussion for development of stronger empowerment by looking at a set of recommendations supporting the strengthening of the subscale components. This set of recommendations would support a stronger access to the elements of empowerment as a method for improving the work environment.

Session 4: Scholarly Product

Summary of Findings

A total of 29 surveys were collected out of the 113 surveys sent using Redcap (response rate of 25%), Two of the survey had missing data, but were not eliminated as the surveys had less than ten percent of the total data missing. Of the 29 surveys collected, 11 surveys were from Unit A and 18 were from Unit B.

Demographic Data

Descriptive statistics were used to describe each unit sub-sample as well as the overall sample. (Table One). Most of the respondents were female (86.2%), working fulltime (86.2%), with 41.4% under the age of 30 and 34.5% under the age of 40. Most had a bachelor's degree in nursing (65.5%) with most only have been in practice for less than 5 years (57.7%). In comparing the units, there was no difference between the units on age, years practicing, years in current role, or years on unit (Table Two).

Data from CWEQ II)

Descriptive statistics were used to describe the CWEQ-II scores for both units. The analysis was done according to the directions provided on the tool by summing and averaging the items to determine a mean score and standard deviation for each question as wells as the totals on the six subscales and total structure empowerment score. A Mann-Whitney *U* test was conducted to compare Unit A to Unit B.

Project Question #1: To Compare the Structural Empowerment Scores Between The Two Nursing Units

The total empowerment score can be categorized into low (6-13), moderate (14-22), and high (23-30) with a range of 6 to 30. Descriptive statistics revealed that both units were in the moderate range of total empowerment with Unit A at 19.55 and Unit B at 21.47. (Table three). A Mann Whitney U test was used to estimate the differences between each of the items and sub-scales on CWEQ II between Unit A and Unit B. Of the nineteen items analyzed, only one item was statistically significant. Unit B (3.28, SD = 0.96) was statistically higher than Unit A (2.36, SD = 1.29) on Access to Resources: Acquiring temporary Help When Needed ($z = -2.07$, $p < 0.05$) (Table Three)

Project Question #2: To Compare the presence of Structures that predict structural empowerment

There are three questions that comprise the opportunity subscale of the CWEQ-II questionnaire and were rated from 1 to 5 with 1 meaning none and 5 meaning a lot. The questions were related to opportunity in challenging work, chance to gain new skills and knowledge on the job, and the tasks use all of your skills and knowledge. The higher the subscale the more access to opportunity. This was the highest rated subscale for both Unit A (4.52, SD = 0.65) and Unit B (4.37, SD = 0.44). Nurses on unit A reported high opportunity for challenging work as a subset questions on the opportunity subscale (4.82, SD = 0.60) as compared to Unit B (4.44, SD = 0.78), indicating high access to opportunity. There was no statistical difference between the two units' scores ($z = -1.22$, $p > 0.05$).

Perception of Access to Information

Three questions comprised the information subscale. The questions related to information included the current state of the hospital, the values of top management, and the goals of top management. Unit A (3.12, SD = 1.45) and Unit B (3.52, SD = 0.87) were the reported means and standard deviations. Unit A had the highest subset question of having information about the current state of the hospital (3.18, SD = 1.47) along with Unit B (3.50, SD = 0.99). There was no significant difference between these scores ($z = -0.35$, $p > 0.05$).

Perception of Access to Support

There are three questions that make up the subscale of access to support subscale. The questions are if you get specific information about things you do well, specific information about things you could improve, and helpful hints or problem solving advice. Unit A (3.06, SD = 1.20) and Unit B (3.63, SD = 0.79) were the reported means and standard deviations. Unit A's highest subscale question was receiving helpful hints or problem solving advice (3.09, SD = 1.22) where as this was the lowest subscale question for Unit B (3.56, SD = 0.98). Unit B's highest subscale question was if you get information about things you do well (3.72, SD = 0.96), which was the lowest scoring question for Unit A (3.00, SD = 1.27). There was no significant difference between these scores ($z = -1.59$, $p > 0.05$).

Perceptions of Access to Resources

The lowest scoring subscale for both Unit A (2.64, SD = 0.98) and Unit B (3.11. SD = 0.66) was access to resources. The questions that are within this subscale include time available

to do necessary paperwork; time available to accomplish job requirements, and acquiring temporary help when needed. The highest scoring question for Unit A (2.73, SD = 1.01), is time available to accomplish job requirements; where as the highest scoring questions for Unit B of (3.28, SD = 0.96) was acquiring temporary help when needed. The lowest scoring questions for Unit A (2.36, SD = 1.29) was acquiring temporary help when needed and Unit B (2.83, SD = 0.79) was time to do necessary paperwork. As stated earlier the Access to Resources: Acquiring temporary help when needed ($z=-2.07$, $p<0.05$) was statistically significant as Unit B mean was 3.28 and ranked higher than Unit A at a mean of 2.36. There was no significant difference between these scores in total resources subscale ($z = -1.34$, $p > 0.05$).

Project Question #3: Compare the presence of structure that enhances structural empowerment – formal and informal power.

