2023

THE RELATIONSHIP BETWEEN NURSE PROFESSIONAL DEVELOPMENT PRACTITIONERS' PERCEPTIONS OF EMPOWERMENT IN THE WORKPLACE AND INTENT TO STAY POST COVID-19 PANDEMIC

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by

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DISSERTATION
Submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy at
The University of Texas at Arlington
August, 2023

Arlington, Texas

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ABSTRACT

THE RELATIONSHIP BETWEEN NURSE PROFESSIONAL DEVELOPMENT PRACTITIONERS' PERCEPTIONS OF EMPOWERMENT IN THE WORKPLACE AND INTENT TO STAY POST COVID-19 PANDEMIC

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The University of Texas at Arlington, 2023

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Nurse Professional Development (NPD) practitioners in the acute care hospital setting are often undervalued despite their crucial role. During the COVID-19 pandemic, they demonstrated adaptability by rapidly transitioning to virtual formats for onboarding nursing staff, while also shouldering the responsibility of ensuring staff competency in caring for COVID-19 patients. Additionally, NPD practitioners faced heavy workloads, having to retrain nursing staff who worked in indirect patient care roles, while also filling in during critical staffing shortages. To date, no studies have been found that explored key factors that predict intent to stay in the NPD practitioner population pre- or post-pandemic. Thereby, to address this gap, this study's purpose was to explore the relationship between NPD practitioners' perception of workplace empowerment and their intent to stay post COVID-19 pandemic. A cross-sectional, descriptive, and correlational design was employed. The study included 313 NPD practitioners from various backgrounds who worked in acute care hospitals across the United States. Employing linear

regression analyses, the relationship between *empowerment* and *intent to stay*, was examined. Results indicated that NPD practitioners' perception of empowerment as a composite construct was significantly associated with their intent to stay, with higher levels of empowerment associated with a greater intent to stay (β =.32, $p < .001$). In a multivariate model, formal power (β = .150, p = .043) and access to opportunities (β =.149, p = .015) were most positively, significantly associated with intent to stay. These findings emphasize the importance of empowering NPD practitioners to promote their commitment to the organization. The study aligns with Kanter's theory of empowerment, highlighting that empowering work environments positively impact retention. Further research can explore other variables such as job satisfaction and work engagement. Overall, the study offers valuable implications to retain NPD practitioners and improve patient care outcomes in the evolving healthcare landscape.

ACKNOWLEDGEMENTS

I would like to express my sincerest gratitude to my dissertation committee chair, Dr. Jessica Smith, and committee members, Drs. Regina Urban and Deborah Behan, for their invaluable guidance and support throughout this research journey. Their willingness to serve as my committee members and individual expertise were instrumental in shaping the outcome of this dissertation. I am truly grateful for their time, patience, and insightful feedback that have significantly contributed to the quality and success of this work. Thank you for your unwavering commitment to my academic growth and for being exceptional advisors.

DEDICATION

I would like to begin by expressing my gratitude to God for instilling in me a "can do" attitude and a spirit of determination. Throughout this journey, no matter how challenging it became, my determination to finish and ability to persevere are the keys to my success. I would like to dedicate this dissertation to my late Granny, Ms. Wessie, whose unexpected loss deeply impacted me during my academic pursuit. I am forever grateful to my husband, Derek, for his unwavering support and for shouldering the responsibilities of our family while I pursued my studies. I also want to extend my heartfelt appreciation to my mother, who has been my rock and support. Lastly, I want to convey my love and aspirations to my daughter Logan, whom I birthed in the middle of a world pandemic. God knew I needed you! To my bonus babies who are not so little anymore, Brook and Kobe, continue striving for excellence and embracing your uniqueness.

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CHAPTER I

Introduction

Nurse Professional Development (NPD) practitioners have an indispensable role in the acute care hospital setting. They are defined as a unit or centrally-based registered nurse whose primary responsibility is the professional development of frontline nurses (Association for Nursing Professional Development (ANPD), 2021). Despite their contributions to frontline nurses and the health care organization, their value within the hospital setting remains largely unrecognized. This lack of recognition became particularly evident in the face of unprecedented challenges posed by the rapid spread of the novel respiratory disease named coronavirus in 2019 (COVID-19). In the face of crisis, NPD practitioners demonstrated remarkable adaptability by shifting from traditional in-person orientation to a hybrid online format for onboarding nursing staff (Weberg et al., 2021; Weiss et al., 2021). Moreover, NPD practitioners had the crucial responsibility of ensuring that nursing staff were competent and possessed the necessary skills to safely care for patients diagnosed with COVID-19 (Weberg et al., 2021). They were also responsible for reviewing and constantly updating information to protect the public, patients, and staff as our understanding of COVID-19 evolved into what we now recognized as a pandemic (Weberg et al., 2021).

Amidst the pandemic, NPD practitioners were also tasked with heavy workloads due to rapid staff turnover and competing demands. Many frontline nursing staff were either leaving their full-time roles for lucrative contract agency jobs and/or leaving the profession entirely (Weiss et al., 2021). As a result of staff turnover, this led to increased pressures from executive leaders to rapidly onboard and orient newly hired staff more frequently in efforts to abate unit/department closures (Fox & Richter, 2021). Concurrent with onboarding new frontline staff,

NPD practitioners also had to reorient and retrain nursing staff who worked in non-clinical or indirect patient care roles (Fox & Richter, 2021; Weiss et al., 2021). These reoriented non-clinical nurses, including NPD practitioners, were now expected to fill in at the unit level during critical staffing shortages. With little time and high stakes, NPD practitioners had to work collaboratively to implement innovative strategies to protect the public and support hospital operations.

The COVID-19 pandemic compounded the rigorous role expectations experienced by NPD practitioners in the hospital setting. Prior to the pandemic, researchers found the role of hospital-based nurse educators as already intense and demanding. This, in part, was attributed to feelings of uncertainty, lack of leadership support, unclear expectations, and a lack of proper guidance and orientation into the role (Fritz, 2018). Due to a lack of research on NPD practitioners, health care administrators have little information to understand factors that influence NPD practitioner's job satisfaction and intent to remain with an organization.

Given the crucial responsibility of NPD practitioners in maintaining frontline staff proficiency, it is essential for researchers to begin identifying approaches that foster their commitment to an organization, especially in light of the heightened role expectations that emerged during and following the COVID-19 pandemic. Using Kanter's Theory of Structural Empowerment (Kanter, 1993), nurse researchers can generate knowledge for health care administrators about whether the degree of workplace empowerment, as perceived by NPD practitioners, influences their intent to stay with the organization. Described in this chapter's remaining sections are the background and significance, problem statement, and the theoretical underpinnings that guided the study, followed by the purpose statement, research questions, conceptual definitions, and assumptions.

Background

Empowerment has emerged as an increasingly studied concept among healthcare professionals, including staff nurses, nurse leaders, and academic nurse educators. Its potential influence on job satisfaction, performance, and organizational commitment makes it a key area of exploration for nursing researchers. Although the concept of empowerment may appear novel within the nursing profession, it has a well-established theoretical foundation. Kanter's (1993, 1997) structural empowerment theory has been widely applied across various populations, such as physical therapy, as well as within non-clinical corporations where organizational behavior and empowerment are deemed valuable (Miller et al., 2001).

Kanter's theory underscores the significance of empowerment in shaping the dynamics between leaders and followers within a professional environment. This concept is particularly relevant in the context of workplace empowerment, which has been found to have a direct impact on organizational commitment among staff nurses in hospital settings (Laschinger et al., 2010). Consequently, to enhance retention of staff nurses organizational leaders have a vital responsibility in creating and sustaining an empowered workforce. In the aftermath of the COVID-19 pandemic, and with the looming threat of a nurse workforce shortage, it is crucial to explore the potential benefits of applying Kanter's theory to the NPD practitioner population. By doing so, hospital executives can develop targeted management strategies that not only enhance retention efforts but also foster a supportive and empowering work environment. This, in turn, can contribute to improved job satisfaction and increased organizational commitment amongst NPD practitioners, which could indirectly influence better patient care outcomes.

Significance

In recent years, turnover and retention rates among registered nurses have become a progressively worse problem for health care organizations in the United States. Last year, registered nurses left the bedside at alarming rates, leading to record-breaking turnover rates for many regions across the States (NSI Nursing Solutions Inc., 2022). In 2021, the registered nurse national turnover rate was at 27.1% (NSI Nursing Solutions Inc., 2022). In 2019, before the pandemic, the national turnover rate for registered nurses was 15.9%. This is particularly concerning given the current and projected nursing shortages, which are expected to intensify as the demand for healthcare services continues to grow (Bureau of Labor Statistics, 2022). Unfortunately, the number of registered nurses working in the NPD practitioner specialty, as NPD practitioners, is unknown nationally, thus one cannot assume the above rates excluded them. To date, no known studies have been conducted that solely explored NPD practitioner retention or turnover rates.

High turnover rates not only impact the quality of patient care but also impose substantial financial burdens on healthcare organizations. On average, the cost of replacing one nurse can range between $34,000 and $60,000, depending on years of experience and specialty (NSI Nursing Solutions Inc., 2022). Average costs include recruitment, training, and orientation expenses, as well as productivity loss during the orientation period. While rising nurse turnover rates are costly, they will likely persist post pandemic.

Conversely, academic nurse educators play a key role in mitigating nursing workforce shortages because they help to prepare the next generation of nurses. However, they too face challenges related to job satisfaction, retention, and turnover. In 2021, over 90,000 qualified students were denied acceptance into baccalaureate and graduate nursing programs due to faculty

vacancies and budget constraints (American Association of Colleges of Nursing, 2021). This further exacerbates a workforce shortage, as the limited availability of academic educators hinders the training of new nurses. Subsequently, this could also affect the quality and comprehensiveness of course content provided in nursing programs.

Given these challenges, NPD practitioners working in hospitals have an even greater responsibility for training and developing nurses, as they must bridge the gap created by the shortage of academic nurse educators. This increased demand for their expertise underscores the importance of addressing job satisfaction, retention, and turnover among NPD practitioners to ensure a well-prepared and competent nursing workforce. In academia, academic nurse educators who perceived higher levels of empowerment reported increased work efficiency and organizational commitment (Sarmiento, Laschinger, & Iwasiw, 2004). In the hospital setting, it is unknown if NPD practitioners (i.e., hospital-based nurse educators) share the same experiences. In fact, there is very little literature on NPD practitioners, in general. Considering the role NPD practitioners have on frontline nursing staff competency and organizational outcomes, health care executives must remain cognizant of what influences their intent to stay.

Statement of the Problem

Nursing practice is rapidly changing due to new technologies, and the increasingly complex health care needs of the population. During the pandemic, NPD practitioners worked tirelessly to equip frontline nursing staff with the essential knowledge and skills needed to provide safe patient care while safeguarding themselves and their families. However, anecdotal evidence suggests that these efforts frequently went unnoticed, leading to frustration and burnout among NPD practitioners (Porter, 2023). Researchers have found empirical evidence supporting the principles within Kanter's theory of empowerment to enhance job satisfaction, mitigate

burnout, and strengthen organizational commitment (Sarmiento et al., 2004; Davies, Laschinger, & Andrusyszyn, 2006; Nedd, 2006; Baker, Fitzpatrick, & Griffin, 2011). Nedd (2006) contended that nurses who perceived a deficiency in empowerment structures in the workplace were more likely to leave the organization.

Concurrently, organizations where workplace empowerment behaviors existed have yielded improvements in academic nurse educators' job performance, satisfaction, and intent to stay (Baker et al., 2011; Sarmiento et al., 2004); however, a study of this kind has yet to be conducted in the population of NPD practitioners. Therefore, it is necessary for nurse researchers to generate knowledge that may inform interventions needed in the hospital setting to influence the NPD practitioners' perception of workplace empowerment.

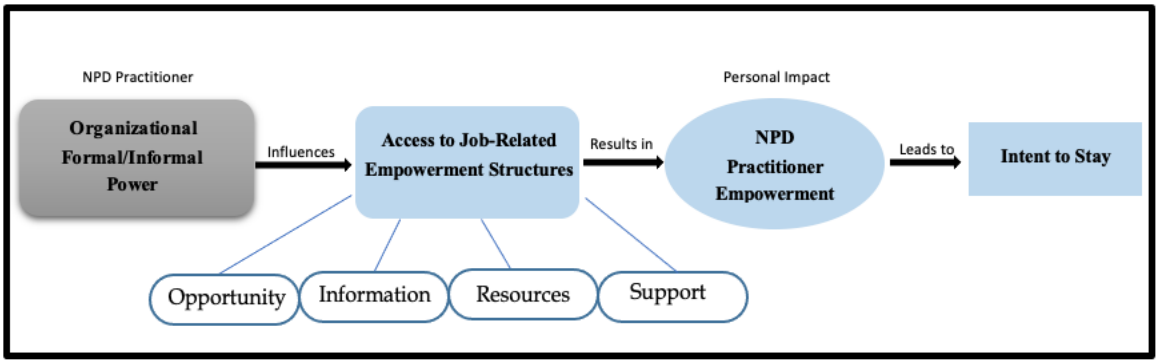
If NPD practitioners continue feeling unsupported in this everchanging health care environment, then this could adversely affect their quality of work and job performance, which may negatively impact the performance of frontline nursing staff. In light of the post-pandemic landscape, it is imperative to understand what influences NPD practitioners desire to stay with an organization. As of today, it is unknown to what degree, if any, a relationship exists between workplace empowerment and intent to stay among the population of NPD practitioners who work in the hospital setting in the United States. Findings from this study addressed this gap in knowledge by examining if NPD practitioners' intent to stay is influenced by their perception of empowerment in the workplace.

Theoretical Framework

Kanter's theory is based on the premise that employees who have access to systemic power factors and organizational empowerment structures are more effective. Kanter (1993) argued that power could emerge from formal and informal sources. Through access to systemic

factors of formal and informal power, the employee has more opportunities and better access to information that positions them in a situation where organizational empowerment can occur. The result is higher job satisfaction, higher motivation, and increased self-efficacy (Kanter, 1993). Using Kanter's Theory as the guiding theoretical model for the proposed study, the principal investigator will examine the relationship between intent to stay and the NPD practitioners' perceived access to formal power, informal power, and the four empowerment structures within the theory: opportunity, information, resources, and support within the acute care hospital setting (see Figure 1.1). In the subsections that follow, there will be a discussion of the main concepts and propositions associated with Kanter's theory.

Figure 1.1 Researcher Proposed Conceptual Framework based on Kanter's Theory of Structural Empowerment (Kanter, 1993)



Main Concepts

Organizational empowerment is defined as the organization's ability to genuinely engage staff and promote mutual interests and opportunities for growth (Erickson, Hamilton, Jones, & Ditomassi, 2003). Organizational empowerment is based on the notion that developing an individual's skills, providing opportunity for growth, and access to resources and information will increase the competence and satisfaction of that individual (Laschinger, 1996). With high organizational empowerment, it is hypothesized that employees are in an environment where they are more productive and effective in attaining organizational goals, regardless of their

personal dispositions (Kanter, 1993). Personal dispositions refer to their individual characteristics, traits, or qualities, which influence their thoughts, feelings, and behaviors. There are four main constructs in Kanter's theory of organizational empowerment: a) systemic power, b) empowerment structures, c) personal impact, and d) work effectiveness.

Systemic Power. Power is viewed as one's ability to execute tasks (Laschinger, 1996). Wong and Laschinger (2013) referred to power as the ability to gather resources (human and material) together to accomplish a common goal. Power is less about ruling over others and more about sharing equitable power amongst the team. Kanter (1993) divided systemic power between two sources: formal and informal power.

