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Four Predictors of Nurses' Organizational Commitment in Health Care Organizations

Mahmoud Al-Hussami

FOUR PREDICTORS OF NURSES' ORGANIZATIONAL COMMITMENT

IN HEALTH CARE ORGANIZATIONS

DISSERTATION

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By

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ABSTRACT

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Barry University, 2007

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Purpose

The purpose of this study was to determine the multiple correlation between the four predictors (job satisfaction, perceived organizational support, transformational leadership behavior, and level of education) on the degree of organizational commitment among registered and licensed practical nurses in South Florida's long-term care facilities. Most studies on health care settings tend to focus on nurses and other medical personnel in acute care settings, resulting in a major gap in the literature on issues and concerns of health professionals in long-term care settings. Studies of this nature are instrumental in helping administrators to better meet the needs of long-term care nurses employed in their organizations, which may have implications for the delivery of services. This study's findings supported the relationship of long-term care nurses' organizational commitment to job satisfaction, perceived organizational support, transformational leadership behavior, and level of education.

Method

The research question addressed in this study was whether relationships existed between organizational commitment and job satisfaction, perceived organizational support,

transformational leadership behavior, and nurses' level of education. The analytical procedure of multiple regression was utilized to determine the predicting strength among organizational commitment and the independent variables: job satisfaction, perceived organizational support, transformational leadership behavior, and nurses' level of education. To obtain the participants for this study, the researcher chose randomly four nursing homes from a total of 53 Medicare/Medicaid certified nursing homes located in Miami-Dade County. Miami-Dade County was divided into four geographical quadrants, north, south, west, east, and the researcher randomly chose one nursing home from each quadrant. A simple random sample was used to select the participants from each nursing home, using a procedure that gives every nurse a known and equal chance of being included in the sample. The participants were randomly chosen from a list of nursing staff provided by each facility. To assure anonymity, the list contained only identifying numbers representing nurses in each of the randomly chosen facilities.

Major Findings

Pearson product-moment correlation coefficients were computed and revealed that positive correlation existed between organizational commitment, the dependent variable, and job satisfaction, perceived organizational support, transformational leadership, and level of education, the independent variables. Of the four independent variables, a multiple regression analysis indicated that job satisfaction and perceived organizational support were most strongly related to organizational commitment. In addition, multiple regression analysis indicated that 91% of the variance in nurses' organizational commitment was explained with all of the independent variables.

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DEDICATION

To my wife, Muna, whose values, support, assistance, patience, and love encouraged me to complete this milestone. To my parents, Jameala and Ogla, for teaching me the value and joy of learning, and installing in me the belief that education offers the keys to a satisfying and happy life. To my children, Rawan, Razan, and Ronza, who were able to realize the value of education in their lives. Lastly, to my brothers and sisters who are great family members and inspiring individuals. Their compassion, courage, and wisdom provided me with the strength to achieve my dreams.

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CHAPTER I

INTRODUCTION

Background of the Problem

The United States is in the midst of a dramatic nursing shortage that is projected to intensify as baby boomers age and the need for health care service grows (Fletcher, 2001; Mark, 2002; Mitchell, 2003). The serious nursing shortage is creating a crisis in the nation's health care system. So many contributing factors are impacting the nursing shortage, that experienced nurses are leaving the field while the younger people do not select nursing as a potential career (Wynd, 2003). In order to alleviate the captioned shortage, the health care administrators are requested to go to great efforts to achieve more progress toward promoting and developing methods for building organizational commitment among nurses and other health care practitioners (McNeese-Smith, 2001).

The Health Resources and Services Administration, Bureau of Health Professions, and National Center for Health Workforce Analysis in 2000 estimated the full-time equivalent supply of Registered Nurses (RNs) at 1.89 million whereas the demand was estimated at 2 million (U.S. Bureau of Health Profession, Health Resources and Services Administration, 2002). The shortage will grow to reach 12% by 2010 and by 2015 is estimated to be 20%. In case the current trends go on, and the issue is not properly addressed, the shortage is projected to grow to 29% by 2020 (U.S. Bureau of Health Profession, Health Resources and Services Administration, 2002). Reasons behind the growth in demand include a larger proportion of elderly persons, an 18% increase in population, and medical advances that require more nurses (U.S. Bureau of Health Profession, Health Resources and Services Administration, 2002).

The shortage of nurses nationwide and locally has been well documented and extended to the long-term care industry (Fletcher, 2001; Mark, 2002; Mitchell, 2003). As a growing segment of the population ages and strains the capacity of these institutions, most are having difficulties in finding and retaining qualified nursing staff (Fenleib, Gunningham, & Short, 1994; Gohen & Van Nostrand, 1995; Kassner & Bertel, 1998; LaPlante, 1993). The Federal Government, by requiring these facilities to have adequate staff to provide adequate care to all residents, has made the problem more urgent for nursing homes. These facilities must have at least one registered nurse on duty for at least eight consecutive hours per day, seven days a week. In addition, either a registered nurse, a licensed practical nurse, or other nursing personnel must be on duty 24 hours a day (Department of Health and Human Services Centers for Medicare and Medicaid Services, 2004).

More than 3.85 million workers were employed in the nation's long-term care delivery systems in 2003 according to estimates developed in 2005 by the United States Department of Labor, Bureau of Labor Statistics. This workforce represents 3.6% of the service sector employment and 3% of the total United States non-farm employment. According to the same estimates, 545,690 of the employed personnel out of 2.2 million direct-care workers were professionals, such as registered nurses and licensed practical nurses, and 1.65 million were paraprofessionals defined to include nurse aides, home health aides, and personal care workers. The long-term care sector also provides over 1.65 million jobs for other health care practitioners, such as physicians, therapists, and administrative staff. According to the United States Department of Labor, Bureau of Labor Statistics (2005), the facility-based services make up to 72% of the total long-term care workforce.

One study conducted by the Department of Health and Human Services for Medicare and Medicaid Services in 2004 showed and stressed the need for 6.5 million long-term care workers by 2050 in order to meet the needs of the nation's aging baby-boom generations. The study also drew the attention to an analysis from the American Health Care Association findings that the United States already requires almost 100,000 health care professionals to immediately meet the existing long-term care requirements. According to the study's estimates, the United States will need 5.6 million nurses, nurse aides, home health aides, and personal care workers by 2050. This number of personnel will care for 27 million Americans in need of long-term care. The study surveyed approximately 16,500 nursing homes throughout the United States, and reported on information collected from five nursing staff positions: Staff Registered Nurses (RNs), Registered Nurses with administrative responsibilities, Directors of Nursing (DONs), Licensed Practical and Vocational Nurses (LPNs), and Certified Nurse Assistants (CNAs). Most of the 52,000 vacancies in the nursing staff are for CNA positions. An additional 13,900 staff RNs and 25,100 LPNs were also estimated to be vacant (Department of Health and Human Services for Medicare and Medicaid Services, 2004). It is believed the nursing shortage presents a major problem for the quality of their work life, the quality of patient care, and the amount of time nurses can spend with patients (Mitchell, 2003).

Looking forward, almost all surveyed nurses see the shortage in the future as a catalyst for increasing stress on nurses, lowering patient care quality, and causing nurses to leave the profession. High nurse turnover and vacancy rates are affecting access to health care (Best & Thurston, 2004). Continuously hiring new employees is costly, and frequent staff turnover affects employees' morale and impairs resident care (Sofie, Belzar, & Young, 2003). Rapid turnover has been found to have negative physical and emotional effects on nursing home residents, leading to a greater incidence of falls, medication errors, fear and anxiety, and feelings of hopelessness (Best & Thurston, 2004; Sofie, Belza, & Young, 2003).

According to Borda and Norman (1997) and Lu, While, and Barriball (2005), the retention and recruitment of nurses have shown that low wages and poor job satisfaction are the primary reasons why nurses leave their positions. Their dissatisfaction is often attributed to heavy workloads, leadership styles, motivation, inadequate training, and lack of respect (Lu, While, & Barriball 2005). Compared to their counterparts in other health care settings, such as those who work for home health care, staffing agencies, and acute care facilities, nursing home facility employees are often underpaid (Lu, While, & Barriball 2005). Wilson (2005) stated that recruitment and retention efforts need to concentrate on increasing financial incentives to these staff members and creating a desirable work place that will lead to greater job satisfaction because the expertise required of direct caregivers and the heavy workload they are assigned often far exceed the financial compensation they receive. One of the possible solutions to reduce turnover mentioned by Lu, While, & Barriball (2005) is to encourage registered nurses to further their education and to pursue advanced degrees. Mitchell (2003) pointed out what may be most threatening to nurses is not a lack of higher education but rather the fact that nursing education is not providing that inherent nursing know-how crucial to the art of the profession.

Despite the large number of studies on organizational commitment (Elloy, 2005; Lee, 2005; Loke, 2001; Lok & Crewford, 1999; McNeese-Smith, 1997; Meyer & Herscovitch, 2001; Silverthorne, 2004; Yoon & Thye, 2002), the influence of job satisfaction, perceived organizational support, leadership behavior, and level of education have received little attention among health care professionals. Research (Dalton & Mesch, 1990; Freund, 2005; Loke, 2001; Lok & Crawford, 1999; Yoon & Thye, 2002) has shown that organizational commitment is affected by job satisfaction, perceived organizational support, leadership behavior, and level of education. Wagner and Huber (2003) identified two key factors, organizational commitment and job tension, as reasons behind nurses leaving their positions. They suggested a model to monitor employee withdrawal behavior in an effort to mitigate the trend. Overall, the themes of organizational commitment, job satisfaction, leadership styles, empowerment, collegial relationship, perceived organizational support, and trust in management are all factors in why a nurse may choose to leave. When the staff members are given support, resources, and the information to enable them to succeed in the role they are playing, staff are more likely to feel that the organizational policies are designed to benefit them. Therefore, they have more commitment to implement the organizational goals and stay in their jobs (Laschinger, Finnegan, & Shamian, 2001).