The Job Activities Scale is a measure of higher formal or position power scale and is measured on and 1 to 5 rating with 1 being none and 5 being a lot. The questions under this subscale are the rewards for innovation, amount of flexibility, and the amount of visibility of my work-related activities. Unit A (2.58, SD = 1.15) Job Activities scale and Unit B (3.09, SD = 0.82) were the reported mean and standard deviations. The highest question under this score was amount of flexibility with Unit A (2.73, SD = 1.27) and Unit B (3.50, SD = 0.79). There was no significant difference between these scores ($z = -1.63$, $p > 0.05$).

The Organizational Relationship Scale is a measure of informal power and higher scores represent stronger alliances in the organization. The questions under this subscale are if there is collaboration on patient care with physicians, being sought out by peers for help with problems,

and being sought by managers for help with problems, and seeking out ideas from professional other than physicians. Unit A (3.64, SD = 0.99) and Unit B (3.75, SD = 0.78) were the reported mean and standard deviation for the Organization Relationship Scale. The highest question in this subscale for Unit A (4.00, SD = 1.10) and Unit B (4.28, SD = 0.83) was being sought out by peers for help with problems. There was no significant difference between these scores ($z = -1.44$, $p > 0.05$).

Global empowerment subscale mean and standard deviation for Unit A were (2.86, SD = 1.42) and for Unit B were (3.61, SD = 0.63). Higher scores represent stronger perception of working in an empowered work environment. The highest scoring question for Unit A (3.00, SD = 1.18) was Work Environment Empowers Me and Unit B (3.67, SD= 0.84). There was no significant difference between the scores ($z= -2.04$, $p>0.05$).

Additional Findings

The literature supported the higher educated nurses tend to perceive themselves as empowered (Donahue, et al, 2008). Thus, education was recoded to create two groups. Diploma and Associates Degree prepared nurses and Bachelor's and Master's prepared nurses in order to compare any differences between the two groups on all items and sub-scales of the CWEQ-II. Those nurses prepared with a Bachelor's or higher tended to acquire temporary help when needed ($z = 3.11$, $p <0.05$) and higher access to resources as compared to Diploma and Associates prepared nurses ($z = -2.16$, $p<0.05$). (Table Four)

Discussion of Findings in Context of Literature

The purpose of this DNP project was to compare the structural empowerment subscales of the CWEQ-II between Unit A, with lower patient satisfaction score and Unit B with higher patient satisfaction scores. The overall scores for both Unit A and Unit B were in the moderate empowerment level with only one question showing a significant difference in the subscale question about acquiring temporary help when needed ($A=2.03$ $p<0.05$) under the resource subscale.

Opportunity was the highest-ranking subscale and resources was the lowest ranking subscale for both Unit A and B. Opportunity has been found to be the key to empowerment by allowing professional growth through the develop of knowledge and skills and has lead to a decrease in organizational commitment (Kanter 1977, 1993). Those with perceived access to opportunity invest in their work; seek ways to learn which contribute to personal growth and development (Kanter 1977, 1993). Unit A and Unit B scores indicate an opportunity to invest in their work and professional development through tuition reimbursement and conferences, workshop and inservices held at the organization. The study by Donahue, et, al, (2008) found the opportunity to be the highest subscale and related the reasons to be high availability of educational opportunities and partnerships with local universities.

The Resource subscale was the lowest subscale for both Unit A and Unit B with the questions acquiring temporary help being significant different between Unit A and Unit B. The scores indicated that Unit B had a stronger ability to access temporary help then Unit A. Laschinger, Almost & Tuer-Hodes (2003) stated that adequate staffing and access to resources makes it possible to deliver the care nurses expect and lack of staffing leads nurses to feeling frustrated and betrayed by nurses. The exploration of this lower subscale should be considered in

respect to obtaining resources to deliver quality care or nurses may be frustrated and unable to meet patient outcomes and satisfaction. This concept could lead one to believe that Unit A with lower patient satisfaction scores which also had the lower perception of access to resources: acquiring temporary help when needed may reflect this concept on this unit.

Laschinger, Finegan, Shamian, & Casier (2000) supported this concept by stating that having sufficient access to support, resources, and information allows nurses to feel more accountable and effective in their work for client outcomes. Further, the authors report that a nursing shared governance model allows for nurse's control over practice and nursing leadership is accountable for allowing nurses to have access to information, support and resources (Laschinger, Finegan, Shamian & Casier, 2000). An analysis of the shared governance structure of Unit A and Unit B would be recommended as 80% of the total sample stated that they did not participate on the unit-based shared governance and 90% did not participate on hospital shared governance.

The correlation of resources with the higher degrees of Bachelor's or master's degree compared to diploma and associates prepared nurse ($z=-2.15$, $p<0.05$) indicates that higher education provides stronger understanding of accessing resources or temporary help for their patient which may lead to higher patient satisfaction scores. It is noted that Unit B has 83% of the staff with higher education of Bachelors degree or higher, than Unit A with 45%. Donahue, et. al, (2003) supported these finding as nurses with master's degree perceived themselves to be highly empowered.