Formal Power. Formal power includes the concepts of job definition, discretion (flexibility), recognition (visibility), relevance (central to the organization purpose) and adaptability (Kanter, 1993; Laschinger et al., 2000). For instance, formal power is portrayed when nurses are allowed to be creative and innovative as it relates to problem solving and decision making. It is achieved when nurses are given autonomy and flexibility to address issues that affect their practice (Laschinger et al., 2000). Visibility is important when others can recognize the individual's independence in making decisions and executing tasks on behalf of their organization (Kanter, 1993).

***Informal Power*.** Laschinger et al. (2000) defined informal power as one having an established network of alliances with peers, subordinates, and executives inside/outside of an organization who can work collectively at achieving a common goal. It is derived from social connections. Nurses who have the support of their peers and their leadership team are thought to possess informal power in an organization (Kanter, 1993). For instance, nurses who can meet

with their upper executive to address concerns and, after that conversation, permission to initiate a change in practice is granted. These nurses may be viewed as having informal power.

Empowerment Structures. Access to empowerment structures within an organization is thought to be a major incentive to an employee's ability to remain productive at work (Laschinger & Havens, 1996). Structures are associated with access to employment opportunities through which an employee can advance, grow professionally, and gain new skills within an organization. Kanter's theory separates job-related empowerment structures into three different concepts: opportunity, power, and proportion structures.

Opportunity structures. Opportunity structures within an organization refer to the provision of advancement opportunities for an employee (Kanter, 1993). They also relate to an organization's mission to train or develop their own staff (Wilson & Laschinger, 1994). Access to opportunity structures implies that an employee can continue lifelong learning and development of their skills as a member of the organization (Laschinger Wong, & Grau 2013). Other opportunities within an organization might include a work-life balance, that is having a work schedule that is conducive to one's lifestyle and family obligations (Laschinger et al., 2000).

The value of opportunities can vary depending on the staff member's job title and level of education but ideally organizations would tailor this accordingly at all levels. Laschinger (1996) argued that nurses who are presented with high levels of opportunity are more likely to stay with an organization throughout their career. Individuals who work in an organization that lacks opportunity are more likely to become complacent in their role and stop seeking solutions to problems or being innovative (Laschinger, 1996). These individuals ultimately are thought to

lack aspirations and motivation to go further in an organization and often are dissatisfied with their employer (Laschinger, 1996).

Power structures. Power structures include access to resources, information, and support (Kanter, 1993; Laschinger et al., 2000). When an individual has access to information when needed, by way of a mentor or input from upper-level management, they have power. Organizations that can provide resources to their staff are thought to provide them with the options to gain knowledge imperative to performing their job duties (Kanter, 1993; Laschinger et al., 2010). When an employee is equipped with information to be successful, they are more likely to perceive their environment as empowering (Laschinger, Finegan, & Wilk, 2009). For example, nurses who have support from more experienced peers or their supervisor when needed perceive that the organization is vested in their best interest.

Feedback and guidance on handling situations that arise within the workplace are forms of support. As a result of ongoing feedback sessions, employees begin to feel empowered and a relationship of dependability and trust is developed which leads to increased job satisfaction and organizational commitment (Laschinger et al., 2000). Lastly, access to resources means having the money and/or equipment one would need to be productive and meet the demands of their job (Laschinger, 1996). If an employee must work in conditions where they don't have the necessary tools to be productive in their role, this can lead to job tension and dissatisfaction. Thus, Kanter's (1993) theory cites this as another important factor in empowerment structures that must exist within the organization.

Proportion structures. Kanter (1993) referred to proportion structures as the social composition of an employee's peers or superiors, that is the gender and race of individuals in the same work environment. If work environment is made up of like individuals, then Kanter's

theory proposes this is more likely to influence empowerment (Laschinger & Havens, 1996). Being different from the norm in an organization can influence proportion structures. Kanter's theory was developed and tested based on the premise that women in large business corporations were treated differently. Kanter argued that failing to have equal proportions within an organization can result in lack of empowerment amongst the minority group; this, in turn, would affect job satisfaction and effectiveness in role duties.

Personal Impact. Personal impact of organizational empowerment on employees refers to the achievement of personal factors including increased self-efficacy, high motivation, and increased organizational commitment, among others (See Figure 1.1). Kanter (1993) argued that through systemic power factors and job-related empowerment structures, positive changes are produced in the employee. Individuals with high self-efficacy address problems with the mindset to improve their work situations, whereas those with poor self-efficacy do little to change their situation, ultimately resulting in job tension and dissatisfaction (Manojlovich, 2005). For instance, researchers have shown that nurses who have high levels of self-efficacy are more likely to perform better within their role and remain motivated to stay with an organization (Laschinger et al., 2013).

Work effectiveness. Laschinger (1999) defined work effectiveness as one's perception of their overall effectiveness in doing their job. Kanter (1993) considered achievement of successes, respect and cooperation in organization, and client satisfaction as components of work effectiveness. The structural empowerment theory's key aspects are opportunities, behaviors, motivation to perform, and individual effectiveness (Kanter, 1993). A sense of teamwork ensues between the employee and the organization when structural empowerment exists. Nurses' freedom to exercise autonomy over their practice has been linked to improved performance and

better patient outcomes, which contributes to work effectiveness (Laschinger & Havens, 1996). Nurses want to exercise autonomy over their practice; therefore, when they are allowed to have input on their work conditions, buy-in occurs. Organizations where structural empowerment exists are thought to have more effective employees and better job satisfaction (Wong & Laschinger, 2013).

Relationships Between Concepts

- Formal power is positively related to opportunity, power, and proportion structures (Kanter, 1993).
- Informal power is positively related to opportunity and power structures (Kanter, 1993).
- Job-related empowerment structures are positively related to organizational commitment (Kanter, 1993).
- Job-related empowerment structures are positively related to work effectiveness and job satisfaction (Kanter, 1993).

Conceptual Definition of Terms

The terms used in this study must be defined for clarity amongst the readers. Clear definitions are provided below for structural empowerment, intent to stay, and NPD practitioners.

Structural empowerment is defined as an organization's provision of job related-empowerment structures, such as opportunity and power, that are necessary for an employee's growth and development (Laschinger & Havens, 1996). These conditions also include the employee having access to resources, shared decision making, and a network of alliances that support their role development and lead to better job performance, motivation, and commitment.

Intent to stay is defined as the nurse's willingness or likelihood that they will continue their employment with an organization (Price & Mueller, 1981). Intent to stay is based on the nurse's response to a series of questions addressing their intent to leave the organization at different time points, specifically in 1-year, 3-year, or 5-year intervals. Thereby, in this study the concepts of intent to stay and intent to leave are used interchangeably.

NPD Practitioner is defined as a registered nurse who works in the hospital setting, as a hospital-based nurse educator, who has a primary responsibility to influence the knowledge, skills, and ability of frontline nursing staff (Harper & Maloney, 2016).

Purpose Statement

The purpose of this quantitative, descriptive correlational study will be to examine if a relationship exists between the NPD practitioners' perception of empowerment in the workplace and their intent to stay in the acute care hospital setting.

Research Questions and Hypotheses

1. Does perception of *empowerment* (X_1) as a composite construct in the workplace predict *intent to stay* (Y) among NPD practitioners in the acute care hospital setting?

   Null Hypothesis (H_0): NPD practitioners' perception of *empowerment* overall does not predict their *intent to stay* in the acute care hospital setting.

   Hypothesis (H_a): NPD practitioners' perception of *empowerment* predicts their *intent to stay* in the acute care hospital setting.

2. To what extent, if any, does each empowerment subscale (i.e., *opportunity* (X_2), *information* (X_3), *resources* (X_4), *support* (X_5), *formal power* (X_6), and *informal power* (X_7)) relate to *intent to stay* (Y) when placed in one model?

a. Does the NPD Practitioners' perception of access to *opportunities* (X_2) relate to *intent to stay* (Y) in the acute care hospital setting?

   H_0: NPD practitioners' perception of access to *opportunities* does not predict *intent to stay* in the acute care hospital setting when evaluated in the same model.

   H_a: NPD practitioners' perception of access to *opportunities* predicts *intent to stay* in the acute care hospital setting when evaluated in the same model.

b. Does the NPD Practitioners' perception of access to *information* (X_3) relate to *intent to stay* (Y) in the acute care hospital setting?

   H_0: NPD practitioners' perception of access to *information* does not predict *intent to stay* in the acute care hospital setting when evaluated in the same model.

   H_a1: NPD practitioners' perception of access to *information* predicts *intent to stay* in the acute care hospital setting when evaluated in the same model.

c. Does the NPD Practitioners' perception of access to *resources* (X_4) relate to *intent to stay* (Y) in the acute care hospital setting?

   H_0: NPD practitioners' perception of *access to information* does not predict *intent to stay* in the acute care hospital setting when evaluated in the same model.

   H_a: NPD practitioners' perception of *access to information* predicts *intent to stay* in the acute care hospital setting when evaluated in the same model.

d. Does the NPD Practitioners' perception of access to *support* (X_5) relate to *intent to stay* (Y) in the acute care hospital setting?

   H_0: NPD practitioners' perception of *access to support* does not predict *intent to stay* in the acute care hospital setting when evaluated in the same model.

H_a: NPD practitioners' perception of *access to information* predicts *intent to stay* in the acute care hospital setting when evaluated in the same model.

e. Does the NPD Practitioners' perception of *formal power* (X_6) relate to *intent to stay* (Y) in the acute care hospital setting?

H_0: NPD practitioners' perception of *formal power* does not predict *intent to stay* in the acute care hospital setting when evaluated in the same model.

H_a: NPD practitioners' perception of *formal power* predicts *intent to stay* in the acute care hospital setting when evaluated in the same model.

f. Does the NPD Practitioners' perception of *informal power* (X_7) relate to *intent to stay* (Y) in the acute care hospital setting?

H_0: NPD practitioners' perception of *informal power* does not predict *intent to stay* in the acute care hospital setting when evaluated in the same model.

H_a: NPD practitioners' perception of *informal power* predicts *intent to stay* in the acute care hospital setting when evaluated in the same model.

Assumptions

Assumptions of the proposed study are following:

1) Work environments that NPD practitioners perceive as empowering have higher levels of access to information, resources, support, and opportunities to learn and develop.
2) NPD practitioners' perception of empowerment structures (i.e., access to information, resources, support, and opportunities to learn and develop) will influence their response to survey questions.
3) Intent to stay is contingent upon the NPD practitioners' perception of empowerment in the workplace.

Chapter Summary

Nurse leaders have a pivotal role in cultivating work environments where all nurses, irrespective of their title and role specialty, feel empowered and autonomous in decision-making (Laschinger et al., 2009). This suggests that studying the strategies that nurse leaders utilize to empower nurses, or the nurses' perceptions of those strategies, may lead to insights that improve job satisfaction and nurse retention among NPD practitioners as well. By linking the nurse leaders' use of empowerment structures to NPD practitioners' intent to stay, a greater understanding of what constitutes effective leadership for this population will result. Kanter's theory can offer guidance for health care executives' development of strategies to reduce turnover of NPD practitioners. As health care organizations continue to review strategies to combat nurse retention and improve patient safety, the nurse leaders' application of concepts within Kanter's theory pose as a key solution to the problem.

CHAPTER II

Literature Review

This chapter presents an examination of the literature regarding structural empowerment and intent to stay for nursing professional development (NPD) practitioners. A brief review of the NPD practitioner role history followed by an overview of their job responsibilities is provided. A detailed examination of relevant literature associated with empowerment and intent to stay will also be highlighted. The chapter concludes with a statement of the specific research problem and purpose for the study.

Search Strategy

Databases accessed for this literature review included Cumulative Index to Nursing and Allied Health Literature (CINAHL), Ebook Collection (EBSCOhost), Academic Search Complete, and MEDLINE. Keywords used to find relevant literature were *nurse professional development (NPD) practitioners, clinical nurse educator*, *empowerment,* and *intent to stay*. The search was limited to the years 2017 to 2022; however, seminal literature outside of this year range was included as it related to the theoretical underpinnings guiding this study. This search, using the prior terms in a combined strategy, yielded a paucity of information. This is problematic, because over the last 20 years, hospital-based nurse educators have gone by a variety of titles that have been driven by both employers and/or the specialty's professional organization.

In a second search, new search terms were added that included *hospital-based educator* and *nurse educator*. The timeframe of the second search was from 2000 to 2022, and it was limited to peer-reviewed journals and articles that were relevant to the additional search terms. Approximately 16 articles were found and reviewed, including both quantitative and qualitative

studies for possible inclusion in this review. Articles were categorized by NPD practitioners, then further categorized by key concepts within the study, such as empowerment and intent to stay. No articles were found that explored NPD practitioners' perception of empowerment and intent to stay, therefore this review will be based on academic nurse educators. Inferences from this literature could suggest that NPD practitioners in the acute care hospital setting experience similar challenges, but this cannot be stated with certainty.

NPD Practitioners

History of the Role

While the title, NPD practitioner, might seem foreign to the average nurse, it is not an entirely new role. In the late 1920's, the NPD specialty was first described by a term called *inservice* (Maloney & Woolforde, 2019). *Inservice* was considered an area of practice at the time that centered around educating nursing staff employed in the hospital setting. Formalization of the role did not occur until the 1960's and 1970's, when the American Nurses Association published information describing the role of inservice educators (Maloney & Woolforde, 2019). Shortly after role guidelines were published, the term *inservice education* was replaced with *nursing staff development*, which later led to the establishment of the NPD specialty (Maloney & Woolforde, 2019).

In the early 2000's, the American Nurses Association collaborated with the now, Association for Nursing Professional Development (ANPD), to construct NPD scope and standards of practice (Maloney & Woolforde, 2019). With this development, NPD practitioners now had a visual blueprint for the expectations of educators who primarily worked in the hospital setting. Today, the practice model is based on an open systems theory that

characteristically describes the cyclic work of an NPD practitioner using three categories: *inputs*, *throughputs*, and *outputs* (Harper & Maloney, 2022).

The *input* section of the model references the NPD practitioner and the learner. Through environmental scanning, the NPD practitioner can identify potential areas of opportunities and gaps in practice (Harper & Maloney, 2022). The *throughput* section of the model describes the role duties and responsibilities of an NPD practitioner (Harper & Maloney, 2022). Lastly, the *outputs* section of the model illustrates the influence NPD practitioners have on the learners and patient outcomes (Harper & Maloney, 2022). For example, the output of an educational initiative aimed at pressure injury prevention might be a reduction in hospital-acquired pressure injuries. The result of this initiative is twofold because it not only enhances the knowledge of frontline staff, but also it contributes to better patient outcomes, i.e., a reduction in hospital acquired pressure injuries. These three categories deliberately describe the daily work of an NPD practitioner.

While the practice model and specialty continue to evolve, the variations in title among NPD practitioners remains an issue. In the hospital setting, NPD practitioners are commonly referred to as clinical nurse educators and/or hospital-based nurse educators. Other titles include clinical resource nurse, nurse instructor, and staff development coordinator. Due to the inconsistencies surrounding these employer-based titles, this could indirectly explain the scarcity of information and research that focuses on this population. In the current study, the NPD practitioner is the preferred title as defined by their primary responsibility to provide clinical education and professional development of frontline nursing staff.

NPD Practitioner Role Responsibilities

Despite the title differences, the role duties are largely the same. For example, Harper, Aucoin, and Warren (2016) found that NPD practitioners top three workload activities included orientation, clinical education, and annual mandatory education associated with regulatory requirements. Tasks related to clinical education included assessing, planning, implementing, and evaluating nursing staff educational activities in the hospital setting (Harper & Maloney, 2016). Similarly, Coffey and White (2019) posited also that the clinical nurse educators' responsibilities included the same things such as, clinical practice support, professional development, and orientation; thereby, indicating that clinical-based nurse educators typically function as NPD practitioners without the title.