A leader’s behavior or leadership style may influence the subordinates’ level of organizational commitment. Studies have been carried out to determine how leadership behaviors can be used to influence employees for better organizational outcome. Many studies concluded that effective leadership is associated with better and more ethical performance (Ivancevich & Matteson, 1993; Loke, 2001; McNeese-Smith, 1995). Fletcher (2001), Friedrich (2001), Janney, Horstman, and Bane (2001), Kleinman (2003), Krairiksh and Anthony (2001), Laborde and Lee (2000), Ribelin (2003), and Wynd (2003) found that the opinions of the employees’ immediate supervisor had more impact on the employee than overall company policies or procedures.

Organizational commitment has been viewed by Chen & Francesco (2003), McDermott, Laschinger, & Shamian (1996), Schwepker (2001), and Wasti (2002) as a dimension of organizational effectiveness, which contributes to increased effectiveness through work performance and reducing turnover. Research has also shown that increased commitment improves work performance and reduces absenteeism and turnover (Wasti, 2005).

Organizational commitment was described by Yoon and Thye (2002) as a construct that affected employees' work behaviors using two approaches. One is the emotional/affective approach, which focused on overall job satisfaction. The other is the cognitive approach, centered on the perceptions of support received from supervisors (organizational support). The authors proposed and tested a new dual-process model of organizational commitment that connects organizational practices and specific job characteristics to the emotions and cognitions of employees. In turn, emotional reactions and cognitive processes are theorized to be the cause of organizational commitment. The captioned model proposed by the authors specifically stipulates that overall job satisfaction and perception of organizational support are key emotional and cognitive processes that mobilize commitment in the work place. The focus of perceived organizational support and job satisfaction were also considered to be predictors of organizational commitment (Amold & Davey, 1999; Ben-Bakr, Al-Shammari, Jefri, 1994; Eisenberger, Fasolo, & Davis- LaMastro, 1990; Kuokkanen, Leino-Kilpi, & Katajisto, 2003; Nystedt, Sjoberg, & Hafflund, 1999).

Meyer and Allen (1991) argued that the three components of commitment, affective, continuance, and normative, have quite different consequences for other work-related behavior, such as attendance, performance of required duties, and willingness to go above and beyond the call of duty. The authors also argued that it was more appropriate to consider affective, continuance, and normative commitment to be components, rather than types of commitment because an employee's relationship with an organization might reflect varying degrees of all three components.

The authors stated that:

> Affective commitment refers to the employee's emotional attachment to, identification with, and involvement in the organization. Employees with a strong affective commitment continue employment with the organization because they want to do so. Continuance commitment refers to an awareness of the costs associated with leaving the organization. Employees whose primary link to the organization is based on continuance commitment remain because they need to do so. Finally, normative commitment reflects a feeling of obligation to continue employment; employees with a high level of normative commitment feel that they ought to remain with the organization (p. 67).

To investigate the effects of job satisfaction, perceived organizational support, leadership behavior, and level of education on the long-term care nurses' levels of organizational commitment, Yoon and Thye's (2002) Dual Process Model of Organizational Commitment and the three components of organizational commitment developed by Meyer and Allen (1991) provided the background to conduct this study on nurses' commitment to the organizations. Meyer and Allen developed a three component model based on the observation that there were both similarities and differences in existing unidimensional conceptualizations of organizational commitment. However, their work did not include the component of leadership behavior. Studies conducted by Loke (2001), Lok and Crawford (2001), McColl-Kennedy and Anderson (2005), Pillai and Williams (2004), Tejeda, Scandura, and Pillai (2001), and Yousef (2000), revealed that leadership behavior was a predictor of organizational commitment, a pertinent component in this study.

The Transformational and Transactional Theory by Bass (1985) and Bass and Avolio (1993) also provided background to this study to explore the effects of leadership behavior on organizational commitment. The authors articulated what is perhaps the most comprehensive theory of the dimensionality of transformational and transactional leadership. Leadership style is categorized into transformational leadership behavior, following Bass (1985) and Bass and Avolio (1994). The style of the leader is considered to be particularly important in achieving organizational goals (Dubinsky, Yammarino, Jolson, & Spangler, 1995). The style categories, transformational, transactional, and laissez faire leadership, have been widely applied in training efforts and evaluation studies (Bass & Avolio, 1994), as well as serving as a typology in academic research (Avolio, 1998; Bass, 1985, 1990, 1997, 1998, 1999; Burns, 1978; Northouse, 2004; Sosik & Dionne, 1997; Tichy & Devanna, 1986).

The Nursing Home Industry

There are two general types of long-term care facilities in the United States: nursing homes and residential care or assisted living facilities. There are approximately 1.9 million nursing home beds in the United States, serving approximately 1.7 million persons, the vast majority of whom are elderly (Zimmerman, Slaoane, & Eckert, 2001). The predominant model of nursing home care is medical: ordered by physicians, planned primarily by licensed nurses, and delivered by certified nursing assistants and other professional or paraprofessional staff (Potter & Perry, 2005). Because nursing homes are tightly controlled by federal regulations, many facilities share similar administrative structures, staffing, and physical characteristics (Potter & Perry, 2005). However, within these regulatory confines, considerable variation in quality of care exists (Zimmerman, Slaoane, & Eckert, 2001). Among the important determinants of the quality in nursing home care are: the experience and satisfaction of the staff (indicated, in part, by low turnover rates), the existence of a competent, inspiring leader, the availability of professional services, the proportion of beds that are private pay, and the existence of extra resources to enhance care (Curran, 1997; Zimmerman, Slaoane, & Eckert, 2001).

The residential care or assisted living facilities provide room, board, 24-hour supervision, assistance with medication, and assistance with activities of daily living (Zimmerman, Slaoane, & Eckert, 2001). Each facility also provides some degree of coordination and access to medical and nursing services, such as physician care, nursing assessment, and nursing procedures (Potter & Perry, 2005). However, the degree of medical and nursing services varies from facility to facility and is typically less intensive than those provided in nursing homes. Furthermore, rehabilitative services, often through home care agencies, tend to be less available in those facilities (Potter & Perry, 2005).

An extended care facility is a type of nursing home facility that provides intermediate medical, nursing, or custodial care for residents recovering from acute or chronic illnesses or disabilities. Extended care facilities include intermediate care and skilled nursing facilities (Potter & Perry, 2005). An intermediate care facility and skilled nursing facility offer skilled care from licensed nursing staff. This may include administration of intravenous fluids, wound care, long-term ventilator management, and physical rehabilitation (Lueckenotte, 1998). Extensive supportive care is provided until residents can move back into the community or into residential care. All nursing home facilities provide around the clock nursing coverage (Potter & Perry, 2005).

The nursing home has been the dominant setting for long-term care (Lueckenotte, 1998). The term nursing facility became the term for nursing homes and other skilled nursing facilities where long-term care is provided. Now, nursing center is the most appropriate term (Potter & Perry, 2005). A nursing center typically provides 24-hour intermediate and custodial care such as nursing, rehabilitation, dietary, recreational, social, and religious services for residents of any age with chronic or debilitating illnesses. The majority of persons living in nursing centers are older adults. A nursing center is a resident's temporary or permanent home with surroundings made to be as homelike as possible (Sorrentino, 2000). In a long-term care setting, the philosophy of care is to provide a planned, systematic, and interdisciplinary approach that helps residents reach and maintain their highest level of function, taking into account their feelings, thoughts, lifestyle, and physical condition (Lueckenotte, 1998; Porter & Perry, 2005; Resnick & Fleishell, 2002).

Problem Statement

Organizational commitment in health care settings is directly related to the quality of the patient care program (McNeese-Smith, 2001). For this reason, health care administrators need to understand the dynamics of commitment and their role in developing and fostering it (Wasti, 2002). The idea of organizational commitment has intuitive appeal because of the relationship of commitment to turnover, absenteeism, and organizational performance (Wilson, 2005). All of these are important to health care executives who are attempting to stabilize a nursing workforce in the presence of a growing nursing shortage. Organizational commitment also affects organizational effectiveness and the quality of work life (McNeese-Smith, 2001). The challenge for health care leaders is to develop strategies that build organizational commitment (Wagner & Huber, 2003). These strategies must include high-leverage commitment builders such as job flexibility, an organizational culture of learning, team spirit, and individual and group recognition (Wagner & Huber, 2003; Wasti, 2002).

Consumer advocates argue that nursing services in nursing homes need to be staffed at a greater level than they are presently to ensure quality of care, while nursing home administrators indicate that they have a problem recruiting and maintaining qualified staff at current staffing levels (Decker, Dollard, & Kraditor, 2001). The challenge for today and the future is to develop and maintain a supply of nursing labor to adequately meet demand (McNeese-Smith, 2001). It is a challenge fiscally in terms of providing the additional funding to train and recruit more individuals into nursing services and to address the comparatively lower wages, fewer benefits, and higher turnover in nursing homes (Decker, Dollard, & Kraditor, 2001).

More research is needed on the disparity in wages and benefits across health care settings and the relationship of this disparity to recruiting and retaining nursing staff in nursing homes (Rowden, 2000). The nature of employee-organization linkages is important to the individuals, the organization, and society as a whole. Stronger linkages (commitment) can result in enhanced feelings of belonging, security, efficacy, greater career advancement and increased compensation, and increased intrinsic reward for the individual. For the organization, it can mean increased employee tenure, limited turnover, reduced training costs, greater job satisfaction, acceptance of organizational demands, and the meeting of organizational goals (Mowday, Porter, & Steers, 1982; Randal, 1987). For society, reduced linkages could affect the levels of productivity and the quality of products and services (Rowden, 2000). According to Wynd (2003), nurses received virtually little attention and no effort was made to make them feel as if they were important parts of the building organization and management team. These feelings led to problems that caused low morale, lack of job satisfaction, and the perception of very little or no organizational support. This current study explored the predictive values of job satisfaction, perceived organizational support, transformational leadership behavior, and level of education on the long-term care nurses' organizational commitment.