Overall, only one question and subscale has significant differences between Unit A with lower patient satisfaction scores and Unit B with higher patient satisfaction score and further exploration of these concepts need to be considered. The creation of an empowered work

environment is needed to support staff to provide quality patient care. The results of a higher education level on the access of resources should place an emphasis on the advancement of degree through tuition reimbursement on the use of onsite educational opportunities.

Lastly, the findings in this study indicated that nurses perceived their work environment as moderate level of structural empowerment. These results are similar to other scores reported in other studies, where Unit A mean was 19.45 and Unit B 21.42. Donahue, et al. (2003) reported a mean of 20.04 and Magnet hospitals in the article by Church (2006) was reported as mean of 20.91. Nurses on Unit A and B practice in a unit that has a moderate level of structural empowerment.

Implications

Implications for Practice

The examination of results should be conducted on a larger scale to review the workplace practices to determine the barriers that prohibit the nurse's access to empowerment structures. Areas of improvement on Unit A and Unit B may be related to autonomy and control over practice that may be resolved through a stronger shared governance model. The shared governance model would allow for nurses to participate in decision-making based on more information, which may increase informal power and information subscales. Through this model nurses would have more access to information and support to achieve departmental goals, which would create an autonomous work unit. The strength of a shared governance model will also become a forum to discuss work issues with open and honest dialogue, which builds trust in the organization (Laschinger, Almost, and Tuer-Hodes (2003). Managers will need to be visible and hold a shared-vision with the nursing staff. Other strategies may include assuring staff nurse participation on hospital and system committees in order to improve the subscales of information

and informal power. Involvement in these committees will provide a "voice" of the bedside nurse at the organizational level.

Implications for Future Research

The results of this project provided this first formal attempt to evaluate the nurse's perception of structural empowerment. The results showed lower subscale results in resources with an overall moderate total structural empowerment scores when comparing Unit A to Unit B. Future studies could include the CWEQ-II after six months and one year to determine a potential increase in the empowerment subscales after unit-based shared governance is implemented to determining if stronger participation in shared governance increases empowerment on these two units.

Implications on Social Change

The implications of this study on social change goes back to the Institute of Medicine's report that recommends nurses practicing at the full scope of their licensure in order to deliver safe and effective nursing care Institute of Medicine (2010). The elements of empowerments subscale are a major contributor of the structure that needs to be put in place in order to allow this vision to come true. Nurses need opportunity to increase their knowledge and return to school, information, and resources to improve patient outcomes and a supportive work environment that is collaborative in nature. Creating this workplace will increase the nurse's ability to practice at their full scope of their licensure.

Project Strengths and Limitations

Strengths

One of the strengths of the study is the ease of the completion of the survey tool. It is an easy Likert scale and can be completed in about 10-15 minutes. The use of Redcap was a good tool to develop the survey in a readable email format. The demographic data collected was needed to look at the characteristics of the sample population. The use of reminders during the process increased the completion rate as more surveys were returned after the reminders. All surveys were greater than 90% completed, which meant that none were eliminated.

Limitations

The largest limitation in this study is the small sample size. The number of survey results returned in a three-week time frame was only 11 for Unit A and 18 for Unit B with at 25% return rate and this number was below the estimated power analysis. Staff nurses have limited time to read emails and this may be a weakness in the project. There was a recruitment issue with the email version of the consent, as nurses often do not get to review emails on a regular basis, which may have been a cause of the low sample size. The project was set up for a three-week recruitment period and with only one email reminder at the halfway point. The email reminder did increase the number of study participants and a longer recruitment period and more frequent email reminders may have increased the sample size.

The CWEQ-II questionnaire has mainly been used in the Ontario, Canada with limited use in the United States, which makes the generalization of findings outside of this population limited. The use of a survey format is a limitation as those reporting may already have higher rates of empowerment and the demographics and results may not represent the population.

Press Ganey survey also is a self-reported tool and there is no way to ascertain if the survey was completed by patient and if the results represents the entire population served by the two units. There also is a delay in the Press Ganey survey results about 2-3 months so the results of the empowerment score does not fully match the patient satisfaction data obtained.

Recommendations for Remediation

Future projects should include a large number of participants with a longer survey collection time period with weekly reminders. Using the institutes such as Digestive Disease Institute versus Medicine Institute would provide a large number of total populations. This would increase the ability to analyze the data to determine the empowerment levels of nurses at the Cleveland Clinic.

Analysis of Self

As a Scholar

Prior to starting my doctoral degree journey, I would have stated I was fearful and lacked confidence that I was up to the standards of a doctoral degree. Although I am a hardworking person, I was not sure if my scholastic abilities would lead me to a doctoral degree although I have two masters, one in nursing and one in Business Administration. Being later in my career, I questioned the cost versus the benefits of saving money for retirement; however, I teach part-time as an adjunct faculty member for an RN to BSN program and realize that the doctoral degree would give me more opportunities to teach after retirement. As a scholar, I feel the engagement in this project has led to other possible projects and has increased my confidence in pursuing these projects. My greatest improvement in skills would be the ability to critically

interpret and synthesize the literature and then figure out how to implement these findings into my work place.