More recently, in a survey published on ANPD members and non-members, NPD practitioners reported having significant involvement in content development for nurses, fine tuning accreditation documentation, and facilitating simulation in the hospital setting (ANPD, 2021). NPD practitioners ensure nurses continue to build on their current knowledge and levels of competency in the clinical practice area. Curran (2014) found that staff nurses' provision of evidence-based, quality patient care was directly linked to their nurse educators' knowledge and experience.

Based on the NPD practice model, the NPD practitioner is responsible for environmental scanning and monitoring nursing practice for continuous quality improvement (Coffey & White, 2019; Harper & Maloney, 2016). Environmental scanning is conducted at the unit and system level to ensure nursing staff are providing optimal patient care. The NPD practitioner must frequently monitor the clinical environment for practice deficiencies and engage in auditing and evaluating data for quality improvement (Harper & Maloney, 2016; Warren & Harper, 2017).

When areas of improvement are identified, these findings must be communicated to the healthcare team and most often education is warranted as the first corrective action strategy.

Knowledge about current performance trends is vital information for the NPD practitioner, because it serves as the background data needed to promote and facilitate change. NPD practitioners are considered the change agents in an organization, meaning they inspire their peers and others to adopt a change or a new initiative (Warren & Harper, 2017). They inspire change by creating a culture of inquiry, and research, in efforts to promote the use of evidence-based practice (Malik, McKenna, & Plummer, 2015). The NPD practitioner is responsible for leading initiatives; therefore, this shifts their role focus from simply providing education to also improving organizational outcomes (Coffey & White, 2019; Warren & Harper, 2017).

In addition to being change agents, NPD practitioners are learning facilitators (Harper & Maloney, 2016). Warren and Harper (2017) describe a learning facilitator as one who can develop educational programs that promote learning and organizational change. Additional NPD practitioner responsibilities include interdisciplinary partnerships, professional role competence, and providing onboarding/orientation for new nurses (Harper & Maloney, 2016; Warren & Harper, 2017). Over the years, the NPD specialty has continued to advance in pursuit of ANPD's strategic goals and focus to increase visibility and recognition of the specialty.

With the complexities and everchanging role responsibilities of the NPD practitioner within the current healthcare system, it is unknown if the NPD practitioner views their role favorably. Anecdotal evidence suggests some hospital leaders have yet to formally align the role responsibilities of the clinical nurse educator with those of the NPD practitioner, thus indicating a possible gap in their knowledge of what constitutes the specialty. To mitigate the confusion

surrounding the NPD practitioner, more research is warranted as we work to advance the specialty. The next section will include a review of the literature testing Kanter's theory of organizational empowerment, followed by intent to stay, and conclude with statement of a specific research problem and purpose.

Review of Literature related to Kanter's Theory of Structural Empowerment

Kanter (1993) maintains that structural empowerment constructs have strong influence on the behaviors and attitudes of employees, thereby yielding empowering work conditions. The theory is based on the premise of two important systemic sources of power, i.e., formal and informal power. Kanter (1993) argued that formal power is based on job role, visibility, and relevance within the organization, while informal power is based on the network of alliances and connections in and outside of the organization. The presence of these systemic forces of power influence employees' access to empowerment structures, such as opportunity and power (Kanter, 1993). The structure of opportunity is believed to provide employees with the potential for career building and advancement (Kanter, 1993) and the structure of power is believed to equip employees with access to information, resources, and support (Kanter, 1993). When employees possess high levels of power it aids in their achievement of organizational goals and results in increased job satisfaction (Kanter, 1993; Laschinger & Finegan, 2005).

A core component of a healthy work environment is empowerment (Wei et al., 2018). As interests in healthy work environments increased, the application of Kanter's theory in the nurse work environment was in the forefront. Many scholars have identified that nurse leaders have a pivotal role in shaping and creating empowering work conditions (Chandler, 1986; Laschinger et al., 1999; Laschinger & Fida, 2015). One of the early researchers to examine work environments and empowerment theory determined there was a significant positive correlation between nurses'

perception of the work environment and the leader's behaviors (Chandler, 1986). The author concluded that nurses who felt powerless were less motivated and disengaged in the workplace. Organizations where empowerment conditions were nonexistent had higher incidences of incivility and bullying (Laschinger & Fida, 2015).

Kanter (1977, 1993) posited that when employees perceived leadership support this yielded more productivity and higher job satisfaction. In a study of staff nurses (n = 537), the authors concluded that the leader's use of empowering behaviors, such as shared decision making, nurse autonomy, mentoring, and support, significantly influenced their subordinate's perception of power and access to empowerment structures (Laschinger et al., 1999). While it is understood that nurse leaders have a pivotal role in ensuring their staff nurses feel empowered and have access to empowering work conditions, very few studies have focused on NPD practitioners. Thus, any conclusions may not apply to the latter group. In the absence of literature that focuses on the NPD practitioner population, the remaining sections will give a broad overview of the literature as it relates to nurse educators in the academic setting.

Review of Literature related to Empowerment in Nurse Educators

The role of a nurse educator is stressful and at times demanding. Nurse educators who work in the academic environment with students or in the hospital setting with licensed nurses, i.e., NPD practitioners, have a pivotal responsibility to influence the professional development of frontline nursing staff (Sarmiento et. al, 2004). In alignment with today's climate, the retention of qualified academic nurse educators remains a significant problem facing the nursing profession (World Health Organization, 2020; American Association of Colleges of Nursing [AACN], 2020). In addition to an aging workforce, academic nurse educators are leaving the organization due to workload, lack of support, and job dissatisfaction (AACN, 2020, Kaufman,

2007; Sarmiento et al., 2004). Many researchers have cited empirical support for Kanter's theory of Structural Empowerment, specifically highlighting its association with job satisfaction (Baker, Fitzpatrick, & Griffin, 2011; Davies, Laschinger, & Andrusyszyn, 2006; Laschinger, Finegan, & Shamian, 2001a; Laschinger, Finegan, Wilk & Shamian, 2001b; Sarmiento et al., 2004); however, only one known study has focused on NPD practitioners (Davies et al., 2006). As with academic nurse educators, NPD practitioners may experience comparable results; however, this cannot be stated with certainty. To follow, an examination of the literature as it relates to the nurse educator's perception of structural empowerment will be discussed, sections will be further categorized by role title, i.e., academic nurse educators, followed by NPD practitioners.

Academic Nurse Educators

Nurse educators who work solely in the academic setting, as in the baccalaureate or graduate level in colleges and universities, are referenced throughout the literature as academic nurse educators or nurse faculty (Baker et al., 2011; Bence, Coetzee, Klopper, & Ellis, 2022; Sarmiento et al., 2004). They educate the generations of students looking to pursue various career paths within nursing. Amongst other duties, academic nurse educators are also expected to supervise students and publish scholarly works. Noting the current and projected shortages facing academic nurse educators, many scholars have explored literature as it relates to their job satisfaction. Thus, the below paragraphs will synthesize that literature as it relates to key study variables.

Researchers have found that when nurse educators perceive their leader and facets of the organization as empowering this influences their level of job satisfaction (Bence et al., 2022; Sarmiento et al., 2004; Gui, Gu, Barriball, While, & Chen, 2014). Gui et al. (2014) conducted a cross-sectional comparison survey that examined overall empowerment in two groups, nurse

educators who worked in mainland China and the United Kingdom. Using a convenience sample, they surveyed 121 nurse educators from doctoral colleges in China (n = 61) and the United Kingdom (n = 60). The authors tested empowerment using the Conditions for Work Effectiveness questionnaire (CWEQ) developed by Laschinger et al. (2001b) and job satisfaction using the Job Descriptive Index (JDI) developed by Balzer (1997). They found significant and positive correlations between workplace empowerment and job satisfaction amongst both groups, the Chinese and United Kingdom participants respectively ($p < .001$).

Similarly, in a Western country, Sarmiento et al. (2004) conducted a descriptive correlational study aimed at understanding the relationships between empowerment and job satisfaction in the nurse educator population. Kanter's theory of structural empowerment was the study's theoretical framework. Data were collected from a sample of 89 college nurse educators who worked in the same province. The researchers found that nurse educators who had access to power structures (both formal and informal) significantly predicted their perception of overall workplace empowerment (β =.42, t = 4.26, p = .0001 and β = .37, t = 3.73, p = .001, respectively). More specifically, job satisfaction was strongly correlated with access to support (r = .610, p = .0001) and access to resources (r = .57, p = .001), indicating that a relationship exists between college nurse educators' perception of job-related empowerment structures and workplace empowerment. Conversely, other researchers identified a lack of role support as a reason qualified nurse educators left the academic setting after their first year (Finke, 2009; Thuss, Babenko-Mould, Andrusyszyn, & Laschinger, 2016).

Previous research conducted on structural empowerment and job satisfaction (Gui, While, Chen, Barriball, & Gu, 2011; Gui et al., 2014; Sarmiento et al., 2004; Thuss et al. 2016; Valdez, Cayaban, Mathews, & Doloolat, 2019) in other countries is consistent with findings in the United

States. In a correlational study, based on associate degree nurse educators who worked in California public community colleges, Baker et al. (2011) sought to identify a relationship between perception of empowerment and job satisfaction. The authors obtained the sample for this study (n = 139) from approximately 600 full-time nurse educators employed throughout California's public community colleges.

Baker et al. (2011) noted that nurse educators perceived moderate levels of structural empowerment in the workplace (M = 3.55), with access to opportunity having the strongest influence on empowerment (M = 4.09). Similarly to Sarmiento et al.'s (2004) study, nurse educators who had more access to resources (r = .57, p = .05) and formal power, i.e., visibility, rewards, and recognition (r = .55, p = .05) were more satisfied with workplace conditions and felt more empowered. These authors also tested the relationship between psychological empowerment and job satisfaction variables, indicating a moderately strong correlation between college nurse educators' perception of psychological empowerment and job satisfaction (r = .73, p = .05). The authors of this study reported low reliability scores (.46 to .63) for empowerment subscales, but they did not report the total reliability score for empowerment indicating a potential limitation. Also, the study findings are not generalizable to the entire population. To date, this was the only known study in the United States that examined the two variables, structural empowerment and job satisfaction, in the academic nurse educator population (Baker et al., 2011); thereby, future research is warranted.

Lastly, Hebenstreit (2012) conducted another study using Kanter's theory of structural empowerment to explore the degree in which the nurse educators' perception of empowerment influenced their innovative behavior and creativity in the workplace (Hebenstreit, 2012). The authors examined the Conditions for Work Effectiveness Questionnaire II (CWEQ-II) developed

by Laschinger et al. (2001b) and the Kleysen and Street's (2001) Measure of Individual Innovative Behavior. Innovative behavior is defined as an individual's ability to take an idea or opportunity and generate new information that influences change at the organizational level (Kleysen & Street, 2001). Using directories from BSN accredited programs by the National League for Nursing Accrediting Commission, the researchers randomly selected 1,000 nurse educators, yielding a final sample size of 221.

Hebenstreit (2012) concluded a significant relationship between the nurse educator's perception of structural empowerment and their use of innovative behaviors (r = .349, p = .01); however, the strongest correlation existed between formal power and innovative behavior (r = .423, p = .01). Findings from this study lend empirical support for Kanter's theory as it relates to the concept of improved work effectiveness and innovation. Inferences drawn from multiple research studies indicate positive associations to Kanter's theory of Empowerment (Baker et al., 2011; Gui et al., 2011; Gui et al., 2014; Hebenstreit, 2012; Sarmiento et al., 2004; Thuss et al., 2016; Valdez et al., 2019) and job satisfaction. It is apparent that nurse educators who feel more empowered are likely to be more satisfied, and innovative as it relates to the achievement of organizational goals.

NPD Practitioners

Empowerment has a positive influence on nurse educators job satisfaction who work in the academic setting. Only one study was found that focused on NPD practitioners and empowerment (Davies et al., 2006). Although the authors referred to their population of interest as "clinical nurse educators," based on the authors' description of the role, it is reasonable to assume this population is congruent with the NPD practitioner. In a nonexperimental study conducted on a convenience sample of clinical nurse educators (n=141) in central Canada,

Davies et al. (2006) examined relationships between perceptions of empowerment, job tension, and job satisfaction. They found that nurse educators in this study perceived moderate levels of empowerment (M = 13.09) and identified access to opportunity (M = 3.25) as the most empowering organizational attribute. The authors also found that formal socialization programs, such as mentoring and coaching, had a significantly positive correlation with the educators' perception of informal power (r = .401, p = .0001). Additionally, the authors concluded that low levels of job tension (r = -.488, p = .01) and job satisfaction (r = .641, p = .01) were associated with higher levels of empowerment.

In summary, the results of this study were comparable to the results of other studies that support Kanter's theory of empowerment influence on job satisfaction (Baker et al., 2011; Gui et al., 2011; Gui et al., 2014; Hebenstreit, 2012; Sarmiento et al., 2004; Thuss et al., 2016; Valdez et al., 2019) and innovative behavior (Hebenstreit, 2012) among academic nurse educators. A weakness of the Davies et al. (2006) study was the use of convenience sample from one provincial registry; thus, the results of this study are only generalizable to that province. Considering this study was conducted in Central Canada, it is unclear whether the same would apply to NPD practitioners working in hospitals across the United States, which highlights the need for a future study. In fact, there were no known studies found within the last 10 years that evaluated the influence of Kanter's theory in the NPD practitioner population, thus indicating a gap in nursing literature.

Review of Literature related to Intent to Stay in Nurse Educators

Nurse turnover is a major problem across health care organizations, especially amidst a workforce shortage. Executive leaders are consistently challenged to identify factors that influence nurse retention at all levels. Previous researchers have linked empowering work

environments among nurse educators, with organizational commitment, retention, and intent to stay (Thuss et al., 2016; Valdez et al., 2019); however, very few studies have examined these selected concepts in the NPD practitioner population. Thus, the remaining sections will explore the literature as it relates to intent to stay in the academic environment, as described in the context of organizational commitment.

Organizational commitment is defined as an employee's intent to continue working for an organization (Laschinger, Finegan, & Wilk, 2009). Researchers have explored the concepts of organizational commitment and intent to stay using theoretical underpinnings from Allen and Meyer's (1991) Model of Commitment (McDermott, Laschinger, & Shamian, 2001; Laschinger et al., 2001c; Laschinger et al., 2009). Turnover intentions have been found to be inversely associated with organizational commitment (Laschinger et al., 2001c; Laschinger et al., 2009; Hauck et al., 2011; Gutierrez, Candela, & Carver, 2012), thereby revealing the importance of organizational commitment and its contextual effects valuable in the NPD practitioner population.

In Jordan, Al-Hussami et al. (2011) conducted a study in nurse faculty to examine relationships among job satisfaction, autonomy, pay, workload, organizational support, and organizational commitment. They found job satisfaction ($r = 0.62$, $p = .01$) and perceived organizational support ($r = 0.69$, $p = .01$) had significantly higher correlations with organizational commitment compared to autonomy ($r = 0.43$, $p = .01$), pay ($r = 0.42$, $p = .01$), and workload ($r = 0.39$, $p = .01$; Al-Hussami et al., 2011). Using stepwise linear regression analyses, the authors were able to identify perceived support as being the strongest predictor of organizational commitment ($\beta = .547$, $p = .0001$), followed by job satisfaction ($\beta = .301$, $p = .002$). Age was also identified as a significant predictor of organizational commitment ($\beta = .116$,

p = .02). Similarly, other researchers also revealed that perceived organization and leadership support significantly influenced job satisfaction (Gutierrez et al., 2012; Gormley & Kennerly, 2011) and intent to stay (Derby-Davis, 2014) among nurse faculty.