Purpose of the Study

The purpose of this study focused on the predictive effects of job satisfaction, perceived organizational support, transformational leadership behavior, and level of education on the degree of organizational commitment among registered and licensed practical nurses in South Florida's long-term facilities using standardized instruments validated in previous research. Most studies of health care settings tend to focus on nurses and other medical personnel in acute care settings resulting in a major gap in the literature on issues and concerns of health professionals in long-term care settings. Studies of this nature and magnitude may be instrumental in helping administrators to better meet the needs of long-term care nurses employed in their organizations, which may have implications for services delivery. These study findings may serve to support the relationship of long term care nurses' organizational commitment (South Florida Long Term Facilities) to job satisfaction, perceived organizational support, transformational leadership behavior, and level of education.

Research has suggested that nurses are an integral part of the health care system (Monroe & Deloach, 2004; Wright, 1999). They are advocates and health educators for patients, families, and communities. When providing direct patient care, they observe, assess, and record symptoms, responses, and progress, assist physicians during treatments and examinations, administer medications, and assist in convalescence and rehabilitation. Nurses also develop and manage nursing care plans, instruct patients and their families in proper care, and help individuals and groups take steps to improve or maintain their health (Kaye & Davitt, 1998; Kulys & Davis, 1986; Munley, 1983; Potter & Perry, 2005). Since nurses perform important functions in long-term facilities and are vital members of the health care team, it is critical for health care administrators to become aware of these practitioners' attitudes and behaviors.

Ensuring adequate staffing in long-term facilities is an ongoing challenge, which requires creative problem solving that focuses on work motivation and job satisfaction. By finding ways to improve salaries of the nursing staff and to create an attractive work place environment, health care administrators will help to ensure that they continue to attract and retain these essential care providers.

Significance of the Study

This quantitative study used the regression analysis method to generate information about the nurses' job satisfaction, perceived organizational support, transformational leadership behavior, and level of education and the predictive values these constructs have on nurses' commitment to the organization (Miami-Dade Nursing Homes). The literature review revealed that the nurses perceived that they were not appreciated and were treated differently than other health care professionals. This perception could contribute to a lack of organizational commitment. On the other hand, it was found that nurses have been very important parts of the health care system. The nurse's primary responsibility is to provide for the patient's physical condition and comfort. Therefore, nurses must be highly skilled in physical assessment and symptom management. They also help to transition dying patients from curative treatment to palliative treatment (Monroe & Deloach, 2004; Wright, 1999). Responsibilities of the nurse include educating the patient and family on physical care, medication administration, skin care, nutrition, and equipment management. They also engage in crisis intervention tasks, advocacy work, and psychoeducational responsibilities like relaying information on advanced directives (Keye & Davitt, 1998; Kulys & Davis, 1986; Munley, 1983).

The nursing work force of the next decade is forecasted to be driven by an increasing demand and decreasing supply of registered and licensed practical nurses, second only to aging of that workforce (laschinger, Finegan, & Shamian, 2001; McNeese-Smith, 2001). Therefore, health care administrators must work harder to promote and develop methods for building organizational commitment among nurses, and among other clinicians, before that imminent shortage occurs. McNeese-Smith (2001) interviewed 30 staff nurses to determine factors that contribute to their commitment, or lack of commitment to their organization. The author identified that organizational commitment is most related to personal factors, opportunities for learning, job satisfaction, plans for retirement, momentary benefits, patient care, coworkers, cultural factors, and job security, in that order. Lack of organizational commitment is most related to conflict with personal needs. However, lack of learning, lack of appreciation and fairness, poor relations with coworkers, career developmental stage, and lack of job security were identified as factors which contribute to the lack of organizational commitment.

Organizational commitment is of particular importance to health care organizations. Employees in these turbulent environments are struggling to maintain high quality patient care with fewer resources. The empirical evidence suggests that employees with high affective commitment are more likely to rise to challenges while employees with high continuance commitment may simply do the minimum. Moreover, Glisson and Durick (1988) found that individuals displaying higher levels of affective commitment were more resistant to job strain and burnout, suggesting that affective commitment may help employees withstand the negative effects of downsizing. For this reason, the authors stated that it is important for health care leaders to promote the factors that encourage affective commitment and reduce those that encourage continuance commitment.

Theoretical Framework

The theoretical framework upon which this study was based was the organizational commitment theory. The Dual Process Model of organizational commitment (Yoon & Thye, 2002) and the Three Components Model of organizational commitment (Meyer & Allen, 1991) provided the theoretical framework to conduct this study. The single theoretical model, Dual Process Model of organizational commitment, focuses on two pathways, job satisfaction and perceived organizational support (Yoon & Thye, 2002). Job satisfaction is typically defined as "a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences" (Yoon & Thye, 2002, p. 98). The perceived organizational support refers to the employees' "global beliefs concerning the extent to which the organization values their contributions and cares about their well-being" (Eisenberger, Huntington, Hutchison, & Sow, 1986, p. 501).

According to the Meyer and Allen (1991) model, organizational commitment is composed of three components. The affective component refers to employees' emotional attachment to, identification with, and involvement in the organization. The continuance component refers to commitment based on costs that employees associate with leaving the organization. Finally, the normative component refers to employees' feelings of obligation to remain with the organization (Meyer & Allen, 1991).

Research Question

The following research question guided this study:

Research Question. What is the multiple correlation between a set of four predictors (job satisfaction, perceived organization support, transformational leadership behavior, and level of education) and the outcome, the nurses' organizational commitment?

Research Hypotheses

The following research hypotheses were addressed in this study:

Research Hypothesis. There is a multiple correlation between a set of four predictors (job satisfaction, perceived organization support, transformational leadership behavior, and level of education) and the outcome, nurses' organizational commitment.

Null Hypothesis. There is no multiple correlation between a set of four predictors (job satisfaction, perceived organization support, transformational leadership behavior, and level of education) and the outcome, nurses' organizational commitment.

Definitions of Terms

Organizational commitment. Organizational commitment in this study was operationally defined as a score on the Organizational Commitment Questionnaire developed by Meyer, Allen, and Smith (1993).

Job satisfaction. Job satisfaction in this study was operationally defined as a score on the Minnesota Satisfaction Questionnaire developed by Weis, Dawis, England, & Lofquist (1967).

Perceived organizational support. Perceived organizational support in this study was operationally defined as a score on the Survey of Perceived Organizational Support (SPOS) scale, developed by Eisenberger, Huntington, Hutchison, and Sowa (1986).

Transformational Leadership. Transformational leadership was operationally defined as a score on the Multifactor Leadership Questionnaire (MLQ) Form 6S developed by Bass & Avolio (1992).

Level of education. Level of education referred to licensed nurses in one of the following four categories: (1) licensed practical nurse, (2) registered nurse with associate degree, (3) registered nurse with a baccalaureate degree, and (4) registered nurse with a master degree in nursing.

Health Care Organization. Health care organization referred to a long-term care nursing home facility.

Assumptions

There were several underlying assumptions in this study. The first assumption was that all nurses participating understood the surveys and responded truthfully to the questions on the assessments. Another assumption was that the surveys were valid for their intended purpose. Furthermore, it was assumed that the criteria for the statistical test chosen for the data analysis were satisfied.

Limitations of the Study

The limitations of the current study included the following:

1. The sample in this study included a larger number of females than males.
2. The information the researcher obtained was dependent on participants' self-reported responses and was subject to human error and bias.
3. The sample the researcher used for this study was from four small nursing home corporations. Results of the study may not be generalizable to other populations.

Settings

The study took place at private, not-for-profit, nursing homes in the Southeastern United States. The nursing population was diverse including a large representation of white non-Hispanic, Hispanic, and Black-non-Hispanic nurses. Four nursing homes were included in the study. The average capacities of these facilities was around eight hundred beds with a total of

192 nurses serving in these facilities. The majority of the nurses were licensed practical nurses with at least eighteen months of training in nursing.

Summary

The purpose of this section was to introduce the problem under study and identify the constructs being investigated. Despite the large number of studies on organizational commitment (Elloy, 2005; Lee, 2005; Loke, 2001; Lok & Crewford, 1999; McNeese-Smith, 1997; Meyer & Herscovitch, 2001; Silverthorne, 2004; Yoon & Thye, 2002), the influence of job satisfaction, perceived organizational support, leadership behavior, and level of education have received little attention among health care professionals. Research (Dalton & Mesch, 1990; Freund, 2005; Loke, 2001; Lok & Crawford, 1999; Yoon & Thye, 2002) has shown that organizational commitment is affected by job satisfaction, perceived organizational support, leadership behavior, and level of education. The next section expands on these constructs by reviewing relevant literature. The review of literature provides the conceptual framework for the study and rationalizes the uses of the independent and dependent variables.

CHAPTER II

REVIEW OF LITERATURE

The purpose of this chapter is to provide a review and discussion of the literature pertaining to this study. In looking at the levels of organizational commitment among nurses, it is first necessary to gain a perspective of the historical patterns of organizational commitment. The second major area of this review is literature linking employee job satisfaction to organizational commitment. The studies reviewed build a foundation for the linkage of job satisfaction to organizational commitment. Third, organizational commitment and perceived organizational support in health care industry and other industries are discussed, illustrating the need for further research on improving nurses' organizational commitment through perceived organizational support. The fourth section reviews current literature on organizational commitment and leadership behavior. Studies have been carried out to determine how leadership behavior can be used to influence employees for better organizational outcome. Finally, the literature reviewed focuses on organizational commitment and nurses' levels of education.