As a Practitioner

As a practitioner, this project had developed my critical thinking and analytic skills to make changes and provide evidence of educational methodologies. Simulation is a new educational methodology and has little evidence of improving patient outcomes with most of the evidence related to increasing confidence levels. As the Senior Director of Nursing Education, this project and journey has allowed me to look at other possible projects within the department to assure value in the nursing education in the acute care setting by providing validated outcomes. Nursing education has been a target for cost reduction and proving educational outcomes will be beneficial.

As a Project Developer

As a nurse educator, education seems to be the major cause of hospital's root cause analysis. This project has given me the ability to critical analysis the steps of a project implementation from the needs assessment through evaluation and create sound educational projects with outcomes. Currently, I am working on a project that will evaluate two teaching methodology (self-learning versus faculty-directed education) using simulation for critical care naïve nurse entering critical care with less than six months of critical care experience. The development of this project and educational programs has given me the confidence to develop and implement other programming in nursing education.

Professional Development

My continuation professional development will be in the dissemination of scholarly work to include publishing future hospital projects through publications, poster displays, and podium presentations. I will be presenting a poster display on a Novice to Expert Educational Model for Simulation, which will demonstrate where my department was over a year ago in their professional usage of simulation as an education modality, the educational effort that occurred using a Novice to Expert education process, and the results of their progress one year later. I have also applied for a podium presentation to 2015 Magnet Conference on the Use of a Nurse Driven Foley Removal Protocol and the educational efforts that occurred to improve the knowledge of CAUTI principles to 11,000 nurses. My goal is to have a publication within two years of the completion of my degree. My support and professional improvement will be through our research department that has mentoring process for professional writing.

The purpose of sharing the project results would be to assure the nurse managers, as stakeholders in the project are aware of the results. The nurse managers can act on the results and improve the nurses' perception of empowerment on the unit. Zaccagnini (2001) states that the purpose of sharing the results from a project is to assure the stakeholders are aware and to improve nursing practice by sharing the results with other healthcare professionals. This sharing provides an opportunity to explore the elements of structural empowerment at the unit level, with possible exploration of future presentations.

In order to use this data effectively, a review of the lower subscales of the structural empowerment can be explored through the literature and the development of a set of recommendations would be proposed and implemented. Nursing leadership of the current units has reviewed the subscales and this is the first attempt in the organization to evaluate the

elements of structural empowerment. The nursing leaders should use both the higher and lower subscale scores identified through this survey and plan future actions and interventions that could improve these subscales.

Focus groups of staff nurses could identify possible causes of the lower subscale scores and then this group could develop an action plan to improve these scores using a shared governance model approach at the unit level. After the action plan has been implemented, repeating the CWEQ-II at six month and one-year intervals can determine any possible improvement in subscales scores. These time intervals would show possible immediate improvement as well as possible sustained improvement. The dissemination of the data from the project could be exhibited via a poster display at the Shared Governance day, which is held every year in the fall at the one of the various hospitals. The data on this poster must show three display points, which would be done as pre-intervention, 6-months post-intervention, and one-year post-intervention.

The poster would exhibit the project questions, literature review, and the pre-assessment as conducted in this research. The data from this project, the six-month evaluation, and one-year evaluation would be displayed in a graphic format. This poster could also be submitted to the 2016 Magnet Convention as the results fit their criteria for poster presentations, as well as future manuscripts of the results.

Summary

In this section, the strengths and limitation that has been developed will be considered for future projects. The project has implications for social change including the ability of nurse to practice to the full scope of their licensure and possible future research using the CWEQ-II.

Although there was no correlation of patient satisfaction and nurse's perception of empowerment, future research needs to be conducted, as this is a worthy cause in the profession of nursing. Magnet hospitals have an environment that empowers nurses though a shared governance model, which include the elements of empowerment in the tool.

Section Five: Executive Summary

The nursing work environment is often toted as one that promotes autonomy and professional practice and the literature indicated that those hospitals with these types of environments have better patient outcomes and patient satisfaction. Nurses that work in an environment that promotes professional practice have higher nurse job satisfaction, less burnout and higher levels of organizational commitment. This opens the door for creating a work environment that promotes nurse empowerment. The beginning steps are to determine the nurse's perception of the elements of structural empowerment, so that a set of recommendations can be developed.

The structural elements of an empowered work environment include information, support, resources, and opportunities and those with higher scores in these subscales have higher job satisfaction. Nurse leaders need to create an environment that have the elements of structural empowerment as this will promote nursing care that is provided according to professional standards, which will lead to higher patient outcomes and satisfaction. Nurse leaders should be aware of the attributes that promote a structural empowerment work environment by encouraging autonomy and decision-making through the use of a shared governance model.