Conversely, Derby-Davis (2014) employed a different theoretical approach, using Herzberg Motivation theory, to ascertain factors that influenced nurse faculty intent to stay. In the sample, 127 nurse faculty members from undergraduate and graduate nursing programs were surveyed to predict their intent to stay. Using a multiple regression analysis, they found a significant relationship between intent to stay (F (4, 94) = 13.196, $p < .001$) and job satisfaction, as described in the context of motivation-hygiene factors, i.e., working conditions, salary, recognition, and advancement opportunities. Other factors such as level of education, years of teaching experience (Derby-Davis, 2014) and employment status, i.e., full-time, or part-time accounted for small variances in the results, thereby indicating that retention of nurse faculty was complex and contingent on a multitude of factors.

In summary, as organizations struggle to retain qualified academic nurse educators, findings from these studies (Al-Hussami et al., 2011; Berent & Anderko, 2011; Derby-Davis, 2014; Gormley & Kennerly, 2011; Gutierrez et al., 2012) demonstrate the importance of leadership and organizational support in retention. To date, no known studies were found that examined any of the above-mentioned variables in the NPD practitioner population, thereby indicating a need for more research in this population.

Review of Literature related to Empowerment and Intent to Stay in NPD Practitioners

It is evident that a vast amount of research explored focuses on the academic nurse educator population. Despite the abundance of literature on the concepts of structural empowerment (Baker et al., 2011; Davies et al., 2006; Gui et al., 2011; Gui et al., 2014;

Hebenstreit, 2012; Sarmiento et al., 2004; Thuss et al., 2016; Valdez et al., 2019), innovative behavior (Hebenstreit, 2012), organizational commitment and intent to stay collectively (Al-Hussami et al. 2011; Berent & Anderko, 2011; Derby-Davis, 2014; Gormley & Kennerly, 2011; Gutierrez et al., 2012), such concepts remain largely unexplored in the NPD practitioner population. To date, only one known study examined the key variables selected for this study together, structural empowerment and intent to stay (Nedd, 2006); however, this study took place in Central Canada among the staff nurse population. While findings from this study highlighted a positive relationship between empowerment and intent to stay, one cannot assume the same applies to NPD practitioners.

Therefore, the purpose of this quantitative, descriptive correlational study is to examine NPD practitioners' perception of empowerment in the workplace and their intent to stay post pandemic. The significance of understanding NPD practitioners' intentions to remain in their roles after the pandemic cannot be overstated, as it enables organizations to identify key factors that may influence retention. By gaining insight into these factors, organizations can implement targeted strategies to enhance retention rates and ensure a stable and dedicated workforce for nurses at all levels. Considering the pivotal role that NPD practitioners have on frontline nursing staff's provision of safe, quality patient care, findings from this study could provide nurse executives with practical strategies geared towards creating an empowering work environment for them. As health care executives face unprecedented times and numerous other constraints in the post-pandemic era, a study of this kind would be relevant and timely.

Chapter Summary

In alignment with ANPDs' call to action for NPD practitioners to collectively advance and advocate for the profession, further exploration of what impacts our work environment and

desire to stay with an organization is value added. It is evident throughout the literature that when employees feel more empowered, organizations are likely to see more productivity, which in turn, can influence the achievement of organizational outcomes. Thereby, a better understanding of what influences NPD practitioners' desires to stay with an organization is imperative. Given the application of empowerment theory in academic nurse educators, NPD practitioners could possibly benefit from the same level of support and access to empowerment structures; however, this remains a gap in nursing literature.

CHAPTER III

Methods and Procedures

This chapter presents the methods and procedures used in the study. The purpose of this study was to determine if a relationship existed between the NPD practitioners' perception of empowerment in the workplace and their intent to stay post pandemic. The research design, sampling, measurement tools, ethical considerations, data collection procedures and analyses are described. The chapter will conclude with a discussion of delimitations.

Research Design

A cross-sectional, descriptive, and correlational design was used in this study. The rationale for selecting this type of design was to describe variables within a single point in time (Grove, Burns, & Gray, 2013). Additionally, the cross-sectional design allowed the principal investigator to examine relationships, or lack thereof, between variables (Grove et al., 2013). There was no manipulation of variables, and the results of the study did not infer cause-and-effect relationships. The variables examined in this study were empowerment as a composite construct, the six subscales of empowerment (i.e., opportunity, information, support, resources, formal power, informal power), and intent to stay. The study aims to address a gap in knowledge by examining the NPD practitioners' perception of workplace empowerment and intent to stay post the COVID-19 pandemic.

Sample

Inclusion and Exclusion Criteria

The target population for this study was registered nurses (RNs) who held a position as an NPD practitioner and work in the acute care hospitals. The actual number of NPD practitioners who work in acute care hospital setting is unknown, due to the varying titles for

NPD practitioners. Thereby, RNs with the title of clinical resource nurse, staff development coordinator, clinical nurse educator, nursing professional development specialist, or nursing instructor were also included in the study. Other inclusion criteria were as follows:

1) Have worked at least 3 months in the role (non-supervisory).
2) Spend less than 50% of their time in direct patient care in their current role.
3) Works full-time in an acute care hospital setting including the ambulatory or outpatient setting.
4) Primary job (non-supervisory) responsibility to ensure nursing professional development and education of frontline clinicians in the acute care hospital or ambulatory care setting.

Potential participants were screened for these criteria using an online screening tool survey with the following questions:

1) Are you currently working in a non-supervisory role as an NPD practitioner, clinical resource nurse, staff development coordinator, clinical nurse educator, or nursing instructor in the acute care hospital or ambulatory setting? (yes/no)
2) Do you work fulltime in a non-supervisory role as an NPD practitioner, clinical resource nurse, staff development coordinator, clinical nurse educator, or nursing instructor in the acute care hospital or ambulatory setting in the United States? (yes/no)
3) Does your job role consist of less than 50% direct patient care? (yes/no)
4) Have you been employed with the organization greater than 3 months? (yes/no)
5) Is your primary job (non-supervisory) responsibility to ensure nursing professional development and education for frontline clinicians in the acute care hospital or ambulatory care setting?

Participants who did not answer "yes" to all questions were excluded from the study. There were no additional exclusion criteria.

Sample Size

The size of the sample needed for statistical power was calculated using G*Power software (Grove & Cipher, 2017). A priori power analysis using a linear regression analysis with 7 predictors (*overall empowerment, opportunity, information, resources, support, formal power, and informal power),* indicated that a minimum of 118 participants would be required for a desired statistical power of .80, an alpha level of .05, and an anticipated moderate effect size (R^2) of .13. A non-probability convenience sample was used for this study. This sampling technique was selected to provide the principal investigator a greater chance at reaching the targeted number of participants (Grove & Cipher, 2017). In another study, conducted by ANPD (2021), the researchers reported a 13% response rate; thereby, it is reasonable to estimate the same response rate for this study.

Study Sample

A total of 425 individuals accessed the survey. However, after applying the exclusion criteria, 80 respondents were excluded, and the sample size was reduced to 345 respondents. The sample included NPD practitioners from all possible ethnic groups and education levels who worked at acute care hospitals throughout the United States. Participants also included NPD practitioners who worked in magnet-designated hospitals, which is an important distinction, as researchers have found the characteristics of magnet-designated hospitals resemble those of a highly empowered work environment (Armstrong & Laschinger, 2006; Upenieks, 2003). Based on a power analysis, a minimum of 118 NPD practitioners were needed to detect a statistically

significant relationship among study variables. The achieved sample size was deemed adequate for the study.

Setting

The sampling frame of participants for this study came from acute care hospitals located throughout the United States. A convenience sample of NPD practitioners who were members of ANPD were also invited to participate in the study. During the recruitment period, there were more than 6,000 ANPD members, but it was unclear how many of them were NPD practitioners employed in acute care hospitals (ANPD, 2022). Following approval by the Institutional Review Board of the University of Texas at Arlington where the principal investigator (PI) is a doctoral student, written permission to conduct the study was obtained from ANPD's Board of Directors. The PI was responsible for submitting a research proposal to the Director of Research at ANPD, who subsequently provided a recommendation to the board of directors to grant permission for the PI to use ANPD members as a sample source. After approval was granted, ANPD sent an email introducing the intent of the study, followed by a reminder email ten weeks later, totaling two emails sent for recruitment. In addition to email communication, ANPD and the PI posted information regarding the study on social media outlets, like LinkedIn. The email contained information about how to participate in the study (Appendix D).

Measurement Methods

The researcher utilized two instruments and a demographic data collection tool in this study. The first instrument, the Conditions for Work-Effectiveness Questionnaire-II (CWEQ-II), was used to measure structural empowerment (Appendix G; Laschinger et al., 2001b). The second instrument, the Intent to Stay scale (ITS), was used to measure participants' intent to leave the organization (Appendix I; Kim, Price, Mueller, & Watson, 1996; Price & Mueller,

1981). Table 3.1 and 3.2 describe both the demographic and key study variables. The sections below will provide more detailed information on the demographic data collection and the measurement tools mentioned above.

Demographic Data Collection

The researcher collected demographic data about each participant's age, gender, ethnicity, shift worked, years as an RN, years as an NPD practitioner, years in the organization, highest degree earned, certification in the NPD specialty, and hospital magnet status (Appendix E). The selection of the first three basic demographic details follows Grove et al.'s (2013) recommendation, as well as research showing a significant correlation with intent to stay and the nursing population (Alonso-Garbayo & Maben, 2009; Engeda, Birhanu, & Alene, 2014; Kane, Rajacich, & Cameron, 2015). First, Engeda et al. (2014) found that age was positively associated with intent to stay among nurses at a hospital in Ethiopia. Second, Kane et al. (2015) found that men who experienced gender bias during their nursing training, had a higher intent to leave. Third, in a study of hospital nurses who immigrated to the United Kingdom from India and the Philippines, researchers found the former were significantly more likely to stay than other ethnicities (Alonso-Garbayo & Maben, 2009).

The remaining eight variables were selected because they are more specific to the study purpose and mirror variables selected by previous researchers. Although no studies were found that assessed shift worked in the NPD practitioner population, Powell (2011) found that staff nurses frequently expressed concerns over lack of leadership access during the later shifts, including evenings and nights. Years as an RN was selected because researchers found that experienced nurses felt significantly more empowered in the workplace than new graduate nurses (Laschinger et al., 1999). Years as an NPD practitioner, years in the organization, and highest

degree earned were selected based on previous research studies in the nurse educator population (Davies et al., 2006; Hebenstreit, 2012).

The hospital's designation as a Magnet® facility was selected because researchers have shown positive correlations between magnet-designated hospitals and staff nurses' perception of structural empowerment (Armstrong & Laschinger, 2006; Laschinger, H. K., Shamian, J., & Thomson, D., 2001c; Kol, İlaslan, & Turkay, 2017; Patrician, Olds, Breckenridge-Sproat, Taylor-Clark, Swiger, & Loan, 2022). The magnet designation is a prestigious recognition awarded by the American Nurse Credentialing Center (ANCC) to hospitals that demonstrate a culture embracing the five components of the magnet model, which includes structural empowerment (ANCC, n.d.). Thereby, this emphasis on structural empowerment within these hospitals has the potential to influence the perception of NPD practitioners. While there are other prestigious designations for healthcare facilities, such as Pathway to Excellence®, it is important to note that the existence and demonstration of structural empowerment within the workplace is not a foundational component for these designations (ANCC, n.d.). Lastly, certification in the NPD practitioner specialty was included because certified NPD practitioners are thought to possess a better understanding of the roles and responsibilities (Harper, Maloney, & Shiners, 2017), thus, this could influence their perception of leadership and organizational support. Table 3.1 indicates the level of measurement and descriptive statistical procedure that will be used to measure each demographic variable.

Table 3.1

Demographic Variables

Demographic Variables	Level of Measurement	Descriptive Statistical Procedures
Gender	Nominal/Ordinal	Frequency (*f*), percent (%)
Ethnicity		
Highest degree earned		

Shift worked		
Hospital Magnet® Status		
Certification in NPD specialty		
Age		
Years as RN	Interval/Ratio	*f*, %, mean, standard deviation (SD)
Years as NPD practitioner		
Years in the organization		

Measurement Tools

CWEQ-II. The CWEQ-II tool was designed to measure the concept of structural empowerment (Kanter, 1993; Laschinger et al., 2001b). Laschinger et al. (2001b) created it by adapting the CWEQ-I, which was derived from Kanter's (1993) ethnographic work in corporate America for use in the general population. Kanter's (1993) theory of structural empowerment posited that access to social structures increases employees' ability to solve challenges and be innovative in the workplace. Structural empowerment can be defined as the availability of social structures within the workplace to promote employee effectiveness and satisfaction (Hebenstreit, 2012). These social structures are described as a) formal power, b) informal power, c) opportunity, d) information, e) support, and f) resources (Kanter, 1993).

The CWEQ-II consists of 19 items that measure each of the above-mentioned social structures, yielding six subscales. Items are ranked on a 5-point Likert scale, summed and averaged. Total scores can range from 6 to 30. Higher scores represent higher perceptions of empowerment in the workplace. This scale is readily accessible to researchers (Laschinger et al., 2001b) and there is no cost associated with using it.

Laschinger et al. (2001b), performed confirmatory factor analysis on the CWEQ-II to determine its construct validity. The CWEQ-II Cronbach's alpha has been reported between .67 and .84 (Laschinger et al., 2001b). Stewart, McNulty, Griffin, and Fitzpatrick (2010) utilized the CWEQ-II in a group of nurse practitioners to evaluate the perception of empowerment within

their work environment and reported Cronbach's alpha of .86. In this study, the Cronbach's alpha for the CWEQ-II was .90. See Table 3.4 for the internal reliability for each of the empowerment subscales.

ITS Scale. Price and Mueller (1981) developed the ITS scale, which was derived from a theoretical model, for clinical nurses. It originally consisted of one question that measured nurses' intentions to stay with the hospital or organization. Kim et al. (1996) later increased the questions from one to six to increase reliability and account for additional aspects of intent to stay. The scale is designed to measure the future intentions of RNs regarding their employment in the hospital, including the likelihood of leaving their current job or organization. This scale has been widely used in various populations such as physicians (Kim et al., 1996) and is easy to access online free of charge (Price & Mueller, 1981).

Table 3.2

Key Study Variables

Key Study Variables	Level of Measurement	Descriptive Statistical Procedure(s) using SPSS	Inferential Statistical Procedures
Structural Empowerment Opportunity Information Resources Support Formal Power Informal Power Intent to Stay	Interval/Ratio	Mean, SD, Min, Max	Linear regression (R^2)

The scale comprises six items that are rated on a 5-point Likert scale, where 1 is *definitely will not leave* and 5 is *definitely will leave*. There are no subscales and scores can range from 6 to 30. Reverse scoring was used for the negative scoring items. Individual scores are summed, with higher scores indicating higher intent to stay with current job or organization and lower scores indicating intent to leave. To put it differently, a higher score on the intent to stay

scale indicates that an individual has a stronger desire to remain with their current job or organization. This can also be interpreted as having a lower intent to leave their current employment. This information can be useful for employers to understand the level of commitment and loyalty of their employees. Construct validity was assessed using exploratory factor analysis (Kim et al., 1996). Cronbach alphas for the ITS scale have consistently been reported between 0.84 – 0.90 (Nedd, 2006). In this study, Cronbach's alpha for the ITS questionnaire was .92.