Organizational Commitment Overview

Studies have found strong positive relationships between organizational commitment and desirable work outcomes such as performance, adaptability, and job satisfaction (Allen, 2003; Allen & Meyer, 1990a, 1996; Angle & Perry, 1981; Chen & Francesco, 2003; Cheng & Stockdale, 2003; Hunt, Chonko, & Wood, 1985; Meryer, Allen & Smith, 1993; Powell & Meyer, 2004; Rentsch & Steel, 1998; Vandenberghe, 2003). Other studies have also found negative relationships between organizational commitment and potentially costly work outcomes such as turnover and absenteeism (Bland, Center, Finstad, Risbey, & Staples, 2006; Dawley, Stephens, & Stephens, 2005; Heffner & Rentsch, 2001; Hom, Katerberg, & Hulin, 1979; Kondratuk, Hausdorf, Korabik, & Tosin, 2004; Meyer, Stanely, Herscovitch, & Topolnytsky, 2002; Rosser & Townsend, 2006). The way in which tasks or the work context were organized, the structure of the organization, and the management hierarchy, together with low levels of employee responsibility, job satisfaction, morale, leadership style, motivation, and perceived organization support, have all been associated with employee absenteeism (Dalton & Mesch, 1990; Rentsch & Steel, 1998). This is a construct which has attracted scholars like; for example, Jaros, Jermier, Koehler, & Sincich (1993). The authors noted that for many decades, "the meaning of organizational commitment, gradually refined, and it has evolved into a complex concept that can serve as a summary index of work-related experiences and as a predictor of work behaviors and behavioral intention" (p. 989). It can be argued that aspects such as these are all reflected within the extent of an individual's organizational commitment (Meyer, Stanely, Herscovitch, & Topolnytsky, 2002; Rosser & Townsend, 2006).

Organizational commitment is the employee's psychological attachment to the organization (Mowday, Steers, & Porter, 1979). It can be contrasted with other work-related attitudes, such as job satisfaction (an employee's feelings about their job) and organizational identification (the degree to which an employee experiences a sense of oneness with their organization). Organizational commitment is also a work attitude that is directly related to employee participation and intention to remain with an organization and it is clearly linked to job performance (Jaros, Jermier, Koehler, & Sincich, 1993; Randall, 1987; Silverthorne, 2004). The multidimensional nature of the commitment was underlined over the years by researchers (Wasti, 2005), who proposed models (Meyer & Allen, 1991; O'Reilly & Chatman, 1986; Penley & Gould, 1988). The model by Meyer and Allen has been widely applied in academic research. This model consists of three components. The normative component refers to employees' feelings of obligation to remain with the organization. The continuance component refers to commitment based on the costs that employees associate with leaving the organization, and the affective component refers to employees' emotional attachment to, identification with, and involvement in the organization (Meyer & Allen, 1991).

Organizational commitment was defined by Porter, Steers, Mowdy and Boulian (1974) as "the strength of an individual's identification with and involvement in a particular organization, and based this assessment on measures of motivation, identification with the values of the organization, and employees' intentions of remaining members" (p. 604). Buchanan (1974) took this definition one stage further and described commitment as being "a partisan affective attachment to the goals and values of an organization, to one's roles in relation to the goals and values, and to the organization for its own sake, apart from its purely instrumental worth" (p. 533). Although Porter et al. (1974) viewed commitment as having three components, namely, a strong belief in and acceptance of the organization's goals and values, a willingness to exert considerable effort on behalf of the organization, and a definite desire to maintain organizational membership, commitment was viewed as a unidimensional construct focusing only on effective attachment (Meyer & Allen, 1991). Their measure of commitment, Organizational Commitment Questionnaire (OCQ), produced a single score reflecting the employee's overall commitment to the organization (Mowday, Steers, & Porter, 1979).

Scholars like Blegen (1993), Cohen and Hudecek (1993), Corser (1998), Dahlke (1996), Farrell and Petersen (1984), Kim, Price, Mueller, and Watson (1996), McNeese-Smith (1995, 1996), Meyer and Allen (1987), Meyer, Paunonen, Gellatly, Goffin, and Jackson (1989), Meyer and Schoorman (1998), and Mowday, Porter, and Steers (1982) have expanded and advanced the understanding of organizational commitment in the intervening years by viewing it as having multiple forms. These scholars were interested in a broader set of bonds that exists between employees and organizations than Porter, Steers, Mowdy and Boulian (1974). Whereas Porter et al. focused on a bond characterized by acceptance of an organization's goals. O'Reilly and Chatman (1986) suggested the bond between an employee and an organization could take three forms: compliance, identification, and internalization. Compliance reflects instrumental behavior designed to gain rewards. Identification occurs when employees behave because they want to keep a relationship with an organization for its attraction. Internalization reflects behavior driven by internal values or goals that are consistent with those of the organization (O'Reilly & Chatman (1986).

Because many of these studies were cross-sectional and correlational in nature, it was not always clear why specific variables were related to commitment. Organizational commitment develops naturally and contributes positively to the organization, and may be considered a value-added factor in work environment (Baruch, 1998; Blegen, 1993; Buchanan, 1974; Cohen & Hudecek, 1993; Corser, 1998; Dahlke, 1996; Farrell & Petersen, 1984; Kim, Price, Mueller, & Watson, 1996; McNeese-Smith, 1995, 1996; Meyer & Allen, 1987; Meyer, Paunonen, Gellatly, Goffin, & Jackson, 1989; Meyer & Schoorman, 1998; Mowday, Porter, & Steers, 1982; Reichers, 1985; Steers, 1977). Although much of the early research on commitment was driven by the strong belief that the concept was of relevance to employees and managers, a few researchers have questioned whether commitment is any longer a relevant focus of research (Allen & Meyer, 1996; Kim, Price, Mueller, & Watson, 1996; Maarchiori & Henkin, 2004; Mathieu & Zajac, 1990; Tett & Meyer, 1993).

Organizational commitment among nurses and other health care practitioners may be decreasing as organizations restructure for greater cost effectiveness (Corser, 1998). In fact, nurses may question why they should have commitment to the organization if they do not feel commitment from their employer. According to Shore and Wayne (1993), employee perception of organization support is strongly related to employee commitment. King and Sethi (1997) stated that organizational commitment is the primary buffer against stress and job displeasure, especially during consolidation of work units. The authors said stress increases dissatisfaction only when organizational commitment is low. Scholars like Romzek (1989), and Williams and Anderson (1991) mentioned that highly committed employees also experience positive affectivity in other areas of their lives, including family and non-work activities. Additionally, researchers found that employees with high organizational commitment are more likely to practice organizational citizenship behavior, defined as voluntary actions that benefit the organization (Williams & Anderson, 1991).

Organizational Commitment and Job Satisfaction

Employees' job satisfaction and their commitment have always been important issues for health care administrators. After all, high levels of absenteeism and staff turnover can affect the administrators' bottom lines, as temps, recruitment, and retraining take their toll (McNeese-Smith, 1996). Satisfied employees tend to be more productive, creative, and committed to their employers, and recent studies have shown a direct correlation between staff satisfaction and patient satisfaction in health care organizations (Al–Aameri, 2000). The traditional model of job satisfaction focuses on all the feelings that an individual has about his/her job (Lu, While, & Barriball, 2005). However, what makes a job satisfying or dissatisfying does not depend only on the nature of the job, but also on the expectations that individuals have of what their job should provide (Spector, 1997).

Job satisfaction is a multivariate human attitude (Smith, 1974). It has been defined by Warr, Cook, and Wall (1979) as "the degree to which a person reports satisfaction with intrinsic and extrinsic features of the job. Total job satisfaction is the sum of all separate items, and overall job satisfaction is reported satisfaction with the job as a whole" (p. 133). Extrinsic factors, the hygiene factors, were found to be job dissatisfiers. Basic components of total job satisfaction were determined to be extrinsic and intrinsic job satisfaction. A frequently cited definition of job satisfaction provided by Locke (1983) is "a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences" (p. 1300).

The work of Maslow (1954) suggested that human needs form a five-level hierarchy ranging from physiological needs, safety, belongingness and love, and esteem to self-actualization (Lu, While, & Barriball, 2005). Based on Maslow's theory, job satisfaction has been approached by some researchers from the perspective of need fulfillment (Conrad, Conrad, & Parker, 1985; Irvine & Ivans, 1995; Spector, 1997). In contrast to the traditional view, Herzberg and Mausner (1959) formulated the two-factor theory of job satisfaction and postulated that satisfaction and dissatisfaction were two separate and sometimes even unrelated phenomena (Lu, While, & Barriball, 2005).

Interestingly, many of the current studies on job satisfaction continue to use Locke's (1983) comprehensive work to describe the causes of job satisfaction. Locke (1983) traced the roots of job satisfaction research through the human relations movement to the early 1970's, and discussed the measurement of job satisfaction dimensions, pointing out that "a job is not an entity but a complex interrelationship of tasks, interactions, responsibilities, incentives and rewards" (p. 1301). The author suggested that various dimensions of job satisfaction exist, for example, environment, management, supervision, promotion, pay and work.

Price (2001) described job satisfaction as the affective orientation that employees have toward their work. The author stated that job satisfaction is a general feeling about the job or a related constellation of attitudes about various aspects or facets of the job. Numerous studies (Lundh, 1999; Nolan, Brown, & Nolan, 1998; Nolan, Nolan, & Grant, 1995) provided a global outline of reported job satisfaction. Nolan, Nolan, & Grant (1995) found that the level of job satisfaction had remained stable, and two factors were dominant in nurses' understanding of satisfaction and morale, namely, the perceived ability to deliver good patient care and good collegiate relationships with co-workers. Nolan, Brown, & Nolan (1998) further found that the vast majority of respondents (85%) considered that their work was interesting, and this was one of the most significant factors influencing job satisfaction. Regarding job satisfaction and morale, the authors found that 35% of respondents considered that their job satisfaction had decreased in the last year and 69% felt that overall morale had fallen.