The author recommends that nurse leader conduct an empowerment survey for their nursing staff to determine the subscale scores and develop an action plan to improve the scores with follow-up repeat measures. Creating focus groups and unit-level decision-making structures such as a shared governance model for nurses on the unit can be one strategy to promote structural empowerment. Units that maximize the expertise of the nurses by allowing them input in their work environment structure will increase the control over their practice and can be accomplished by providing information, support, and resources. Providing the opportunity to

grow through advancing professional development opportunities may provide a stronger understanding of how to access resources, which will also lead to improved patient outcomes and satisfaction. Nursing leadership has the opportunity to change the work environment for the nursing staff and understand the relationship between empowerment, job satisfaction, patient satisfaction, and organizational commitment.

References

American Association of Colleges of Nursing. (2006). The essentials of doctoral education for advanced nursing practice. Retrieved from http://www.aacn.nche.edu/publications/position/DNPEssentials.pdf

American Association of Colleges of Nursing (2014). Hallmarks of the professional nursing practice environment. Retrieved from http://www.aacn.nche.edu/publications/white-papers/hallmarks-practice-environment.

American Nurses Credentialing Center. (2013). ANCC Magnet Recognition Center. Retrieved from http://www.nursecredentialing.org/Magnet.x

Armstrong, K., Laschinger, H., & Wong, C., Workplace empowerment and magnet hospital characteristics as predictors of patient safety climate. *Journal of Nursing Care Quality, 24*(1), 55-62. DOI: 10.1097/NCQ.0b013e31818f5506

Boev, C. (2012). The relationship between nurses' perception of work environment and patient satisfaction in adult critical care. *Journal of Nursing Scholarship, 4*, 368-375. DOI: 10.1111/j.1547-5069.2012.01466.x

Bogue, R., Joseph, M., & Sieloff, C. (2009). Shared governance as vertical alignment of nursing group power and nurse practice council effectiveness. *Journal Of Nursing Management*, *17*(1), 4-14. doi:10.1111/j.1365-2834.2008.00954.x

Casey, M., Saunders, J., & O'Hara, T. (2010). Impact of critical social empowerment on psychological empowerment and job satisfaction in nursing and midwifery settings. *Journal of Nursing Management*, *18*, 24-34. http://dx.doi.org/10.1111/j.1365-2834.2009.01040.x

Chandler, G. E. (1986). The relationship of nursing work environments to empowerment and powerlessness. Doctoral dissertation, University of Utah.

Church, J. A. (2006). Empowerment, structure, process, and outcome in Magnet and non-Magnet staff nurse practice: a quantitative study. Doctoral dissertation. University of Phoenix

Cleveland Clinic. (2014). Nursing leadership. Retrieved from http://my.clevelandclinic.org/nursing-institute/about/who-we-are.aspx.

Cleveland Clinic. (2015). Annual Summit by Toby Cosgrove. Retrieved from http://www.cleveland.com/healthfit/index.ssf/2015/03/cleveland_clinic_ceo_toby_cosgroves_state_of_the_clinic_address_today_watch_here_for_live_coverage.html

Donahue, M. O., Piazza, I. M., Griffin, M. Q., Dykes, P. C., & Fitzpatrick, J. J. (2008). The relationship between nurses' perceptions of empowerment and patient satisfaction. *Applied Nursing Research*, *21*, 2-7. http://dx.doi.org/10.1016/j.apnr.2007.11.001

Empower. (2014). In Merriam-Webster's Online Dictionary. Retrieved from http://www.merriam-webster.com/dictionary/empower.

Glickman, S., Boulding, W., Manary, M., Staelin, R., Roe, M., Wolosin, R., Magnus Ohman, E., Pererson, E., & Schulman, K. (2010). Patient satisfaction and it relationship with clinical quality and inpatient morbidity in acute myocardial infarction. *Cardiovascular Quality and Outcomes, 2*, 188-185. Retrieved from EBCSOhost.

Hospital Consumer Assessments of Healthcare Providers and Systems. (n.d.). *Background.* Retrieved from http://www.hcahpsonline.org/home.aspx.

Institute of Medicine. (2003). Keeping patients safe: Transforming the work environment of nurses. Retrieved from http://www.iom.edu/Reports/2003/Keeping-Patients-Safe-Transforming-the-Work-Environment-of-Nurses.aspx

Institute of Medicine. (2010). *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press.

Kanter, R.M. (1977, 1993). Men and women of the corporation (2nd ed.) New York: Basic Books.

Kutney-Lee, A., McHugh, M. D., Sloann, D.M., Cimiotti, J.P., Neff, D. F., Aiken, L.H. (2009). Nursing: A Key to patient satisfaction. *Health Affairs*, 28, 669-677. Doi:10.1377/hlthaff.28.4.w669.

Kramer, M., Scmalenberg, C., Maguire, P., Brewer, B. B., Burke, R., Chmielewski, L., … Waldo, M. (2008). Structures and practices enabling staff nurses to control their practice. *Western Journal of Nursing Research*, *30*, 539-559. http://dx.doi.org/10.1177/0193945907310559

Laschinger, H. K. S. (2014). Conditions of work questionnaire II. Retrieved from http://publish.uwo.ca/~hkl/tools/cweq/index.html.