Table 3.3

Internal Reliability Values for Instruments (n = 313)

Instrument	***N* of items**	**Cronbach's Alpha**
Empowerment	19	.90
Opportunity subscale	3	.76
Information subscale	3	.90
Support subscale	3	.70
Resources subscale	3	.79
Formal Power (JAS)	3	.62
Informal Power (ORS)	4	.73
ITS	6	.92

Procedures

After receiving IRB approvals and ANPD's endorsement to recruit for this study, data were collected by the principal investigator using Question Pro™, an internet-based survey platform. Online surveys are advantageous because they help to maintain anonymity (Wright, 2017). Participants were allowed to access the survey link at any time, but if they exited the survey prematurely, they had to restart the survey from the beginning. The author screened for incomplete entries indicating participants who did not finish the entire survey. The approximate length of time to complete the survey was estimated at 10 minutes, however, average time of completion was 9 minutes. Upon survey completion, all electronic data were stored in a

password-protected computer and in a shared file located in a secure OneDrive password-protected site provided by the university. Access to this file was restricted to the author and the dissertation chair, who were the only individuals authorized to access the data. Given that the number of NPD practitioners currently working in the acute care hospital systems across the United States is unknown, it was not possible to capture a response rate reflecting acute care NPD practitioners as the denominator. However, given that there were approximately 6,000 ANPD members at the time of this study, and there were 425 responses, the estimated response rate was about 7% (425 / 6000 x 100 = 7.08%) before excluding incomplete cases, cases with missing values, and outliers.

Ethical Considerations

Both the chair and the principal investigator (PI) completed Human Subjects Training, which ensures awareness of the ethical considerations involved in conducting research involving human subjects. The shared folder containing the study data will be retained for a period of three years, in accordance with the policy of the University of Texas Arlington. This approach ensured that data were stored securely and in compliance with the relevant ethical and legal requirements, thereby safeguarding the confidentiality and privacy of the study participants.

Participants were informed before the start of the study that participation was strictly voluntary. Upon selecting an internet link to participate in the study, participants saw an informed consent that detailed the risks and benefits of participating in this study. Participants were not asked for any personally identifying information, such as name or date of birth, to maintain confidentiality. At the end of the letter, a statement read, “Upon clicking the survey link, you will be invited to continue with the study. Continuing with the study will represent your consent to be in the study”. After participants clicked the survey link, the screening tool

questions followed by the demographic questionnaire appeared. If the participants wished to exit the survey at any time they could do so without penalty.

Data Screening

Descriptive statistics and analyses were computed for the variables using the Statistical Package of Social Science (SPSS) version 29. SPSS is a statistical program that many researchers and statisticians use that aids in the data analysis process (Grove & Cipher, 2024). Data from QuestionPro™ were exported to a Microsoft Excel spreadsheet to observe for any missing points or errors in the participant responses. Any missing data could skew results, so each case was reviewed individually to determine if missing data imputation could be used to allow the maximum number of participants to examine the main study variables. All decisions regarding the data screening process are described in the below paragraphs.

Data Cleaning

Upon exporting survey data from question pro to an excel spreadsheet, the data were observed for any errors or patterns of missing data. There were no obvious patterns or errors in the data, thereby the spreadsheet was imported to SPSS for further analysis. In SPSS, frequencies were computed to check for errors, such as scores that were outside the possible range of scores and to identify cases with missing values. To allow for easier identification, the values and labels for each of the categorical variables were coded in the variable view. Of the 345 respondents remaining, cases of missing data were observed. A further explanation regarding how the missing values were handled is described below.

Missing Values

Missing values within a dataset can significantly distort study findings, thereby, all missing values should be analyzed for patterns and the extent of missingness (Grove & Cipher,

2024). The extent of missingness refers to the amount of missing values within the dataset. To calculate the extent of missingness, one can add up the number of missing cells and divide it by the total number of missing and non-missing cells (Grove & Cipher, 2024). Thereafter, it's imperative to examine for patterns as it can reveal any potential biases in the remaining values of the dataset. To identify patterns, researchers can use Little's test, which determines whether a significant value is present, indicating the presence of a pattern (Little & Rubin, 1987). If Little's test is non-significant, then the researcher can use imputation methods, like estimation maximation, without influencing the internal and external validity of the study (Grove & Cipher, 2024). Tabachnick and Fidell (2019) emphasize the importance of examining missing values in a dataset to ensure accurate study findings.

Upon initial examination of the data for this study, a total of 44 missing values were detected, which accounted for 0.5% of the dataset. Subsequent analysis revealed that the first item on the ITS questionnaire had 26 missing responses. It was observed that the wording of the first question on the ITS scale was ambiguous. The instructions for the following section of the survey were merged with the first question, which may have resulted in respondents unintentionally skipping this item.

To investigate the presence of a pattern in the ITS variable, a Little's missing completely at random test was conducted. The results of this test indicated a significant value, suggesting that there was evidence of non-random missing data. As a result, the decision was made to exclude the 26 cases with missing data from item-one within the ITS scale from the overall dataset. These cases represented less than 2% of the total dataset. This decision was made in accordance with the general rule that if the amount of missing data is less than 5% of the total dataset, it can be handled through various methods such as list-wise deletion or imputation

(Tabachnick & Fidell, 2019). After deleting these cases, another Little's test was performed to determine if the remaining cases with missing data were missing completely at random. This test yielded a non-significant value, χ^2=176.48(df = 153), p = .094, indicating that the remaining data were missing completely at random. Therefore, estimation maximization was used to compute any additional missing data (Little & Rubin, 1987).

Screening for Outliers

Of the remaining 319 cases, the data were also screened for outliers. It is imperative to check for outliers prior to performing many parametric statistical tests, because they can affect the normality of your data (Tabachnick & Fidell, 2019). For outlier detection, each variable was examined based on the standardised (z) score. Any z-scores +3≥ or ≤-3 were considered as outliers. The standardised (z) scores of the scale variables are summarized in Table 3.4. The results indicated that the standardised (z) score of six cases were beyond the acceptable threshold of ±3. Therefore, these six cases were detected as univariate outliers and subsequently selected for exclusion from the sample, resulting in a final sample size of 313 (Tabachnick & Fidell, 2019). The final sample size (n=313) exceeded the minimum number of 118 participants needed to achieve statistical power. This concluded the data screening phase of the process, thereafter, assumptions testing was performed.

Table 3.4

Standardized Z-score

Variable	First Standardized Value (n = 319)		First Standardized Value (n = 313)	
	Lower Bound	**Upper Bound**	**Lower Bound**	**Upper Bound**
Overall Empowerment	-3.468	2.201	-2.560	2.254
Opportunity	-3.399	1.414	-2.771	1.460
Information	-2.867	1.512	-2.946	1.514
Support	-2.465	2.056	-2.527	2.062
Resources	-2.365	2.202	-2.390	2.191
Formal Power	-2.694	2.087	-2.757	2.093
Informal Power	-3.057	2.069	-2.868	2.112
Intent to Stay	-1.464	2.648	-1.464	2.738

Assumptions Testing for Linear Regression

Performing assumptions testing is important for most parametric statistical tests. This helps to ensure that the data meets the necessary assumptions for the analysis, thereby reducing the likelihood of errors and biases in the study findings. One of the key assumptions to test for is the normality of the data, which can be assessed through examining the skewness and kurtosis of the variables. To determine the skewness and kurtotic values for each variable, descriptive statistics were computed, the results are found in Table 3.5. The absolute values for the CWEQ-II (-.164/-.354) and ITS (-.423/-.055) were not greater than ±1, indicating that the shape of the distribution fairly approached a normal curve (Grove & Cipher, 2017). Visual inspection of the histograms also showed the hypothesized variables fairly approached normality, see Figure 3.1. Overall, the results of assessing deviation from normality showed that the value of skewness for the variables ranged between -0.423 and 0.623, within the acceptable range of ±1. Table 3.5 also indicated that the kurtosis value of the variables ranged between -0.555 and 0.053, within the acceptable range acceptable range of ±1. Therefore, it can be concluded that the data set for all variables approximately reflected a normal distribution (Byrne, 2013; Grove & Cipher, 2017), despite significant Kolmogorov-Smirnov statistic values for all variables except empowerment (p = .200), as shown in Table 3.5.

Table 3.5

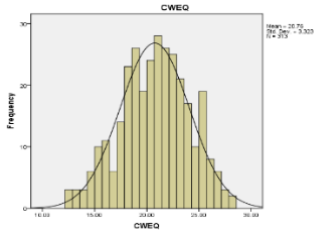
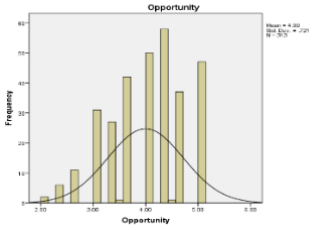
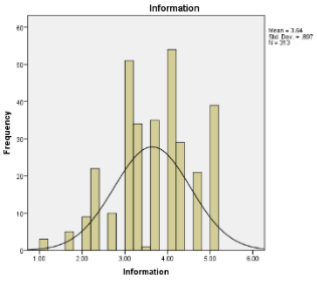
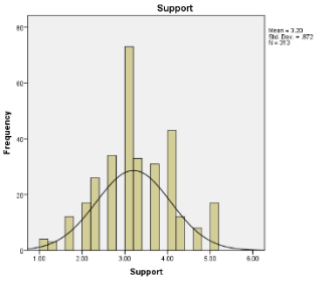
Normality Test Results

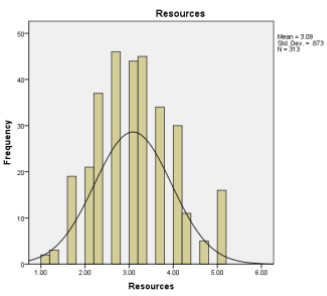
Variable	Kolmogorov-Smirnov		Skewness	Kurtosis
	Statistic	P-value		
Empowerment	0.034	0.200	-0.164	-0.354
Opportunity	0.136***	0.000	-0.423	-0.555
Information	0.112***	0.000	-0.335	-0.334
Support	0.122***	0.000	0.037	-0.18
Resources	0.094***	0.000	0.233	-0.311
Formal Power	0.101***	0.000	-0.137	-0.337
Informal Power	0.088***	0.000	-0.293	-0.27
Intent to Stay	0.117***	0.000	0.623	0.053

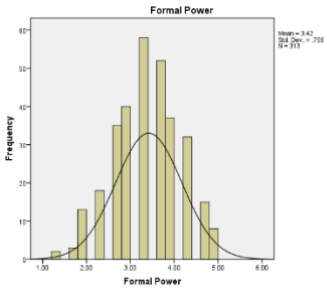
Visual inspection of the scatterplot indicated a linear relationship between the variables, thereby, the homoscedasticity of residuals assumption was fulfilled. The Durbin-Watson statistic of 1.90, within the acceptable range of 1.5 and 2.5, showed independence of residuals (Norusis, 1995). The collinearity diagnostics of tolerance and variance inflation factor (VIF) were used to examine if multicollinearity existed among the independent variables (Grove & Cipher, 2017). In this study, the tolerance values ranged from .53 to .77, and VIF statistics ranged from 1.29 to 1.89. Since the tolerance and VIF values were greater than .20 and less than 5, respectively, this indicated the absence of multicollinearity. The data met the assumptions for a regression statistical test.

Figure 3.2

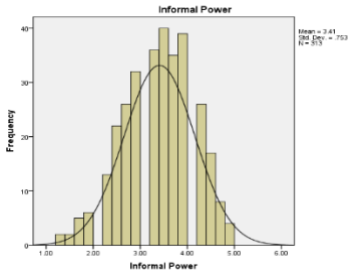
Histogram and Normal Curve of the Hypothesized Variables

Empowerment	**Opportunity**
	
Information	**Support**
	
Resources	**Formal Power**

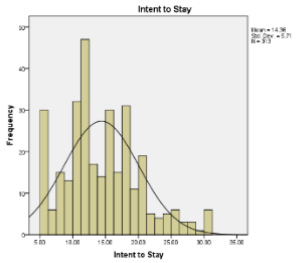




Informal Power



Intent to Stay



Delimitations

A potential limitation of this study was the NPD practitioner's willingness to be truthful about their perceptions of the organization. Self-report instruments can result in response bias. Participants may feel pressure to select responses that are socially acceptable rather than responses that represent their true feelings. The sample was not randomly selected which also poses a source of selection bias. The correlational research design selected posed another limitation because one cannot draw conclusions or establish causality among the research variables. Lastly, the findings from this study were not generalizable to all NPD practitioners.

Chapter Summary

This chapter described the methods and procedures performed for this cross-sectional, descriptive, correlational research study. The PI used a convenience sample from the governing organization of the NPD specialty, ANPD, to recruit participants from various regions throughout the United States. Participants were issued a link to complete a web-based survey that was based on the measurement tools detailed above, specifically the CWEQ-II and the ITS

questionnaire. Demographic information was also obtained via the survey. Following data collection, SPSS was used for data analysis to answer the research questions. Descriptive statistics were computed to identify errors and outliers in the data, and missing values were imputed via estimation maximization. Thereafter, assumption testing for linear regression analysis was conducted and met. The study results are presented in the subsequent chapter.

CHAPTER IV

FINDINGS

The purpose of this chapter is to report the findings of this descriptive, cross-sectional correlational study conducted on NPD practitioners' perception of empowerment in the workplace and self-reported intent to stay in the acute care hospital setting. The research is guided by Kanter's (1977) theory of organizational empowerment. The principal investigator examines, to what extent, does empowerment as a composite construct reliably predict intent to stay, followed by an examination of the predictive influence among each of the empowerment subscales: opportunity, information, resources, support, formal power, and informal power and intent to stay. The chapter begins with a description of sample characteristics, thereafter, the quantitative analysis of each research question is reported. The chapter will conclude with a summary of the findings.

Sample Description

The electronic survey was accessed 1400 times, and this resulted in a total of 425 participants. Of these surveys, 80 were removed based on exclusion criteria, 26 were incomplete, and 6 were considered as outliers. After excluding outliers and the incomplete cases, the final sample size included 313 NPD practitioners from hospitals across the United States. Table 4.1 summarizes demographic variables measured at the nominal level. The sample of NPD practitioners was mostly female (95.9%), and the majority identified as non-Hispanic Caucasian (82.1%). The second highest ethnicity was African Americans, followed by Asians. The most prevalent ages ranged from 30-45 years (46.7%), followed by 46-59 (37.9%) years of age. Sixty-eight percent of the sample reported the highest nursing degree earned was a bachelor's degree (68.3%), followed by a master's degree (21%). Less than 2% of the sample reported having a

doctoral degree. Majority of respondents reported working day shift (98.7%); however, one response was missing which could be attributed to the participant working remotely which was not included as an option on the survey. Approximately, 60% of the respondents reported that they were currently employed in a Magnet® designated organization. Forty-two percent of sample participants reported being board certified in the NPD specialty.