In addition to providing a general outline of reported job satisfaction, Price (2002) explored key areas of job satisfaction using the Mueller and McCloskey (1990) satisfaction scale. It is a 5-point likert scale (5 = very satisfied, 1 = very dissatisfied) comprised of 31 items on eight dimensions: extrinsic rewards, scheduling, balance of family and work, co-workers, interaction opportunities, professional opportunities, praise and recognition, control and responsibility. The results demonstrated that over half of the respondents (58%) were generally satisfied with their job. The authors identified that highest satisfaction was related to co-workers and extrinsic rewards (mean = 3.8 and 3.5, respectively) and the most dissatisfaction was with the amount of control and responsibility they had and with professional opportunities (mean = 2.7 and 2.6, respectively). The individual items on this scale with which nurses were most satisfied were identified as annual leave, nursing peers and hours worked (79%, 78%, & 76% of respondents scored 4 or 5, respectively).

From another point of view, Lee's (1998) cross-sectional survey examined the level of job satisfaction regarding six job components (autonomy, professional status, pay, interaction, task requirements, and organizational policies) using the Index of Work Satisfaction (Stamps & Piedmonte, 1986). The first part addresses the relative importance of each of the six job components, using 15 sets of paired comparison statements. The second part is a 4-item likert scale that requires subjects to respond to one of seven choices from strongly disagree to strongly agree to measure current levels of satisfaction regarding each of the six components. The results showed that nurses were dissatisfied more than satisfied (mean = 3.46) and reported most satisfaction with professional status (mean = 4.17) and most dissatisfaction with task requirements (mean = 2.81). The level of need for autonomy was below the mid-score of the sub-scale with no significant relationship ($r = .11$, $p > .1$) between their satisfaction with job autonomy and their individual need for autonomy.

Organizational commitment and job satisfaction are popular topics in the study of work-related attitudes; however, contradiction exists as to the causal relationship. The majority of theoretical and empirical evidence suggests that job satisfaction is an antecedent to organizational commitment (Bagozzi, 1980; Brown & Peterson, 1994; Mathieu & Hamel, 1989). However, some support exists for the role of job satisfaction as an outcome of organizational commitment (Bateman & Strasser, 1984). More recently, Koslowsky, Caspy, & Lazar (1991) found no evidence to support a causal relationship but determined that a high correlation exists. The results of their study were consistent with a number of studies that included both variables (Knoop, 1995; Mathieu & Zayac, 1990; Shore & Martin, 1989).

A positive relationship between job satisfaction and organizational commitment has been reported by studies involving qualified professionals. A study was conducted by Wu & Norman (2005) in a nursing department of a medical university in China with a sample (75) of full time final year (clinical practice year) degree level nursing students. The authors found a positive correlation between job satisfaction and organizational commitment ($r = .464$, $P < .01$) indicating that student nurses who were more satisfied with the nursing as a job were also more committed to the health care service. Redfern, Hannan, Norman, & Martin (2002) reported a strong relationship between job satisfaction and organizational commitment ($r = .60$, $P < .001$), in a study of the health care staff in the United Kingdom. The aim of their study, which was carried out in a nursing home for older people, was to determine the feasibility of working with health care workers and very frail service users to investigate links between the levels of work satisfaction and organizational commitment. Similarly, Al-Aameri (2000) found a strong positive correlation between job satisfaction and organizational commitment with a sample of registered nurses in Saudi Arabia ($r = .59$, $P < .01$). The means and standard deviations showed that nurses were satisfied with their jobs to some extent, and they were slightly committed to their hospitals. The study's findings showed that age was significantly correlated with satisfaction and commitment, but experience was correlated only with commitment. Moreover, analysis of variance showed that nurses differ in their degree of commitment in terms of their marital status and nationality. This finding is consistent with a large survey of qualified nurses in the United States conducted by Ingersoll, Olsan, Drew-Cates, DeVinney, and Davies (2002), which revealed a closely positive correlation between job satisfaction and organizational commitment ($r = .63$, $P < .001$).

Knoop (1995) investigated the relationship between job satisfaction and organizational commitment among hospital nurses. The hypothesis was that involvement in work and job, commitment to the employing organization, and satisfaction with the job (overall, and with specific facets of the job) would be significantly correlated. The results showed that involvement was not related to overall satisfaction but only to two specific facets, satisfaction with work and promotion opportunities. In contrast, the degree of relationship between overall and various facets of satisfaction and commitment and between involvement and commitment was moderately high. The author also reported that organizational commitment was positively related to overall job satisfaction ($r = .64$, $P < .001$). Furthermore, the regression analysis revealed that organizational commitment explained 41% of the variance in job satisfaction.

The forementioned studies were not only consistent in reporting a positive correlation between job satisfaction and organizational commitment, but also showed the correlation was strong across studies. However, Draper, Halliday, Jowett, and Norman (2004) found a negative relationship between job satisfaction and dimensions of commitment with a sample of National Health Service cadets ($t = -2.572$, $P < .011$). Overall, the literature (Baugh & Roberts, 1994; Bedeian & Armenakis, 1981; Clark & Larkin, 1992; Deconinck & Bachman, 1994; Fletcher & Williams, 1996; Liou, 1995; Yoon & Thye, 2002) tended to suggest a positive relationship between the two variables. In 1996, Yoon and Thye (2002) conducted a study on two large Korean companies to examine the relationship between organization commitment and job satisfaction. The researchers used cluster sampling to randomly select participants by regions and business domains. A total of 3,500 questionnaires were distributed, with 2,585 participants returning the response on the due date. The findings of the study indicated that a positive correlation of .51 existed between job satisfaction and organization commitment. In contrast, Curry, Wakefield, Price, and Mueller (1986) found no relationship between the two variables. On the other hand, Vandenberg and Lance (1992) examined the causal order of job satisfaction and organizational commitment, and found that organizational commitment causes job satisfaction.

Although the causal sequence is still in question, it is clear that organizational commitment and job satisfaction are associated variables that affect organizational outcome such as turnover intentions (Shore & Martin, 1989), absenteeism (Sagie, 1998), and work performance (Shore & Martin, 1989). Furthermore, both organizational commitment and job satisfaction have been linked with constructs of importance in the service environment, such as citizenship behaviors (Schappe, 1998; Williams & Anderson, 1991) and prosocial behaviors (Bettencourt & Brown, 1997). In terms of commitment, employees who were more committed were less likely to leave their jobs and more likely to perform well (Howard & Gould, 2000; Mathieu & Zajac, 1990).

Organizational Commitment and Perceived Organizational Support

The subject of perceived organizational support has attracted considerable interest of the researchers as an attempt to understand the intensity and stability of employee dedication to work organizations. Major views of employee dedication focus on affective attachment and calculative involvement, respectively, which were usually considered to be conceptually and empirically distinct (Campbell, Dunnette, Lawler, & Weick, 1970; Eisenberger, Cotterell, & Marvel, 1987; Meyer & Allen, 1984; McGee & Ford, 1987; Meyer, Paunonen, Gellatly, & Goffin, 1989; Mowday, Porter, Steers, 1982; Mowday, Steers, & Porter, 1979; Organ & Konovsky, 1989; Porter & Lawler, 1968; Rusbult & Farrell, 1983). Eisenberger, Huntington, Hutchison, and Sowa (1986) suggested that, to meet needs for approval affiliation, esteem, and to determine the organization's readiness to compensate increased effort with greater rewards, employees formed a general perception concerning the extent to which the organization valued their contributions and cared about their well-being. Employees from nine organizations were given 36 statements about the degree to which the organization appreciated their contributions and would treat them favorably or unfavorably in diverse situations. The employees were found to view their evaluation by the organization as positive or negative to a consistent degree across various dimensions and to believe that such evaluations would influence many aspects of their treatment.

The employees' perception of being valued, important, and cared about by the organization would encourage the incorporation of organizational membership and role status into employee's self-identity and thereby increase prosocial acts carried out on behalf of the organization (Brief & Motowidlo, 1986; Meyer & Allen, 1984; Organ & Konovsky, 1989). Employees in health care organization may use perceived organizational support to judge the potential gain of material and benefits that would result from activities favored by the organization (Casper & Buffardi, 2004). Innovation and problem solving were found to be associated with perceived organizational support (Eisenberger, Fasolo, & Davis-LaMastro, 1990). Mowday, Porter, & Steers (1982) mentioned that "employees' strong involvement in the organization had been noted to include performance that goes beyond that call of duty" (p. 150) and O'Reilly & Chatman (1986) said that "the individual receives no immediate reward which benefits the larger organizations" (p. 495).

Researchers have found that perceived organizational support is positively related to organizational commitment (Casper & Buffardi, 2004; Chen, Aryee, & Lee, 2005; Cheung, 2000; Eisenberger, Fasolo, & Davis-LaMasto, 1990; Eisenberger, Huntington, Hutchison, & Sowa, 1986; Lok & Crawford, 1999; Naumann, Bennett, Bies, & Martin, 1998; Settoon, Bennett,

& Liden, 1996; Yoon & Thye, 2002). Eisenberger, Huntington, Hutchison, and Sowa (1986) defined perceived organization support as “people’s global beliefs about the extent to which the organization cares about their well-being and values their contributions” (p. 501). The relationship between perceived organizational support and organizational commitment was based on social exchange theory and norm of reciprocity (Fuller, Barnett, Hester, & Relyea, 2003). Social identity theory suggests that people “remain loyal when they felt that their organizations value and appreciate them” (Tyler, 1999, p. 235). However, social identity theory maintains that when people felt that their organization valued and appreciated them, it was a sign of organizational respect for them or of their high status within the organization (Chattopadhya, 1999; Gardner & Pierce, 1998; Tyler, 1999).