Laschinger, H. K. S., Almost, J., & Tuer-Hodes, D. (2003). Workplace empowerment and Magnet hospital characteristics. *Journal of Nurse Administration*, *33*, 410-422. Retrieved from EBSCOhost

Laschinger, H.K.S., Finegan, J., Shamian, J., & Casier, S. (2000). Organizational trust and empowerment in restructure healthcare setting: Effects on staff nurse commitment. *Journal of Nursing* Administration, 30(9), 413-425. Retrieved from EBSCOhost.

Laschinger, H.K.S., Finegan, J., Shamian, J., & Wilk, P. (2001). Impact of structural and psychological empowerment on job strain in nursing work settings: Expanding Kanter's model. *Journal of Nursing Administration*, 31(5), 260-272.

Manojlovich, M. (2007). Power and empowerment in nursing: Looking backward to inform the future. *The Online Journal of Issues in Nursing* , *12*(1), 1-10. http://dx.doi.org/DOI: 10.3912/OJIN.Vol12No01Man01

Ned, N. (2006). Perceptions of empowerment and intent to stay. *Nursing Economics*, *24(1)*, 13-18. Retrieved from EBSCOhost

Patrick, A., & Laschinger, H. K. (2005). The effect of structural empowerment and perceived organizational support on middle level nurse managers' role satisfaction. *Journal of Nursing Management*, *14*, 13-22. Retrieved from EBSCOhost

Partners Healthcare. (2013). Research electronic data capture. Retrieved from http://rc.partners.org/edcredcap.

Press Ganey. (2013). Driving targeted performance improvement. Retrieved from http://www.pressganey.com/index.aspx

Purdy, N., Spence Laschninger, H. K., Finegan, J., Kerr, M., & Olivera, F. (2010). Effects of work environments on nurse and patient outcomes. *Journal of Nursing Management*, *18*, 901-913. http://dx.doi.org/10.1111/j.1365-2834.2010.01172.x

Ryles, S. M. (1999). A concept analysis of empowerment: Its relationship to mental health nursing. *Journal of Advanced Nursing*, *29*(3), 600-607. Retrieved from EBSCOhost.

Rao, A. (2012). The contemporary construction of nurse empowerment. *Journal of Nursing Scholarship*, *44*, 396-402. http://dx.doi.org/10.1111/j.1547-5069.2012.01473.x

Smith, L. M., Andrusyszyn, M. A., & Laschinger, H. (2010). Effects of workplace incivility and empowerment on newly graduate nurses' organization commitment. *Journal of Nursing Management* , *18*, 1004-1015. http://dx.doi.org/10.1111/j1365-2834.2010.01165.x

Sparks, A. M. (2012). Psychological empowerment and job satisfaction between baby boomer and generation X nurses. *Journal of Nurse Management*, *20, 451-460. Doi:10.1111/j.1365-2834.2011.01282.x*

Upenieks, V. V. (2003). Nurse perceptions of job satisfaction and empowerment: Is there a difference between nurse employed at magnet versus non-magnet hospitals? *Nursing Management*, 34, 43-44.

Zaccagnini, M. E. & White, K. W. (2011). *The Doctor of Nursing Practice essentials: A model for advanced practice nursing*. Sudbury, Maine: Jones and Bartlett Publishers.

Appendix A: Demographic Data

1. Age: _____

2. Male: _____
   Female: _____

3. Unit working: _____ (drop down selection of two units selected)

4. Full-time: _____
   Part-time: _____
   Other: (List) _____

5. Highest Degree earned in Nursing
   Diploma: _____
   Associates degree in nursing
   Bachelor's degree in nursing
   Master's degree in nursing
   Doctor's degree in nursing

6. Are you pursing a degree in Nursing?
   Yes: _____
   No: _____
   Degree pursing: _____

7. Are you certified in a nursing specialty
   Yes: _____
   No: _____
   Certification obtained in _____

8. Number of years practicing as a registered nurse: _____

9. Number of years practicing in current role: _____

10. Number of years practicing on this unit? _____

11. Do you participate in the unit-based shared governance committee?
    Yes: _____
    No: _____

12. Do you participate in the hospital-based shared governance committee?
    Yes: _____
    No: _____

Appendix B: Conditions of Work Effectiveness Questionnaire II

CONDITIONS OF WORK EFFECTIVENESS QUESTIONNAIRE - II

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

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

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

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

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

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

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

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

IN MY WORK SETTING/JOB:

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

within the institution is

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

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

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

Appendix C: Sample Consent

Conditions of Work Questionnaire II

Principal Investigator: Cynthia Willis

This letter invites you to participate in an evidenced-based research study. Please read the information to help decide whether you want to take part in this survey. The purpose of the study is to review the empowerment levels of two medical surgical units and compare them to the unit's patient satisfaction scores. You are eligible to participate in this survey if you work full-time or part-time on the one of the two medical-surgical units. PRN and float staff are not eligible to participate.