Table 4.1

Demographic Variables Frequency and Percentages

Variables		**Frequency**	***n (%)***
What gender do you identify as?	Male	11	3.5%
	Female	300	95.8%
	Transgender	0	0.0%
	Non-binary	1	0.3%
	Prefer not to answer	1	0.3%
	Other	0	0.0%
What is your age?	18-29	14	4.5%
	30-45	147	47.0%
	46-59	119	38.0%
	Over 60	33	10.5%
	Prefer not to answer	0	0.0%
Please specify your ethnicity (select all that apply)?	Non-Hispanic Caucasian	256	81.8%
	African American	21	6.7%
	Asian	15	4.8%
	Latino or Hispanic	9	2.9%
	Identifies with 2 or more races	7	2.2%
	Other/Unknown	3	1.0%
	Prefer not to say	2	0.6%
Highest nursing degree earned?	Diploma or Associates	28	8.9%
	Bachelor's degree	214	68.4%
	Master's degree	66	21.1%
	PhD or DNP degree	5	1.6%
What shift do you work?	Day shift	309	98.7%
	Evening/Night shift	3	1.0%
Do you currently work in a Magnet® designated organization?	Yes	186	59.4%
	No	127	40.6%
Do you currently hold the Nursing Professional Development (NPD) board certification?	Yes	131	42.0%
	No	181	58.0%

Table 4.2 provides further description of the demographic variables. Participants in the study averaged 19 years ($_{SD}$ = 10.68) of experience as a registered nurse. Most respondents

reported working at their current organization on average 11.42 years (SD = 9.73), however, the sample had approximately equal distribution of years with their current employer. Roughly 25% of respondents reported having worked between one and five years, while another 25% had worked between six and ten years with their current organization. Similarly, 25% of participants also reported working for the same organization for over 15 years. Approximately half of the respondents reported having worked as an NPD practitioner between 1-5 years (48.9%, M= 5.97 years, SD = 6.79), with the average reporting that they've worked as an NPD practitioner about 6 years. Less than 10% of the respondents reported having worked as an NPD practitioner for more than 15 years. Conversely, only 40 respondents, which accounted for 12.8% of the total sample, reported having worked as an NPD practitioner for less than a year.

Table 4.2

Descriptive Statistics of Demographic Variables

Variables		**Frequency**	***n (%)***	**Mean *(SD)***
Years as a registered nurse?	1-5 years	13	4.2%	19.10 *(10.68*)
	6-10 years	65	20.8%	
	11-15 years	72	23.0%	
	>15 years	163	52.1%	
Years in current organization?	<1 year	18	5.8%	11.42 *(9.73)*
	1-5 years	80	25.6%	
	6-10 years	82	26.2%	
	11-15 years	54	17.3%	
	>15 years	79	25.2%	
Years as an NPD practitioner?	<1 year	40	12.8%	5.97 (*6.79)*
	1-5 years	153	48.9%	
	6-10 years	73	23.3%	
	11-15 years	17	5.4%	
	>15 years	30	9.6%	

Descriptive Statistics for Study Variables

The means and standard deviations of NPD practitioners' scores on the key study variables are presented in Table 4.3. The CWEQ-II was scored using Likert scale responses, which ranged from 1 (*never*), 3 (*some*) to 5 (*a lot*). The overall empowerment score was computed based on the sum of the six subscales: access to opportunity, information, support,

resources, formal, and informal power, with scores ranging from 6 to 30. Higher scores on the CWEQ-II were indicative of higher perceptions of empowerment in the workplace. The results of the study indicated that the total scores on the CWEQ-II ranged from 12.25 to 28.25, which reflected the NPD practitioner's perception of *overall empowerment* in the workplace. The NPD practitioners in this study perceived moderate levels of empowerment within their organization, with a mean score of 20.75 ($_{SD}$ = 3.23).

The range of scores for each of the subscales, such as formal power (Job Activities Scale or JAS), informal power (Organizational Relationship Scale or ORS), opportunity, information, support, and resources ranged from 1 – 5, where 1 is none and 5 is a lot. A subscale mean score was obtained by summing and averaging the items for each participant. Higher scores represented higher levels of perceived access to the respective subscales in the workplace. In this study, NPD practitioners perceived stronger *access to opportunities* (*M = 3.99, $_{SD}$ = .721)*, followed by *access to information* (*M = 3.64, $_{SD}$ = .897), formal power* (*M = 3.41, $_{SD}$ = .756),* and *informal power* (*M = 3.40, $_{SD}$ = .752*), respectively. *Access to resources* and *support* were the least empowering aspect of NPD practitioners' work environment, *M = 3.08, $_{SD}$ = .873* and *M = 3.20, $_{SD}$ = .872*, respectively.

On the ITS scale, there were six-items with responses ranging from 1-5, where 1 is *definitely will not leave* and 5 is *definitely will leave*. The items were reverse coded, thereby higher scores indicated than an individual was more likely to stay with their current employer, while lower scores indicated the individual would more likely be leaving their current employer in either 1-year, 3-years, or 5-years maximum. Total scores ranged from 6 – 30. In this study, NPD practitioners reported that they were more likely to remain with their current organization

(*n= 313, M* = 21.64, *SD = 5.71*). The average score on the empowerment scale was relatively high, with a mean score of approximately 22.

Table 4.3

Descriptive Statistics of Study Variables (n = 313)

Scale Variables	M	SD	Min - Max
Empowerment	20.75	3.32	12.25 - 28.25
Opportunity subscale	3.99	.721	2.00 – 5.05
Information subscale	3.64	.897	1.00 – 5.00
Support subscale	3.20	.872	1.00 – 5.00
Resources subscale	3.08	.873	1.00 – 5.00
Formal Power (JAS)	3.41	.756	1.33 – 5.00
Informal Power (ORS)	3.40	.753	1.25 – 5.00
Intent to stay (ITS)	21.64	5.71	6.00 – 30.00

Test of Hypotheses

Research Question #1

Does perception of *empowerment* (X_1) as a composite construct in the workplace predict *intent to stay* (Y) among NPD practitioners in the acute care hospital setting?

To answer the research question of whether perception of *empowerment* as a composite construct in the workplace predicts *intent to stay* among NPD practitioners in the acute care hospital setting, a simple linear regression analysis was used. With *overall empowerment* as the predictor and *intent to stay* as the dependent variable, the model for predicting *intent to stay* was statistically significantly, $F(1, 311) = 35.43$, $p < .001$. This indicated that we can reject the null hypothesis, which was the NPD practitioners' perception of overall empowerment does not predict their intent to stay in the workplace.

In this study, NPD practitioners' perception of *empowerment* in the workplace significantly predicted their *intent to stay* in their current workplace, $\beta = .32$, $p < .001$, and R^2 was .10. This indicated that 10% of the variance in *intent to stay* can be explained by *empowerment*. Higher levels of *empowerment* are predictive of more *intent to stay* among NPD practitioners.

Thereby, when NPD practitioners' perception of overall *empowerment* within the workplace increased by one standard deviation, their *intent to stay* will increase by .32 standard deviations.

Table 4.4

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.319[a]	.102	.099	5.42

a. Predictors: (Constant), Overall Empowerment

Coefficients[a]

		Unstandardized Coefficients		Standardized Coefficients		
	Model	B	Std. Error	Beta	*t*	Sig.
1	(Constant)	10.236	1.940		5.276	<.001
	Overall Empowerment	.549	.092	.320	5.952	<.001

a. Dependent Variable: Intent to Stay

Research Question #2

To what extent, if any, does each empowerment subscale, i.e., *opportunity* (X_2), *information* (X_3), *resources* (X_4), *support* (X_5), *formal power* (X_6), and *informal power* (X_7) relate to *intent to stay* (Y) when placed in one model?

To answer the research question regarding the extent, to which, each empowerment subscale when entered in one model as independent variables (*opportunity, information, resources, support, formal power, and informal power*), predicts the dependent variable (*intent to stay*), a multiple linear regression analysis was used. A significant regression equation was obtained ($F(6, 306) = 7.26, p < .001$), with an R^2 *was .125*, see table 4.4. This indicated that 12.5% of the variance in *intent to stay* can be explained by the model. Correlation coefficients for each of the subscales were computed to examine the association between the predictor variables and intent to stay. *Intent to stay* was positively correlated with all predictor variables, as presented in Table

4.6. Remaining questions will describe which of the empowerment subscales included in the model contributed to the prediction of the dependent variable, *intent to stay*.

Table 4.6

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.353[a]	.125	.108	5.39

a. Predictors: (Constant), Informal power, Support, Resources, Opportunity, Information, Formal Power

Coefficients[a]

		Unstandardized Coefficients		Standardized Coefficients		
Model		B	Std. Error	Beta	*t*	Sig.
1	(Constant)	9.794	2.058		4.762	<.001
	Opportunity	1.180	.483	.149	2.446	.015
	Information	.646	.415	.101	1.557	.122
	Support	-.190	.404	-.029	-.471	.638
	Resources	.798	.412	.122	1.936	.054
	Formal Power (JAS)	1.130	.556	.150	2.033	.043
	Informal Power (ORS)	-.277	.469	-.037	-.590	.555

a. Dependent Variable: Intent to Stay

Table 4.7

Correlation coefficients between Predictor Variables and Intent to Stay (n = 313)

Predictor Variables	**Coefficients**
Empowerment	.32**
Opportunity subscale	.24**
Information subscale	.23*
Support subscale	.15**
Resources subscale	.25**
Formal Power (JAS)	.30**
Informal Power (ORS)	.14*

**. Correlation is significant at the .01 level (2-tailed).
*. Correlation is significant at the .05 level (2-tailed).

a. Does the NPD Practitioners' perception of *access to opportunities* (X_2) relate to *intent to stay* (Y) in the acute care hospital setting?

Results of this analysis indicated that *access to opportunities* in the workplace significantly predicted *intent to stay* among NPD practitioners working in an acute care hospital setting, β =.149, p = .015. Higher *access to opportunities* is predictive of more *intent to stay* among NPD practitioners. Thus, when NPD practitioners' perception of their *access to opportunities* within the workplace increases by one standard deviation, their *intent to stay* will increase by .15 standard deviations. This demonstrates sufficient evidence to support the hypothesis that the perception of *access to opportunities* among NPD practitioners predicts their *intent to stay.*

b. Does the NPD Practitioners' perception of *access to information* (X_3) relate to *intent to stay* (Y) in the acute care hospital setting?

Results of this analysis indicated that *access to information* in the workplace did not significantly predict *intent to stay* among NPD practitioners working in an acute care hospital setting, β = .101, p = .121. Thereby, we can reject the hypothesis that the perception of *access to information* among NPD practitioners predicts their *intent to stay.*

c. Does the NPD Practitioners' perception of *access to resources* (X_4) relate to *intent to stay* (Y) in the acute care hospital setting?

Results of this analysis indicated that *access to resources* in the workplace did not significantly predict *intent to stay* among NPD practitioners working in an acute care hospital setting, β = .122, *p* = .054. Thereby, we can reject the hypothesis that the perception of *access to resources* among NPD practitioners predicts their *intent to stay.*

d. Does the NPD Practitioners' perception of *access to support* (X_5) relate to *intent to stay* (Y) in the acute care hospital setting?

Results of this analysis indicated that *access to support* in the workplace did not significantly predict *intent to stay* among NPD practitioners working in an acute care hospital setting, $\beta = -.029$, $p = .638$. Thereby, we can reject the hypothesis that the perception of *access to support* among NPD practitioners predicts their *intent to stay.*

e. Does the NPD Practitioners' perception of *formal power* (X_6) relate to *intent to stay* (Y) in the acute care hospital setting?

Results of this analysis indicated that perception of *formal power* in the workplace significantly predicted *intent to stay* among NPD practitioners working in an acute care hospital setting, $\beta = .150$, $p = .043$. Higher perceptions of *formal power* were predictive of higher *intent to stay* among NPD practitioners. Thus, when NPD practitioners' perception of *formal power* within the workplace increases by one standard deviation, their *intent to stay* will increase by .15 standard deviations. This demonstrates sufficient evidence to support the hypothesis that the perception of *formal power* among NPD practitioners predicts their *intent to stay.*

f. Does the NPD Practitioners' perception of *informal power* (X_7) relate to *intent to stay* (Y) in the acute care hospital setting?

Results of this analysis indicated that perception of *informal power* in the workplace did not significantly predict *intent to stay* among NPD practitioners working in an acute care hospital setting, $\beta = -.037$, $p = .555$. Thereby, we can reject the hypothesis that the perception of *informal power* among NPD practitioners predicts their *intent to stay.*

Chapter Summary

This chapter presented the findings of this cross-sectional, descriptive, correlational research study designed to answer the two research questions. Sample characteristics were described. Findings regarding the relationship between empowerment as a composite construct, followed by *opportunity, information, resources, support, formal power,* and *informal power* with *intent to stay* were presented. Interpretation of the correlation coefficients yielded significant relationships with all the variables and *intent to stay*. Interpretation of the regression analysis indicated that *opportunity* and *formal power* were the only variables that significantly predicted *intent to stay.* Thereby, when NPD practitioners' perception of *formal power* and *access to opportunities* increased, their *intent to stay* in their current organization increased.

CHAPTER V

DISCUSSION

The purpose of this chapter is to analyze and interpret the results of this study within the context of the theoretical framework and existing literature that guided the study. The chapter begins with an interpretation of the major findings, followed by a description of sample characteristics and instrument reliabilities. Thereafter, the chapter presents implication of the findings, followed by a review of limitations or weaknesses in the study. The remaining sections present recommendations for future research, conclusion, and chapter summary.

Interpretation of Major Findings

Empowerment and Intent to Stay

This study is the first to explore the relationship between workplace empowerment and intent to stay among NPD practitioners working in acute care hospitals pre- and post-pandemic. The results revealed workplace empowerment significantly predicted intent to stay. As NPD practitioners' perception of their work empowerment overall increased, their intent to stay with an organization increased, which is consistent with the only known study that evaluated the key variables of the current study (Nedd, 2006). These results contribute to the existing knowledge and emphasize the importance of fostering workplace empowerment to enhance retention among NPD practitioners in acute care settings.

Empowerment accounted for 10% of the variance in intent to stay, which could explain why other researchers factored in other variables like job tension and satisfaction (Baker et al., 2011; Davies et al., 2006; Laschinger et al., 2001b; Laschinger et al., 2009), and burnout (Sarmiento et al., 2004) to gain a more comprehensive understanding of factors influencing intent to stay. In this study, NPD practitioners perceived their workplace as moderately

empowering, which is consistent with the previous research on staff nurses and nurse educators in the academic setting (Armstrong & Laschinger, 2006; Baker et al., 2011; Davies et al., 2006; Hebenstreit, 2012; Sarmiento et al., 2004). Furthermore, NPD practitioners reported higher levels of workplace empowerment overall than clinical educators (Davies et al., 2006), college educators (Sarmiento et al., 2004) and staff nurses (Armstrong & Laschinger, 2006; Arslan Yürümezoğlu, H., & Kocaman, G., 2019). This suggests that NPD practitioners may experience a more empowering work environment than nurses working in other roles and educational settings, which may be attributed to the positioning of NPD practitioners, as nurse leaders, within some organizations. Given that, nurse leaders often have more decision-making authority and the ability to influence practices within their healthcare organization, which can contribute to a sense of empowerment.

Other studies that examined if empowerment predicted constructs comparable to intent to stay, like organizational commitment (Al-Hussami et al., 2011) and intent to leave (Arslan Yürümezoğlu, H., & Kocaman, G., 2019) had similar findings. Although Nedd (2006) conducted a similar study involving registered nurses in Florida hospitals, direct comparisons should be interpreted with caution. Other variables associated with workplace empowerment, like job tension, job satisfaction, organizational commitment, and innovative behavior, have yet to be explored in the NPD practitioner population, however, these variables warrant further exploration as they may provide nurse leaders insight into key strategies aimed at improving retention (Davies et al., 2006; Gui et al., 2014; McDermott et al., 1996; Sarmiento et al., 2004; Laschinger et al., 2009; Laschinger et al., 2001a; Laschinger et al., 2001c) and innovative behavior (Baker et al., 2011). Innovative behavior refers to the ability and willingness to generate new ideas, solutions, and approaches to problems or challenges that originate within the

hospital setting. In the post-pandemic climate, this level of thinking and motivation to spearhead initiatives aimed at enhancing the staff nurse and patient experience is paramount, as it can lead to advancements in healthcare practices and quality patient outcomes. Nonetheless, while this study is the first of its kind in the NPD practitioner population, it adds to the growing body of empirical evidence supporting the impact of organizational aspects on the behaviors of nurses, including NPD practitioners.