Eisenberger and his colleagues (Eisenberger, Fasolo, & Davis-LaMastro, 1990; Eisenberger, Huntington, Hutchison, & Sowa, 1986) have argued that employees developed generalized beliefs about the extent to which an organization was supportive of its employees. Earlier work by Buchanan (1974) found that managers’ beliefs that the organization recognized their contribution and could be depended upon to fulfill promises were positively associated with affective commitment. More recently, Meyer, Allen, and Gellatly (1990) have shown that organizational dependability enhanced affective commitment. Eisenberger, Fasolo, and Davis-LaMastro (1990) observed a positive relationship between affective commitment and the extent to which employees believed the organization provided them with needed support, valued their contribution, and cared about their well-being. These investigations did not directly explore links between these variables and continuance commitment; although they suggested that perceived support would also enhance this form of commitment by creating an atmosphere of trust in the organization’s willingness to fulfill its obligations toward employees.

Although it is logical to assume a positive relationship between employee perceptions of organizational support and their levels of organizational commitment and job involvement, there has been little empirical research on the relative influence of perceived organizational support on two distinct forms of organizational commitment. In the direct investigations of the link between these variables, Shore and her colleagues (Shore & Tetrick, 1991; Shore & Wayne, 1993) found strong positive correlations between perceived organizational support and affective commitment, but a lack of association between support and continuance commitment. The authors have suggested that perceptions of caring on the part of the organization may lead employees to experience affective attachment, whereas continuance commitment is more likely to be influenced by perceptions of being poorly treated rather than perceptions of support from the organization. Shore and Wayne (1993) studied perceived organizational support among 383 employees and 231 supervisors in a large multinational firm. The authors operationalized organizational support as "employees' global beliefs concerning the extent to which the organization values their contributions and cares about their well-being" (p. 744). Perceived organizational support was identified as an effective organizational commitment variable that also raised questions about the role of the organization in terms of what the organization provided to employees. A correlation of .30 ($p < .05$) was obtained between organizational commitment and perceived organizational support.

In a recent study done by O'Driscoll & Randall (1999) to explore the role of perceived organizational support and satisfaction with rewards in explaining job involvement and two forms of organizational commitment (affective and continuance commitment) with samples of dairy workers in Ireland and New Zealand, the results revealed that perceived organizational support was significantly linked with affective and continuance commitment, although its relationship with continuance was negative ($r = 5.32$, $p < .00$, $r = - 3.36$, $p < .001$, respectively). Also Cheung (2000) found the same in his study. The author collected data from 927 employees in eight high-technology companies in Taiwan. Cheung found that employees' organizational commitment and perceived organizational support exhibited strong reciprocal and positive relationships, with control for a number of background characteristics ($r = .784$, $p < .05$).

Organizational Commitment and Transformational Leadership Behavior

The term transformational leadership has drawn heightened attention from social scientists for many years (Avolio & Bass, 1999; Bass, 1985; Bryman, 1992; Conger, 1989, 1999; House, 1977; Northouse, 2004; Westley & Mintzberg, 1989). Previous research on Bass's (1985) theory of transformational leadership had primarily focused on comparing the effects of transformational and transactional leadership on individual performance, satisfaction, and effectiveness. Studies in this type of leadership have shown that transformational leadership is positively related to employees' satisfaction (Bass & Avolio, 1994). Transformational leadership has also been linked to outcomes such as leadership effectiveness, innovativeness, quality improvement, and both subjective and objective ratings of performance (Barker, 1990; Bass, 1999; Brown & Keeping, 2005; Chen & Silverthorne, 2005; Dionne, Yammarino, Atwater, & Spangler, 2004; Kelloway, Barling, & Kelley, 2004; Krapohl & Larson, 1996; Ozaralli, 2003).

Lately, scholars have conducted more research on transformational leadership than on all other leadership theories combined (Ozaralli, 2003). As a result, the dimensions comprising transformational leadership affect on critical organizational attitudes and outcomes are well established in the leadership literature (Avolio & Bass, 1999; Bass, 1999). The concept of transformational and transactional leadership was first proposed by Burns (1978). Burns attempted to link the roles of leadership and followers (Northouse, 2004), and described transformational leadership as “a process in which leaders and followers raise one another to higher levels of morality and motivation” (p. 170). The author distinguished between the two types of leadership: transactional and transformational. Transactional leadership refers to the bulk of leadership models, which focus on the exchanges that occur between leaders and their followers (Northouse, 2004). Transformational leadership refers to the process whereby an individual engages with others and creates a connection that raises the level of motivation and morality in both the leader and the follower (Barnett & McCormick, 2004; Epitropaki & Martin, 2005; Northouse, 2004).

Bass (1985) developed a model and measures of transformational, transactional, and laissez-faire leadership and described transformational and transactional leadership as being at opposite ends of a continuum (Northouse, 2004). However, several revisions have been made to the model. Bass and Avolio (1994) proposed that transformational leadership is characterized by certain behaviors including idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration. Idealized influence describes leaders who act as strong role models for followers; followers identify with these leaders and want very much to emulate them. These leaders usually have very high standards of moral and ethical conduct and can be counted on to do the right thing. Inspirational motivation is descriptive of leaders who communicate high expectations to followers, inspiring them through motivation to become committed to and a part of the shared vision in the organization. Intellectual stimulation refers to behavior that increases awareness of problems and influences followers to be innovative and creative by questioning assumptions, reframing problems, and approaching old situations in new ways. Individual consideration refers to leader behavior that provides support, encouragement, and coaching to followers (Bass & Avolio, 1997). Transactional leadership diverges from transformational leadership in that the transactional leader does not individualize the needs of subordinates nor focus on their personal development. Transactional leaders exchange things of value with subordinates to advance their own as well as their subordinates' agenda (Northouse, 2004).

Previous research has devoted a great deal of attention to the relationship between leadership behavior and organizational commitment. The findings in this area, however, are not entirely consistent. Several studies found a positive relationship between the two variables (Rowden, 2000; Yousef, 2000). In contrast, Savery (1991) reported no linkages between organizational commitment and leadership behavior. Rowden (2000) studied a total of 245 respondents from six organizations in the south eastern United States. The author measured the relationship between the six leadership behaviors; vision and articulation, sensitivity to members' needs, environmental sensitivity, unconventional behavior, taking personal risks, and not maintaining the status quo defined by the Conger-Kanungo Scale (1994), and two organizational commitment dimensions; a strong-belief in the acceptance of the goals and values of the organization for which the employee works, and a strong desire to maintain membership in the organization. The Pearson Correlations revealed that five of the six Conger-Kanungo factors were significantly correlated with the two commitment factors. These findings indicated that leaders' sensitivity to members' needs was related to organizational commitment, having a clear vision and articulating it seemed related to commitment, and the manager's need to be clear about the goals and values of the organization. Yousef (2000) investigated the potential mediating role of organizational commitment in the relationship of leadership behavior with the work outcomes of job satisfaction and job performance in a non-western country where multiculturalism is a dominant feature of the work force. Results indicated that there were significant positive relationships between leadership behavior and organizational commitment

($r = .54$, $p < .01$). The results of moderated multiple regression analysis showed that national culture has moderating impacts on the relationship between leadership behavior and job satisfaction. However, it has no moderating impacts on the relationship between leadership behavior and organizational commitment and job performance, or the relationships between organizational commitment and job satisfaction and performance.

Empirical research suggested that all of the subdimensions of transformational leadership and contingent reward are strongly positively associated with organizational commitment (Bycio, Hackett, & Allen, 1995; Kirkpatrick & Locke, 1996; Podsakoff, MacKenzie, & Bommer, 1996; Rafferty & Griffin, 2004). Podsakoff, MacKenzie, & Bommer (1996) examined the influence of four subdimensions of transformational leadership and a range of substitutes for leadership on affective commitment to the organization. Results indicated that only one of the leadership factors, articulating a vision, was significantly positively associated with affective commitment. Kirkpatrick and Locke (1996) conducted an experimental study with students who engaged in a simulated assembly task. These authors reported that vision positively affected congruence between the participants' beliefs and the leader's beliefs and values, trust in the leader, the extent to which the leader intellectually stimulated participants, and the extent to which individuals saw the leader as charismatic. In addition, participants in the vision condition reported that the experimental task was more interesting, challenging, and important, while individuals in the no-vision condition reported that the task was unstimulating, boring, and not worthwhile.

Bycio, Hackett, & Allen (1995) examined the relationship among the subdimensions of transformational and transactional leadership and continuance commitment. These authors hypothesized that contingent reward would be significantly positively associated with continuance commitment. Contrary to expectations, however, the only leadership factor that was associated with continuance commitment was management-by-exception. The authors explained the result by focusing on the composition of the continuance commitment scale, which contains items measuring individuals' perceptions of their investments in the organization and the availability of alternative employment possibilities. Bycio, Hackett, & Allen (1995) argued that contingent reward should increase investments in an organization but would not influence individuals' perceptions of their employment opportunities. Rafferty & Griffin (2004) studied the dimensions of transformational leadership among a large public agency that was responsible for developing and implementing the policies and programs related to government buildings, capital works initiatives, procurement development, and administrative services in Australia. The authors distributed 3,307 surveys, and only 1,398 responded (response rate of 42.2%). The findings of the study revealed that inspirational leadership had a positive relationship with affective commitment ($\beta = .34$, $p < .001$). In addition, intellectual stimulation ($\beta = .17$, $p < .001$) was significantly positively associated with affective commitment. However, vision did not display a significant unique positive relationship with affective commitment ($\beta = -.07$, $p > .05$).