If you decide to participate, the extent of your involvement will be limited to completing the enclosed survey, Conditions for Work Effectiveness Questionnaire II (CWEQ II). It will take you approximately 20 minutes to complete the questions. No compensation will be provided for your participation

Participation in research is voluntary. Your decision will not impact you current or future performance reviews. You may withdraw your participation at any time without penalty by contacting the principal investigator. This is a minimal risk survey, with a risk to the confidentiality of your information that might identify you. All information collected will be used only for this research and will be kept confidential. There will be no connection to you specifically in the results or in future publication of the results. You will experience no direct benefit from participating but knowledge gained will improve how we can empower our bedside nurses. Once the study is completed, I would be happy to share the aggregate results with you if desire.

If you have any questions about research, please contact Cynthia Willis at email ciwill@ccf.org. If you have questions about your rights as a research subject, contact the Institutional Review Board at 216-444-2924.

By completing the SURVEY, you are indicating your agreement to participate in the survey. To begin the survey, click on the link below.

Link to Survey

Table One: Descriptive Statistics

Demographic data for total population and Unit A and Unit B population

	Total Sample		Unit A		Unit B	
	Range	Mean (SD)	Range	Mean (SD)	Range	Mean (SD)
Age (Years)	22 to 65	34.10 (11.50)	22 to 65	37.09 (14.29)	23 to 52	32.28 (9.41)
Years Practicing	<1 year to 38	9.53 (10.89)	< 1 year to 38	10.58 (14.18)	1 to 26.5	8.88 (8.70)
Years in Current Role	<1 year to 31	6.55 (8.05)	< 1 year to 31	7.48 (10.46)	< 1 year to 25	6.04 (6.66)
Years in Current Unit	<1 year to 25	5.77 (5.70)	< 1 year to 8	4.18 (3.20)	<1 year to 25	6.6.5 (6.63)

	Total Sample		Unit A		Unit B	
	N	%	N	%	N	%
Gender						
Female	25	86.2	11	100	14	77.8
Male	4	13.8	0	0	4	22.2
Work Status						
Full Time	25	86.2	11	100	14	77.8
Part Time	3	10.4	0	0	3	16.7
PRN	1	3.4	0	0	1	5.5
Highest Degree						
Diploma	4	13.8	2	18.2	2	11.1
Associates	5	17.2	4	36.4	1	5.6
Bachelors	19	65.5	4	36.4	15	83.3
Masters	1	3.5	1	9	0	0
Pursuing degree						
Yes	10	34.5	4	36.4	6	33.3
No	19	65.5	7	63.6	12	66.7
Certified						
Yes	5	17.2	3	27.2	2	11.1
No	24	82.8	8	72.8	16	88.9
Unit Shared Governance						
Yes	6	20.7	2	18.2	4	22.2
No	23	79.3	9	81.8	14	77.8
Hospital Shared Governance						
Yes	3	10.3	1	9	2	11.1
No	26	89.7	10	91	16	88.9

Table Two: Differences in Unit A and Unit B

	Unit A	Unit B	
	M (SD)	M (SD)	t, p
Age (years)	37.09 (14.29)	32.28 (9.41)	1.097, p>0.05
Years Practicing	10.58 (14.18)	8.88 (8.70)	.381, p>0.05
Years in Current Role	7.48 (10.46)	6.04 (6.66)	.444, p>0.05
Years in Current Unit	4.18 (3.20)	6.6.5 (6.63)	-1.106, p>0.05

Table Three: Descriptive Statistics for Conditions for Work Effectiveness Questionnaire II

	Unit A	Unit B	z, p
	M (SD)	M (SD)	
Access to Opportunity			
Challenging work	4.82 (0.60)	4.44 (0.78)	-1.575, p>0.05
Gain new skills and knowledge	4.36 (0.81)	4.33 0(.59)	-.348, p>0.05
Task that use skills and knowledge	4.36 (1.03)	4.33 (0.49)	-.906, p>0.05
Total Access to Opportunity Subscale	4.52 (0.65)	4.37 (0.44)	-1.219, p>0.05
Access to Information			
Current state of hospital	3.18 (1.47)	3.50 (0.99)	-.351, p>0.05
Values of top management	3.09 (1.45)	3.39 (0.85)	-.445, p>0.05
Goals of top management	3.09 (1.45)	3.50 (0.79)	-.659, p>0.05
Total Access to Information Subscale	3.12 (1.45)	3.52 (0.87)	-.523, p>0.05
Access to Support			
Specific Information about things you do well	3.00 (1.27)	3.72 (0.96)	-2.649, p>0.05
Comments about things to improve	3.09 (1.45)	3.61 (0.85)	-1.107, p>0.05
Helpful hints or problems solving	3.09 (1.22)	3.56 (0.98)	-1.194, p>0.05
Total Access to Support Subscale	3.06 (1.20)	3.63 (0.79)	-1.585, p>0.05
Access to Resources			
Time available to do paperwork	2.55 (1.04)	2.83 (0.79)	-.688, p>0.05
Time available to accomplish job requirement	2.73 (1.01)	3.22 (0.81)	-1.330, p>0.05
*Acquiring temporary help when needed	2.36 (1.29)	3.28 (0.96)	-2.073, p<0.05
Total Access to Resources Subscale	2.64 (0.98)	3.11 (0.66)	-1.340, p>0.05
Job Activities Scale (JAS)			
The rewards for innovation on the job	2.36 (1.36)	2.67 (1.14)	-.742, p>0.05
Flexibility in my job	2.73 (1.27)	3.50 (0.79)	-1.813, p>0.05
Visibility of my work-related activities	2.64 (1.21)	3.11 (0.96)	-1.248, p>0.05
Total Job Activities Scale	2.58 (1.15)	3.09 (0.82)	-1.631, p>0.05
Organizational Relationship Scale (ORS)			