The second research question that guided this study examined the relationship between NPD practitioners' perception of each empowerment structure (*opportunity, information, resources, support, formal power,* and *informal power*) and *intent to stay*. A multivariate regression analysis was conducted to identify if empowerment subscales predicted intent to stay when examined in the same model. The multiple regression model significantly predicted intent to stay, $F(6, 306) = 7.246$, $p < .001$, adjusted $R^2 = .107$. Results revealed that access to *opportunity* and *formal power* significantly predicted intent to stay ($\beta = .150$, $p = .015$; $\beta = .150$, $p = .043$, respectively). In the Nedd (2006) study, formal power did not significantly predict intent to stay in staff nurses, but access to opportunities did. Furthermore, access to resources was the only other variable that approached significance ($\beta = .122$, $p = .054$). As with the other variables, access to information, support, and informal power failed to predict intent to stay when examined in the same multivariate model.

Nonetheless, the current study highlighted that when NPD practitioners perceived access to opportunity within the workplace, they were more inclined to remain with that organization. This finding aligns with anecdotal evidence, which indicates that NPD practitioners may face limitations in terms of advancement opportunities within their specialty after transitioning from staff nurse to preceptor and then to NPD practitioner. Therefore, organizations should consider

providing them with growth and advancement opportunities, like career ladders, to retain them. This also includes offering chances for NPD practitioners to enhance their knowledge and skills, as well as opportunities to expand their capabilities within the field. By doing so, organizations can create an empowering environment that influences and promotes NPD practitioner retention.

Additionally, NPD practitioners in this study perceived formal power within their workplace as a predictor of intent to stay, suggesting that NPD practitioners value leaders who recognize and understand the impact of their work on organizational goals, such as quality outcomes and nurse retention. NPD practitioners feel more empowered when they are valued and when their work is visible to higher-level stakeholders within the organization. This implies that when NPD practitioners receive acknowledgement and appreciation for their contributions, they experience a greater sense of empowerment compared to staff nurses.

In summary, these findings suggests that NPD practitioners' perception of professional development opportunities (access to opportunity), along with feeling valued and recognized (formal power), plays a significant role in their intent to stay within the organization. Kanter's theory (1993, 1997) posits that as perception of power and empowerment structures increase, this ultimately leads to improved organizational commitment (Derby-Davis, 2014), increased work effectiveness (Hebenstreit, 2012), and job satisfaction (Baker et al., 2011; Davies et al., 2006; Gui et al., 2014; McDermott et al., 1996; Sarmiento et al., 2004; Laschinger et al., 2009; Laschinger et al., 2001a). The relationships between empowerment and organizational commitment, work effectiveness, and job satisfaction have yet to be explored in the NPD practitioner population, thereby more research is warranted.

Correlation analyses revealed significant positive correlations between intent to stay and all empowerment structures. After overall empowerment, formal power ($r = .30$, $p = .001$)

revealed the highest correlation, followed by access to resources (r = -.25, p = .001), opportunity (r = -.24, p = .015), and information (r = -.23, p = .001) with intent to stay. The weakest correlation among NPD practitioners was access to support (r = .150, p = .008) and informal power (r = .142, p = .012). Conversely, Nedd (2006) reported the strongest correlations between intent to stay after overall empowerment, was opportunity, followed by support, resources, and informal power among registered nurses.

In Nedd's (2006) study, staff nurses desired more professional development opportunities, while NPD practitioners desired more visibility regarding their individual work and contributions. These findings highlight the differences between the needs of staff nurses and NPD practitioners, hence why the approach should change. In each empowerment structure, i.e., opportunity, information, resources, support, formal power, and informal power, NPD practitioners had higher means than nursing staff (Nedd, 2006; Armstrong and Laschinger, 2006), but they were comparable to nurse educators in various settings (Sarmiento et al., 2004, Davies et al., 2006, Baker et al., 2011). Overall, these findings emphasize the unique needs of NPD practitioners after the COVID-19 pandemic posed many challenges and exacerbated old ones for them while working in the acute care hospital setting.

Comparison of Sample Characteristics to the Literature

Consistent with previous studies on NPD practitioners, the sample size characteristics of this research study indicated that majority of participants were female (95.9%), non-Hispanic Caucasian (82.1%), between the ages of 30 and 59 years old (Harper et al., 2016; Harper et al., 2017). Most participants in the study had a bachelor's (68.3%) or master's degree (21.1%), with very few having a doctoral degree (1.6%). This is consistent with a 2020 National Nurse

Workforce study on registered nurses, which found that only a small percentage held a master's or doctoral degree (Nedd, 2006; Smiley et al., 2021).

NPD practitioners in this study had an average of 19.1 years of experience as a registered nurse, with most having worked at their current organization for over a decade. Additionally, approximately half of the respondents reported having worked as an NPD practitioner for 1-5 years, with a mean of 5.97 years of experience. A significant percentage of participants worked in Magnet® designated organizations (59.6%) and were board certified in the NPD specialty (58.0%). This information may be relevant to the literature on NPD practitioners as it provides insight into the characteristics and qualifications of individuals who may perceive higher levels of empowerment in the workplace. Further research is warranted to determine how this information correlates with the broader literature on NPD practitioners and intent to stay.

Comparison of Sample Instrument Reliabilities to the Literature

In a similar study (Nedd, 2006), alpha coefficients were utilized to evaluate the reliability of the same instruments used in this study to measure empowerment and intent to stay, the CWEQ-II and ITS scale, respectively. Nedd (2006) reported higher alpha coefficients for overall empowerment and most of its subscales, except for the information subscale, which was slightly higher in the current study. The intent to stay instrument had a higher alpha coefficient in the current study compared to previous studies (Kim et al., 1996; Nedd, 2006). While the Nedd (2006) study reported higher alpha coefficients overall, the current study still demonstrated acceptable levels of reliability for the CWEQ-II and ITS. This indicated that both instruments are reliable for measuring the intended constructs of empowerment and intent to stay (Laschinger et al., 1996; Laschinger et al., 2004, Armstrong & Laschinger, 2006; Nedd, 2006).

Implications of the Findings

Nursing Workforce

Staff Nurses. The global pandemic presented many challenges for health care systems and nurses. The impact has been so profound that many nurses are opting to leave the profession outright, while those who are eligible for retirement and have been for quite some time, are choosing to leave now (Hooper, 2023). Given the current climate, the results of this study support Kanter's theory that NPD practitioners who perceive their workplace as empowering are more likely to stay with their organization post pandemic. This finding is particularly important in the post pandemic climate because NPD practitioners are invaluable to staff nurse development in the acute care hospital setting. It implies that creating an empowering work environment for NPD practitioners can contribute to their retention, which in turn can positively impact the growth and development of staff nurses in the challenging post-pandemic landscape.

In the current study, NPD practitioners reported moderate levels of empowerment, that were predicted by their perception of formal power. Formal power can be interpreted as the authority and influence that comes from specific job characteristics. These characteristics include things like being able to make decisions based on your own judgment, being adaptable and creative in your work, being visible and recognized within the organization, and having a central role in achieving the organization's purpose and goals. In other words, this may indicate that NPD practitioners thrive in environments replete with shared decision making that which permit flexibility and creativity as it relates to mitigating problems in nursing practice. Thereby, NPD practitioners' perception of formal power in the workplace could have a significant influence on staff nurse turnover and the provision of quality patient care in the hospital setting.

In fact, Harper et al. (2022) found that NPD practitioners were significantly instrumental in influencing retention for new graduate nurses. This data was collected during the COVID-19 pandemic, thereby indicating that NPD practitioners played a key role in supporting new graduate nurses' as they transitioned into the hospital setting during an unprecedented time. In addition, Harper et al. (2022) also found that amidst the pandemic, organizations with a higher number of NPD practitioners had a reduction in nurse turnover rates overall. Nonetheless, NPD practitioners were imperative to organizational stability during the pandemic, thereby efforts to empower and retain them should be prioritized among hospital leaders.

Furthermore, regarding quality care, NPD practitioners had the primary responsibility for developing a variety of staff nurses, from newly licensed clinicians to the most experienced clinicians. These responsibilities included providing education and skill training on evidenced-based changes in practice and organizational guidelines. As a result, NPD practitioners' contributions likely yielded an indirect influence on patient outcomes during a very challenging time for nurses and patients. Harper et al. (2022) found that more NPD practitioners were associated with better readmission rates for conditions like heart failure and pneumonia, and better patient experience scores.

Harper et al. (2022) study findings revealed that during the pandemic, NPD practitioners played a crucial role in staff nurses' retention and provision of quality care, which ultimately posed financial benefits for hospital organizations. Unfortunately, anecdotal evidence suggests that NPD practitioners' efforts during this time often went undervalued and unrecognized. Thereby, the current study results revealed that this lack of recognition could influence their decision to remain with an organization. Given the impact NPD practitioners have in the hospital

setting, investing in their empowerment and perception of formal power is crucial as we navigate the post-pandemic landscape and look to identify strategies to improve retention at all levels.

Nurse Leaders. As previously mentioned, nurse leaders have a pivotal role in creating empowering work environments, whether you are working in academic or health care institutions. In support of Kanter's theory, this can be achieved by providing access to opportunities, resources, information, support, and both formal and informal power. Put differently, nurse leaders should prioritize creating a space that promotes growth and professional development by providing the necessary resources to address the challenges NPD practitioners face. In a recent study, NPD practitioners reported high levels of exhaustion and disengagement during the pandemic (Porter, 2023). Additionally, Porter (2023) found that NPD practitioners who had more than a year experience had higher levels of disengagement and exhaustion during the second wave of the pandemic. Although the Porter (2023) study was conducted during the pandemic, it is unclear if these issues remain in the post-pandemic climate. Today, this is especially problematic because although the pandemic has ended, the heavy workload and heightened expectations to perform among NPD practitioners remains, which could contribute to burnout (Porter, 2023).

With the current and projected shortages upon us, nurse leaders must employ a different approach to leadership. Considering NPD practitioners found overall empowerment, formal power, and access to opportunity to be the most empowering and influential on their decision to remain with an organization. This means nurse leaders should focus on providing the chance for NPD practitioners to gain new skills and knowledge on the job. This might also include providing access to relevant educational resources, supporting attendance at conferences or workshops, and fostering a culture of continuous learning within the organization. Recognizing

and valuing their pursuit of knowledge can help NPD practitioners feel motivated and engaged in their role. Oftentimes, the NPD practitioners' influence on staff nurses and organizational outcomes goes unnoticed and undervalued, the current study findings emphasize the importance of nurse leaders recognizing and rewarding them for their contributions in designing and implementing effective educational programs aimed at ensuring frontline staff have the necessary knowledge, skills, and abilities to provide safe patient care is imperative. Further research is needed to explore other variables mentioned above in the post pandemic climate, such as work effectiveness, engagement, burnout, and job satisfaction, in the NPD practitioner population. Understanding these variables could prove beneficial to nursing leaders as they seek strategies to improve retention at all levels post pandemic.

Lastly, based on the findings and supporting literature, the implications for nursing practice as it relates to NPD practitioners themselves, revealed that a significant difference existed between the needs of other nurses and NPD practitioners. Staff nurses perceived access to opportunities as having the greatest impact on their intent to stay (Nedd, 2006), while NPD practitioners perceived formal power as more influential. In other words, NPD practitioners desired recognition for the vital role they played in the success of the organization. On the contrary, access to opportunity and formal power were the only two subscales that significantly predicted intent to stay among NPD practitioners when the six subscales were all placed in one model. This suggests that nurse leaders should focus on providing NPD practitioners with opportunities for professional growth and increased visibility regarding their individual work and contributions.

Implications for Nursing Public Policy

Findings from this study can influence public policy in several ways, one of which includes funding. The results of this study demonstrated a positive association between access to information, opportunities, resources, support, formal and informal power. Specifically, the availability of opportunities within the workplace was found to be a significant predictor of their likelihood to stay. However, it is necessary to note that NPD practitioners did not perceive a high level of support and resources in their workplace which is consistent with studies involving academic nurse educators (Baker et al., 2011; Davies et al., 2006; Sarmiento et al., 2004). Therefore, it is imperative to implement initiatives aimed at providing the necessary support, access to information, and resources for NPD practitioners. These measures will not only enhance their teaching methodologies but also improve their overall work effectiveness. As the generations in the workforce change, the approach to education and learning should change.

Funding can aid in the purchase of additional resources aimed at enhancing the learning acquisition of clinical nurses, such as simulation equipment and virtual reality tools. Lastly, this information can influence public policy by informing legislators and healthcare administrators about the importance of providing NPD practitioners with access to resources, support, and opportunities for their own professional development. Often upon assuming the NPD practitioner role, there is no career ladder, thereby they may become stagnant which could ultimately impact their engagement and work effectiveness.

Implications for Theory

The findings in this study contribute to the existing findings associated with Kanter's Theory of Structural Empowerment (1993, 1997), where aspects of the work environment are shown to influence behaviors among nurses, like intent to stay and/or organizational

commitment. This study yields empirical evidence that workplace empowerment significantly predicts intent to stay among NPD practitioners. The research reveals that access to empowerment structures influence intent to stay, which in turn, can be explained by organizational commitment as identified within the theory. Lastly, the study shows that NPD practitioners reported higher levels of workplace empowerment overall compared to clinical educators, college educators, and staff nurses (Baker et al., 2011; Davies et al., 2006; Nedd, 2006; Sarmiento et al., 2004). This suggests that NPD practitioners may experience a more empowering work environment than nurses working in other roles and educational settings. Overall, these findings contribute to the existing knowledge in support of Kanter's theory (1993, 1997), nurse leaders can gain valuable insights into the factors that influence NPD practitioners' intent to stay as more concepts within this theory are explored.

Recommendations for Future Research

Further research is needed to explore the influence of workplace empowerment on other variables, like innovative behavior and job satisfaction, and intent to stay in the NPD practitioner population. Additionally, it may be important to examine if more empowered and engaged NPD practitioners leads to better quality patient outcomes and/or improved retention in the workforce. A comparative study of empowerment and intent to stay using demographic variables may provide insight as to the differences among NPD practitioners in various settings, like those working in magnet designated versus non-magnet designated hospitals. While Nedd (2006) did not find significance between personal characteristics and empowerment, there may be an opportunity to explore this further in the NPD practitioner population. Additionally, similar to the Porter (2023) study, an examination of work engagement, empowerment, and burnout in the post pandemic climate may yield valuable insight as to the current juxtaposition between these

variables and intent to stay. Nonetheless, all this information could provide a guiding framework for hospital leaders to identify what it takes to retain NPD practitioners, which can ultimately enhance patient care outcomes and reduce financial costs associated with turnover.

Limitations

Several limitations existed within this study, the first being the selected design, followed by recruitment and sample, missing values approach, and the approach to normality. While a descriptive correlation study design allows for the examination of relationships between variables, it does not establish causality. Additionally, the study relied on self-report instruments which is subject to recall and social desirability bias, thereby affecting the validity of findings. In addition, the cross-sectional nature of the study limits the ability to assess changes as time progresses post-pandemic. Another limitation of this study is the absence of pre- or during-pandemic data in the existing literature for comparison with the post-pandemic data.

An additional limitation of the study was the use of a convenience sample which could limit the generalizability of the study findings; however, to combat this the sample included participants from across the United States. Although the sample was recruited nationwide, with respect to demographic variables there was not equal representation of all ethnicities. Majority of sample participants identified as non-Hispanic Caucasian; however, this aligns with racial breakdowns of the nursing workforce today. Additionally, the current study did not control for confounding variables like remote work, degree level, generational differences, hospital magnet status, and certification which could significantly impact the associations observed.