In attempting to integrate both behavioral and relational perspectives of leadership and test their applicability in determining employees' organizational commitment, Lee (2005) conducted a study where he measured leadership behavior using Bass and Avolio's multifactor leadership questionnaire (1997). The findings from hierarchical regression analysis revealed that transformational leadership has positive association with organizational commitment ($\beta = .208$, $p < .05$). Catano, Pond, & Kelloway, (2001) studied the concept of organizational commitment and leadership behavior in volunteer organizations. The primary objective of their study was to explore the effects of leadership behavior and organizational commitment. The results of the study of 212 Canadian volunteer leaders from an international social chartable organization showed that volunteer leaders were more psychologically involved and committed to their organization than comparable leaders from a trade union. The volunteer leaders rated higher than their union counterparts in transformational leadership and socialization. Union leaders were more transactional and held stronger Marxist work beliefs. Both volunteer and union leaders reported similar humanistic views on work. There were no differences with respect to inter-role conflict that both types of leaders experienced.

In two studies conducted by McNeese-Smith (1995, 1996) to explore the relationship between leadership behaviors and employee outcomes, leadership behaviors were focused on the five behaviors identified by Kouzes and Posner (1988): challenging the process, inspiring a shared vision, enabling others to act, modeling the way, and encouraging the heart. Employee outcomes were limited to job satisfaction, productivity, and organizational commitment. The first study was conducted in Seattle with a sample of nursing staff and employees of clerical and support departments. The second study was conducted in Los Angeles with a sample of nursing staff alone. Both studies showed a consistent positive, statistically significant, correlation between the employees' perception of their manager's use of the five leadership behaviors and the employee outcomes. The correlations in the Seattle hospitals were low to moderate. The author concluded that there are other factors besides the use of leadership behaviors influencing employee outcomes.

The study replicated in Los Angeles showed similar but stronger statistically significant correlations between the manager's use of the five leadership behaviors and the employee outcomes. Although there were drastic differences in the geographical area, hospital types, funding and size samples, and political and socioeconomic climate of the two communities, the second study supported the findings of the first. Nevertheless, in the two studies the author found it is difficult to evaluate individual leadership's unique predictive contribution because there were high inter correlations among the leadership behaviors.

In another descriptive study (McNeese-Smith, 1997), where the influence of manager behavior on nurses' job satisfaction, productivity and commitment was explored, nurses felt that job satisfaction was most influenced by managers' leadership style. The characteristics of a manager that influenced job satisfaction included the provision of recognition and thanks, meeting nurses' personal needs, helping or guiding the nurse, using leadership skills to meet unit needs, and supporting the team. The author found that besides providing recognition and support, managers who created a positive climate in the work environment helped nurses to be more productive. Also, nurses' organizational commitment was influenced by the managers' use of their leadership behaviors, such as being appreciative, supportive, and visionary, having the ability to trust others, role modeling, and creating open communication. In a study done by Frank, Eckrick, & Rohr (1997) to investigate the factors that facilitate quality nursing care-giving, the most critical theme to emerge from the interviews of seven nurses was leadership. Good leadership was found to make a difference in the effectiveness of the care system. The authors found that nurse managers were the organizers who facilitated outstanding performance in the delivery of nursing care. In so doing, nurse mangers must be supportive and, at the same time, have faith in their people. Supporting the findings is the study done by Morrison, Jones, & Fuller (1997). The authors found that both transactional and transformational leadership was positively related to job satisfaction, as was empowerment.

Loke (2001) studied the effects of leadership behaviors on job satisfaction, productivity, and organizational commitment among registered nurses in an acute care setting in Singapore.

The study explored the relationships between five leadership behaviors identified by Kouzes and Posner (1988); challenging the process, inspiring a shared vision, enabling others to act, modeling the way, and encouraging the heart, and the employee outcomes. The author used survey questionnaires to elicit responses from 100 registered nurses and 20 managers belonging to the same organization. Data collected included demographic characteristics and the degree to which the five types of leadership behaviors were used as perceived by the nurse managers and the registered nurses. In addition, the level of nurse job satisfaction, the degree of productivity, and the extent of organizational commitment were described. The employee outcomes, productivity, job satisfaction, and organizational commitment, were found to be statistically correlated to the managers' use of leadership behaviors. In the regression analysis, leadership behaviors explained 8.8% of the dependent variable of productivity, 29.2% of job satisfaction and 21.8% of organizational commitment.

Organizational Commitment and Level of Education

The field of nursing is one of the most exciting and challenging careers that an individual can enter. Today's nurse receives a formal education in an institution with a set curriculum that has been approved by the state board of nursing (Christensen & Kockrow, 1999). There are various routes for becoming a professional registered nurse (RN). Initially, hospital schools of nursing were developed to educate nurses to work within those institutions. As nursing increasingly defined its own body of knowledge, formalized educational processes developed to ensure a consistent level of education in institutions. Such consistency was also necessary for RN licensure (Potter & Perry, 2005).

Currently in the United States the most frequent route an individual can choose to become a registered nurse is through completion of an associate degree or baccalaureate degree program. Graduates of both programs are eligible to take the National Council Licensure Examination for Registered Nurses (NCLEX-RN) to become registered nurses in the state in which they will practice. The associate degree program is a 2-year program that is usually offered by a university or junior college. This program focuses on the basic sciences and theoretical and clinical courses related to the practice of nursing. Graduates of this type of program take the state board examination for registered nurse licensure. The baccalaureate degree program usually encompasses four years of study in a college or university. The program focuses on the basic sciences and on theoretical and clinical courses, as well as courses in the social sciences, arts, and humanities to support nursing theory (Potter & Perry, 2005).

After obtaining a baccalaureate degree in nursing, a nurse can pursue further education in any number of graduate fields, including nursing. A nurse completing a graduate program can receive the degree of Master of Arts (MA) in nursing, or Master of Science in nursing (MSN). The graduate degree provides the advanced clinician with strong skills in nursing science and theory with emphasis in the basic sciences and research-based clinical practice. A master's degree in nursing can be valuable for nurses seeking roles of nurse educator, clinical nurse specialist, nurse administrator, or nurse practitioner (Potter & Perry, 2005). The need for nurses with doctorate degrees is rising. Expanding clinical roles, new areas of nursing such as nursing informatics, and rapidly advancing technology are just a few reasons for increasing the number of doctoral prepared nurses. A professional doctoral program in nursing (DSN or DNSc) emphasizes the application of research findings to clinical nursing. Other programs emphasize more basic research and theory and award the degree of Doctor of Philosophy (PhD) in nursing (Potter & Perry, 2005).

Previous organizational studies have shown that level of education affects organizational commitment (Angel & Perry, 1981; Buchko, Weinzimmer, & Sergeyev, 1998; Hrebiniak, 1974; Lee, 2005; Mathieu & Zajac, 1990; Meyer & Allen, 1984, 1988; Mottaz, 1988; Mowday, Steers, & Porter, 1979). Also, it has been reported to be negatively correlated with organizational commitment (DeCotiis & Summers, 1987; Koch & Steers, 1978; Mathieu & Zajac, 1990; Morris & Sherman, 1981; Mottaz, 1988, Mowday, Porter, & Steers, 1982). It has been argued that this inverse relationship is attributable to the fact that more highly educated individuals have higher expectations or greater alternative job opportunities (Grau, Chandler, Burton, & Kolditz, 1991; Mathieu & Zajac, 1990). They are therefore more likely to feel that they are not being rewarded adequately by their employers, and so the level of organizational commitment is diminished (DeCotiis & Summers, 1987). On the other hand, Sikorska-Simmons (2005) examined the role of organizational culture, job satisfaction, and level of education as predictors of organizational commitment among staff in assisted living. Findings showed that education is a significant predictor of organizational commitment. Staff members who were more educated tended to report higher levels of commitment ($\beta = .10$, $p < .05$). Results from the Buchko, Weinzimmer, and Sergeyev (1998) study, using 180 workers from a privatized Russian organization, revealed that education was not significantly correlated with organizational commitment ($r = .059$, $p > .05$). DeCottis and Summers (1987) tested an attitudinal model of organizational commitment using a sample of 367 managerial employees. Several aspects of the organization including perceived structure, process, and climate, as well as job satisfaction were found to be predictive of the commitment ($r = .03$, $p < .5$).

Using an exchange perspective based on work rewards and work values, the Mottaz (1988) study was concerned with assessing the relative importance of various influences on organizational commitment. Data from 1,385 workers representing a variety of occupations suggested that the model employed explained a large proportion of the variations in the work attribute. The results indicated that education had a significant impact on organizational commitment. However, the author found that when the demographic variables were in the analysis, the effect of education was positive (Multiple $R = .007$, $F = 24.30$), but when work rewards were entered, the effects became negative (Multiple $R = -.41$, $F = 145.38$). Mottaz (1988) suggested that education may have a positive effect on organizational commitment by increasing the availability of both intrinsic and extrinsic rewards, but a negative effect when rewards are held constant. Mottaz (1986) investigated the relationship between education and organizational commitment. The data indicated that education had an indirect positive effect on organizational commitment by increasing work rewards, but a direct negative effect when work rewards were held constant. The data further indicated that the latter finding was due to the higher work values associated with increased education. Finally, the results suggested that the effect of education on organizational commitment was, for the most part, through intrinsic rewards and values.