	Unit A	Unit B	z, p
Collaborating with physicians	3.73 (1.10)	3.67 (1.41)	-.116, p>0.05
Being sought out by peers	4.00 (1.10)	4.28 (0.83)	-606, p>0.05
Being sought out by managers	3.09 (1.30)	3.44 (1.15)	-789, p>0.05
Seeking out ideas from other professionals	3.73 (1.01)	3.61 (0.85)	-333, p>0.05
Total Organization Relationship Scale	3.64 (0.99)	3.75 (0.78)	-.317, p>0.05
Total Structural Empowerment	19.55 (5.22)	21.47 (3.30)	-1.438, p>0.05
Global Empowerment			
Work environment empowers me	3.00 (1.18)	3.56 (0.92)	-1.417, p>0.05
Work is empowering	2.73 (1.19)	3.67 (0.84)	-2.219, p>0.05
Total Global Empowerment	2.86 (1.42)	3.61 (0.63)	-2.036, p>0.05

Table Four: Differences in Empowerment Levels between Educational Status

	Diploma/Associates	Bachelor/Masters	
	n=10 M (SD)	n=19 M (SD)	z, p
Access to Opportunity			
Challenging work	4.52 (0.85)	4.563 (0.68)	-3.22, p>0.05
Gain new skills and knowledge	4.2 (0.79)	4.42 (0.61)	-.710, p>0.05
Task that use skills and knowledge	4.30 (1.059)	4.37 (0.50)	-5.14, p>0.05
Total Access to Opportunity Subscale	4.33 (0.67)	4.47 (0.45)	-.352, p>0.05
Access to Information			
Current state of hospital	3.50 (1.51)	3.31 (0.83)	-.764, p>0.05
Values of top management	3.50 (1.51)	3.16 (0.80)	-1.148, p>0.05
Goals of top management	3.50 (1.51)	3.26 (0.80)	-.985, p>0.05
Total Access to Information Subscale	3.5 (1.49)	3.30 (0.90)	-.929, p>0.05
Access to Support			
Specific Information about things you do well	3.50 (1.35)	3.42 (1.02)	-3.08, p>0.05
Comments about things to improve	3.20 (1.62)	3.53 (0.77)	-.313, p>0.05
Helpful hints or problems solving	3.20 (1.23)	3.47 (1.02)	-.717, p>0.05
Total Access to Support Subscale	3.30 (1.28)	3.47 (0.83)	-.393, p>0.05
Access to Resources			
Time available to do paperwork	2.60 (1.075)	2.79 (0.79)	-339, p>0.05
Time available to accomplish job requirement	2.80 (1.03)	3.15 (0.83)	-.897, p>0.05
*Acquiring temporary help when needed	2.00 (0.81)	3.42 (1.02)	-3.114, p<0.05
*Total Access to Resources Subscale	2.47 (0.76)	3.17 (0.75)	-2.157 p<0.05
Job Activities Scale (JAS)			
The rewards for innovation on the job	2.30 (1.42)	2.68 (1.11)	-.946, p>0.05
Flexibility in my job	2.70 (1.16)	3.47 (0.91)	-1.68, p>0.05
Visibility of my work-related activities	2.80 (1.31)	3.00 (0.94)	-.433, p>0.05
Total Job Activities Scale	2.60	3.05	-1.318, p>0.05

	Diploma/Associates	Bachelor/Masters	
	(1.13)	(0.87)	
Organizational Relationship Scale (ORS)			
Collaborating with physicians	3.70 (1.49)	3.68 (1.20)	-.238, p>0.05
Being sought out by peers	4.20 (1.14)	4.16 (0.83)	-.396, p>0.05
Being sought out by managers	3.30 (1.25)	3.32 (1.20)	-0.24, p>0.05
Seeking out ideas from other professionals	4.00 (0.94)	3.47 (0.41)	-1.361, p>0.05
Total Organization Relationship Scale	3.80 (1.03)	3.66 (0.77)	-.624, p>0.05
Total Structural Empowerment	20,0 (5.13)	21.131 (3.63)	-.849, p>0.05
Global Empowerment			
Work environment empowers me	2.90 (1.10)	3.58 (0.96)	-1.647, p>0.05
Work is empowering	3.10 (1.37)	3.42 (0.90)	-.675, p>0.05
Total Global Empowerment	3.00 (1.20)	13.5 (0.71)	-1.039, p>0.05