Lastly, the normality distribution of the variables, followed by the missing values approach yielded a limitation in the current study. While the skewness and kurtosis values for the study variables were within the acceptable range, the Kolmogorov-Smirnov statistic values were

significant for all variables except empowerment, raising concerns about the normality of the data which could impact the study's findings. Estimation maximization was the approach used to impute missing values which relies on the data being completely missing at random, thereby, this could result in biases.

Conclusion

In the post-pandemic landscape and amidst the current nursing shortage, a study examining NPD practitioners' perception of empowerment in the workplace and their intent to remain with the organization is highly relevant and timely. This study can provide valuable insights into the factors that contribute to the retention of NPD practitioners, who play a crucial role in supporting and developing the nursing workforce. If NPD practitioners perceive high levels of empowerment in the workplace, this may positively impact their job satisfaction, motivation, and commitment to the organization. This, in turn, can contribute to their intent to remain with the organization, which is particularly important in the current nursing shortage. The current study provided nurse leaders with practical strategies to promote empowerment, such as providing opportunities for professional growth, involving NPD practitioners in decision-making processes, and recognizing their contributions. Ultimately, the findings of this study can inform organizational policies and practices aimed at retaining NPD practitioners, which is crucial for addressing the nursing shortage and ensuring the availability of a skilled and experienced workforce in the post-pandemic healthcare landscape.

Chapter Summary

This chapter provided a discussion about the findings of this cross-sectional, descriptive, correlational research study designed to determine the relationships between empowerment as a construct and intent to stay, and empowerment subscales and intent to stay. Sample

characteristics were described. Findings regarding the relationship between empowerment as a composite construct, followed by opportunity, information, resources, support, formal power, and informal power with intent to stay were presented. Interpretation of the Pearson correlation results yielded significant relationships with all empowerment subscale variables and intent to stay. Interpretation of the regression analysis indicated that opportunity and formal power were the only predictors that significantly predicted intent to stay when all empowerment subscales are included as predictors of intent to stay in a multivariate model. In summary, the study emphasizes the importance of workplace empowerment for NPD practitioners and suggests that nursing leaders should focus on providing opportunities, formal power, and other resources to enhance nurse retention.

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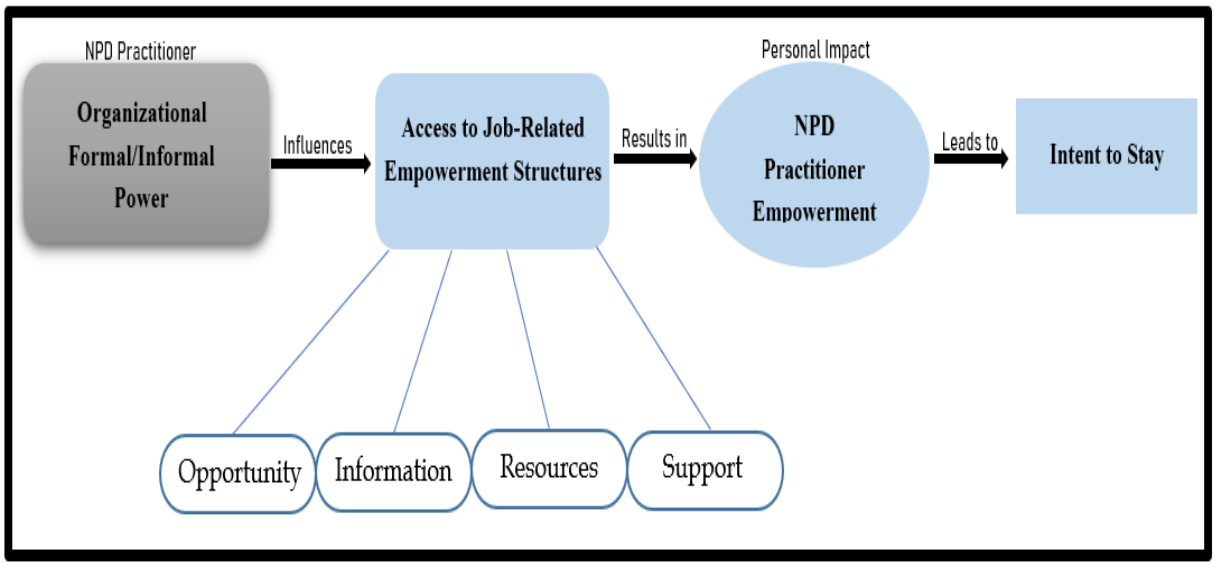
APPENDICES

Appendix A

Researcher Proposed Framework



This framework is based on Kanter's Theory of Structural Empowerment (Kanter, 1993)

Appendix B

Measurement Tools

Empowerment Structures	● Conditions of Work Effectiveness Questionnaire II (CWEQ-II) modified from the CWEQ I – 19 items and 6 subscales using a 5-point Likert scale. Subscales include access to information, opportunity, resources, support, formal and informal power. Confirmatory factor analysis has evidence of construct validity and reliabilities range from 0.79 to 0.82 (Laschinger et al., 2001).
Personal Impact Organizational Commitment	● Intent to Stay (ITS) tool will be used to measure organizational commitment. The ITS tool consists of six items using a 5-point Likert scale. This instrument does not contain any subscales and scores can range from 6 to 30. Exploratory factor analysis has evidence of construct validity and reliabilities range from 0.84 to 0.90 (Nedd, 2006).

Appendix C

Invitation to Participate in the Study

Dear Nurse Professional Development Practitioners,

My name is Tashiana Roberts-Jackson, RN, and I am a doctoral student currently conducting a study to examine the relationships between structural empowerment and intent to stay in Nurse Professional Development (NPD) practitioners. I am also actively working as an NPD Specialist in a large healthcare system.

I am asking for you to complete a short survey that asks about structures within your organization that might influence your perception of empowerment in the workplace and intent to stay with your current employer. Your responses are valuable and will help generate new knowledge about the NPD specialty and what it takes to retain us, which is important for our profession and our patients.

No personally identifying information will be asked. Your information will be kept confidential and anonymous, thereby neither your employer nor colleagues will be able to access your responses.

Participation in this study is entirely voluntary. If at any point you wish to not continue with the study, you may do so without penalty. Participation in this study is also considered your voluntary informed consent. When you are ready to proceed, please click below if you would like more information.

Click here to proceed **OR** Scan QR code below with your smartphone.

If you have any questions pertaining to this research study, please contact me at Tashiana.roberts@mavs.uta.edu (*Principal Investigator*). Again, thank you for agreeing to participate in this study. Without your participation, this research would not be possible

Warmest regards,

Tashiana Roberts-Jackson

Appendix D

Informed Consent Letter

Dear Nurse Professional Development Practitioner,

My name is Tashiana Roberts-Jackson, and I am asking you to participate in a UT Arlington research study titled, "The Relationship Between Nurse Professional Development Practitioners' Perceptions of Empowerment in the Workplace and Intent to Stay Post the COVID-19 Pandemic." This research study is about examining the relationships between workplace empowerment and intent to stay among Nurse Professional Development (NPD) practitioners.

The purpose of this study is to generate new knowledge about the NPD specialty, specifically as it relates to empowerment and what it takes to retain us.

You can choose to participate in this research study if you are at least 18 years old and a registered nurse with the title of clinical resource nurse, staff development coordinator, clinical nurse educator, nurse professional development practitioner/generalist/specialist, nursing instructor or similar with a primary responsibility to educate and develop frontline nursing staff in the hospital or ambulatory care setting.

Reasons why you might want to participate in this study include to share your experience as an NPD practitioner as it relates to empowerment in the workplace and how that influences your intent to stay with the organization, but you might not want to participate in this study if you if you are uncomfortable with sharing your personal experiences. Your decision about whether to participate is entirely up to you. If you decide not to be in the study, there won't be any punishment or penalty; whatever your choice, there will be no impact on any benefits or services that you would normally receive. Even if you choose to begin the study, you can also change your mind and quit at any time without any consequences.

If you decide to participate in this research study, the list of activities that I will ask you to complete for the research are

1. Read through this Informed Consent and contact me should you have any unanswered questions; then make your choice about whether to participate.
2. If you agree to participate, you will be asked to complete initial screening questions followed by a demographic questionnaire.
3. Lastly, you will answer survey questions as it relates to empowerment in the workplace and intent to stay.

It should take no longer than 10 minutes to complete and there will be no additional requests.

Although you probably won't experience any personal benefits from participating, the study activities are not expected to pose any additional risks beyond those that you would normally experience in your regular everyday life or during routine medical / psychological visits; however, if any, there is the a) potential time loss from taking the survey, b) potential for psychological distress while thinking about intent to leave; c) potential for a breach of data from participants; d) potential for perceived coercion if respondents are highly engaged with activities of the Association of Nursing Professional Development (ANPD). To minimize risks, the following strategies will be used: a) The survey is completely voluntary, and you will be able to exit the survey at any time without penalty; b) your information will be stored on a password-protected computer and no personally identifiable information will be obtained; c) this research is <u>not</u> being conducted by ANPD but rather a doctoral student from the University of Texas at Arlington.

You will not be paid for completing this study. There are no alternative options to this research project.

The research team is committed to protecting your rights and privacy as a research subject. We may publish or present the results, but your name will not be used. While absolute confidentiality cannot be guaranteed, the research

team will make every effort to protect the confidentiality of your records as described here and to the extent permitted by law. If you have questions about the study, you can contact me at Tashiana.roberts@mavs.uta.edu. For questions about your rights or to report complaints, contact the UTA Research Office at 817-272-3723 or regulatoryservices@uta.edu.

You are indicating your voluntary agreement to participate by clicking on the "I agree" button below.

Warmest regards,
Tashiana Roberts-Jackson, MSN, BS, RN-BC, NPD-BC

Appendix E

Demographic Questionnaire

INSTRUCTIONS: Answer each question by filling in the correct answer.

1. What gender do you identify as?
    a. Male
    b. Female
    c. Transgender
    d. Non-binary
    e. Prefer not to answer
    f. Other
2. Please specify your ethnicity (select all that apply)?
    a. African American
    b. Asian
    c. Latino or Hispanic
    d. Native American
    e. Native Hawaiian or Pacific Islander
    f. Non-Hispanic Caucasian
    g. Other/Unknown
    h. Prefer not to say
3. What is your age?
    a. 18 – 29
    b. 30 – 45
    c. 46 – 59
    d. Over 60
    e. Prefer not to answer
4. Highest nursing degree earned?
    a. Diploma or Associates
    b. Bachelor's Degree
    c. Master's Degree
    d. Ph.D. or DNP
5. What shift do you work?
    a. day
    b. evening/night
6. Do you currently work in a magnet® designated organization?
    a. yes
    b. no
7. Do you currently hold the Nursing Professional Development (NPD) board certification?
    a. yes
    b. no
8. How long have you worked as a registered nurse? ___ years __months
9. How long have you worked at your current organization? ___ years __months
10. How long have you worked as an NPD practitioner? ___ years __months

Appendix F

Permission to Use the Conditions for Work Effectiveness Questionnaire – II

From: Sarah Prezeau <sarah.prezeau@uwo.ca>
Sent: Tuesday, September 13, 2022 9:41:03 AM
To: Roberts-Jackson, Tashiana Michelle <tashiana.roberts@mavs.uta.edu>
Cc: hkltools <hkltools@uwo.ca>
Subject: RE: Request permission to use CWEQ II

[External]

Thank you for your e-mail inquiry! I monitor this e-mail to ensure people receive access to the tools and information by the late Dr. Laschinger, who unfortunately passed away in 2016.

Yes, please go ahead and use the tools. You can find them on the website here.
Best of luck with your research project!

Take care,
Sarah

Sarah Prezeau, PhD (she/her)
Research Officer, School of Nursing
Faculty of Health Sciences | Western University
FIMS & Nursing Bldg., Rm. 3312
On-Site: Mondays, Tuesdays & Thursdays*
T: 519.661.2111, ext. 80225
E: sarah.prezeau@uwo.ca | LinkedIn

Appendix G

Conditions for Work Effectiveness Questionnaire – II

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

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

1. Challenging work	1	2	3	4	5
2. The chance to gain new skills and knowledge on the job	1	2	3	4	5
3. Tasks that use all of your own skills and knowledge	1	2	3	4	5

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

1 = No Knowledge 2 3 = Some Knowledge 4 5 = Know A Lot

1. The current state of the hospital	1	2	3	4	5
2. The values of top management	1	2	3	4	5
3. The goals of top management	1	2	3	4	5

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

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

1. Specific information about things you do well	1	2	3	4	5
2. Specific comments about things you could improve	1	2	3	4	5
3. Helpful hints or problem-solving advice	1	2	3	4	5

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

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

1. Time available to do necessary paperwork	1	2	3	4	5
2. Time available to accomplish job requirements	1	2	3	4	5
3. Acquiring temporary help when needed	1	2	3	4	5

In my work setting/job: **(JAS)**

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

1. The rewards for innovation on the job are	1	2	3	4	5
2. The amount of flexibility in my job is	1	2	3	4	5
3. The amount of visibility of my work-related activities within the institution is	1	2	3	4	5

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

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

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

Appendix H

Permission to Use the Intent to Stay Scale

Permission to use the Intent to Stay Scale was granted in Price (2001) as follows, "the reader may use the items in the Appendix as he/she deems appropriate. Permission is not necessary" (p. 618).

Appendix I

Intent to Stay Scale

For the next six items, please rate your job intent to stay on a scale of:

(1) Definitely will not leave

(2) Probably will not leave

(3) Uncertain

(4) Probably will leave

(5) Definitely will leave

Which of the following statements most clearly reflects your feelings about your future in the hospital?

1. Rate your intent to stay in your current job and present hospital for one year.....1 2 3 4 5

2. Rate your intent to stay in your current job and present hospital for three years….1 2 3 4 5

3. Rate your intent to stay in your current job and present hospital for five years. ….1 2 3 4 5

4. Rate your intent to leave your current hospital for a similar job at another hospital in one year. ……...1 2 3 4 5

5. Rate your intent to leave your current hospital for a similar job at another hospital in three years. ……...1 2 3 4 5

6. Rate your intent to leave your current hospital for a similar job at another hospital in five years…….1 2 3 4 5

Appendix J

Approval to Recruit ANPD Members

Gmail Tashiana Roberts-Jackson <trobertsjackson@gmail.com>

Inquiry re: Access to ANPD members email or direct mail address for research study

Harper, Mary <mharper@anpd.org> Tue, Dec 20, 2022 at 4:06 PM
To: Tashiana Roberts-Jackson <trobertsjackson@gmail.com>

Hi Shauna,

Great news! You've been approved to recruit ANPD members to participate in your research! Please let me know what type of documentation you need for your IrB submission and I'll prepare it for you.

Congratulations on another step toward your PhD!!

Happy Holidays,

Mary

Mary Harper, PhD, RN, NPDA-BC®

Director of Research & Inquiry

Association for Nursing Professional Development

330 N. Wabash Avenue | Suite 2000| Chicago, IL 60611

Phone: 386,793,6725

Join us at the 2023 Aspire Convention, March 14-17!

[Quoted text hidden]

Appendix K

IRB approval

[Institutional Review Board]: IRB # 2023-0178 - Protocol was approved

Mentis Support <system@mentis-support.uta.edu>
Wed 2/8/2023 9:32 AM
To: Roberts-Jackson, Tashiana Michelle <tashiana.roberts@mavs.uta.edu>

Dear Tashiana Roberts-Jackson,

IRB has approved the protocol # 2023-0178. You can access the protocol following this link
http://mentis.uta.edu/#irb/protocol/view/id/44524

Regards,

Mentis Support