In the review and meta-analysis of the antecedents, correlates, and consequences of organizational commitment, Mathieu and Zajac (1990) found that education exhibited a small negative correlation ($r = -.092$) with commitment. Although the magnitude of the relationship was small, it was significantly stronger (i.e., more negative), $t(14) = 2.00$, $p < .05$, for attitudinal as compared with calculative commitment. Mowday and colleagues (Mowday, Porter, & Steers, 1982) concluded that “this inverse relationship may result from the fact that more educated individuals have higher expectations that the organization may be unable to meet” (p. 30). It may also be that more educated employees have a greater number of job options and are less likely to become entrenched in any one position or company (Mowday, Porter, & Steers, 1982).

Summary

Organizational commitment has been viewed as a dimension of organizational effectiveness, which contributes to increased effectiveness through work performance and reducing turnover (Chen & Francesco, 2003; McDermott, Laschinger, & Hamian, 1996; Wasti, 2002). Research has also shown that increased commitment improves work performance and reduces absenteeism and turnover (Wasti, 2005), which are costly to the organization. Despite growing concerns with staff turnover, little is known about factors that predict organizational commitment among nursing staff in nursing homes, and no research exists on staff commitment and job satisfaction, perceived organizational support, transformational leadership, and level of education in nursing homes. Researchers who examined predictors of nurses' commitment in health care organizations focused on hospital nurses, and it is unknown to what extent their findings apply to nursing staff in nursing homes (Knoop, 1995; McNeese-Smith, 1995; Price & Mueller, 1981). Those who work in nursing homes tend to be less educated and occupy less autonomous jobs than hospital nurses. Factors that predict their work attitudes might be different from the factors that predict attitudes of hospital nurses.

Researchers have made major efforts to develop an understanding of organizational commitment that centered around two independent constructs. The first focused on the importance of job satisfaction, the second was guided by the individual's perceived organizational support. Job satisfaction is the affective orientation that an employee has toward his or her work (Price, 2001). It can be considered as a global feeling about the job or a related constellation of attitudes about various aspects or facets of the job (Bhuian & Bulent, 2002;

Mowday, Porter, & Steers, 1982). It was concerned with the intrinsic and/or extrinsic feelings an individual had about the aspects of the job (Bhuian & Bulent, 2002). Perceived organization support has been defined as “people’s global beliefs about the extent to which the organization cares about their well-being and values their contributions” (Eisenberger, Huntington, Hutchison, & Sowa, 1986, p. 501). Although extensive research has focused on each construct independently, few attempts have been made to incorporate the two constructs into one path geared toward organizational commitment (Yoon & Thye, 2002). Regardless of the differences, studies have shown that both job satisfaction and perceived organizational support are strongly related (Elloy, 2005; Lee, 2005; Loke, 2001; Lok & Crewford, 1999; McNeese-Smith, 1997; Meyer & Herscovitch, 2001; Silverthorne, 2004; Yoon & Thye, 2002).

CHAPTER III

METHODOLOGY

The following section discusses the method and procedures that were used in answering the aforementioned research question. This section begins with a discussion of the design, population and sample, data collection procedures, research question and hypotheses, variables of the study, instrumentation, and reliability and validity of the instruments. The last section provides an overview of the method of analysis.

Design

The study utilized the analytical procedure of multiple regression to determine whether job satisfaction, perceived organizational support, transformational leadership, and level of education predict a score on the Nurses' Organizational Commitment Questionnaire. Multiple regression is a technique that enables researchers to determine a correlation between a criterion variable and the combination of two or more predictor variables (Fraenkel & Wallen, 2003). It makes use of the correlation between variables and the notion of a straight line to develop a prediction equation in which the independent variables are each assigned a weight based on their relationship to the dependent variable (Munro, 2005).

To obtain the participants for this study, the researcher randomly chose four nursing homes from a total of 53 Medicare/Medicaid certified nursing homes located in Miami-Dade County (Stabley, 2005). Miami-Dade County was divided into four geographical quadrants, north, south, west, and east; the researcher randomly chose one nursing home from each quadrant. The participants were randomly chosen by the directors of nursing from a list of nursing staff provided by each facility. To assure anonymity, the list had only identifying numbers representing nurses in each of the randomly chosen facilities.

Population and Sample

The population targeted in this study included licensed practical and registered nurses employed in Miami-Dade nursing homes. There are a total of 714 Medicare/Medicaid certified nursing home facilities in Florida (Decker, Grahn, Matthews-Martin, & Dollard, 2003; Horrigan, 2004). A total of 53 Medicare/Medicaid certified nursing homes are located in Miami-Dade County (Stabley, 2005). The total nurses working in Florida’s health care system are 187,672 (140,278 are registered nurses and 47,394 are licensed practical nurses). A total of 5,829 registered nurses and 10,366 licensed practical nurses are working in skilled nursing homes (Florida Center for Nursing, 2006). Out of the total number of nurses, 42% of RNs employed in nursing have associate degree; 26% have a baccalaureate degree; 25% have a nursing diploma; and 7% have a master/doctoral degree. The demographic breakdown of nurses is divided into 72.2% of the RN degree recipients in Florida are non-Hispanic white, approximately 13% are Black/African American, close to the percentage in the state general population (14.2%). Approximately 9% are Hispanic/Latino, less than the percentage in the general population (14.3%). The mean age for RNs is 46.1, and for LPNs are 44.1(Florida Center for Nursing, 2006). According to the business offices in the target facilities, there were a total of 192 nurses of which 25% were RNs, providing nursing care for 788 residents.

A simple random sample was used to select 15 participants from each one of the four nursing homes, using a procedure that gives every nurse a known, nonzero, and equal chance of being included in the sample (Salkind, 2003). Before the sample was drawn, every participant in the sampling frame was assigned a unique identifying number, and then all numbers placed on a list for each nursing home; after that the nursing directors of the randomly chosen facilities selected a total of 60 nurses.

Data Collection Procedures

The sample groups were invited to participate voluntarily by a recruitment letter attached to the survey questionnaire (Appendix A). The purpose of the study was explained and the nurse was allowed to decline if he/she did not want to participate. The instruments and the survey questions were assembled in packets and were distributed by nursing directors to each individual employee who met the study criteria. The questionnaire was completed in a private room and took about 45 to 60 minutes. Written guidelines were given to the administrators of the questionnaire to assure that each nurse received the same directions and information (Appendix B). After the questionnaire was completed, the nurse deposited the questionnaire in a sealed envelope in the collection box to assure anonymity. The information provided by the participants was completely anonymous and no names or identifying numbers were collected on any of the instruments.

Research Question and Hypotheses

The following research question and hypotheses were addressed in this study:

Research Question. What is the multiple correlation between a set of four predictors (job satisfaction, perceived organization support, transformational leadership behavior, and level of education) and the outcome, the nurses' organizational commitment?

Research Hypothesis. There is a multiple correlation between a set of four predictors (job satisfaction, perceived organization support, transformational leadership behavior, and level of education) and the outcome, nurses' organizational commitment.

Null Hypothesis. There is no multiple correlation between a set of four predictors (job satisfaction, perceived organization support, transformational leadership behavior, and level of education) and the outcome, nurses' organizational commitment.

Variables of the Study

The dependent variable of the study was organizational commitment. The independent variables were job satisfaction, perceived organizational support, transformational leadership behavior, and level of education. Although the researcher included in the Nurses' Organizational Commitment Questionnaire gender, ethnicity, age, work experience, and transactional leadership, no attempt was made to categorize these distinctions as predictors of organizational commitment.

Data Collection Measures

In addition to demographic information, the Nurses' Organizational Commitment Questionnaire focused on respondents' level of organizational commitment, job satisfaction, perceived organizational support, and leadership behavior. All items of organizational commitment and perceived organizational support were responded to on a 7-point likert strongly scale. The items from job satisfaction and leadership behavior were responded to on a 5-point likert scale. Total scores on each measure were obtained by averaging across items.

Demographics. Although the survey of Nurses' Organizational Commitment Questionnaire consisted of questions measuring demographics such as gender, ethnicity, level of education, age, years in career, and years with the present organization. This study used only the level of education as a predictor of organizational commitment. According to the literature review, it is believed that the level of education is considered an important factor of the organizational commitment. Respondents were asked if they were: LPN, RN with associate degree, RN with baccalaureate degree, and RN with master degree.

Organizational Commitment. The dependent variable, organizational commitment, was measured by a 23 item index called Organizational Commitment Questionnaire (OCQ) developed by Meyer, Allen, and Smith (1993) with an estimated Cronbach's alpha .85 (Feather & Rauter, 2004). Development of the affective, continuance, and normative commitment scales were based on the scale construction principles outlined by Jackson (1970) and described in detail by Allen and Meyer (1990b). Briefly, definitions of the three constructs were used to develop an initial pool of items that were then administered to a sample of men and women working in various occupations and organizations. Items were selected for inclusion in the scales on the basis of a series of decision rules that took into account the distribution of responses on the 7-point agree-disagree scale for each item, item-scale correlations, content redundancy, and the desire to include both positively and negatively keyed items (Appendix B, Section B).

Many studies have examined the construct validity of Meyer and Allen (1990b) three-component model and its measures. Allen and Meyer's (1996) reviewed results from over 40 samples and claimed that construct validity was strong enough to support the continued use of the scale. However, Meyer, Allen, and Smith (1993) modified the three scales. The revised measure contained six items for each of the three subscales. Meyer and colleagues' (1993) study indicated that the modified scales have acceptable reliability ($\alpha = .82$ for affirmative commitment, .74 for continuance commitment, and .83 for normative commitment), convergent validity, and construct validity. However, there was still a high correlation between affirmative and normative commitment ($r = .75$) (Meyer, Allen, & Smith, 1993).

Internal consistency of the three parts of the scale (affirmative, continuance, and normative commitment) has been typically estimated by using coefficient alpha. The number of estimates obtained for the scale range from a low of 20 for the normative commitment to a high of more than 40 for the affective commitment. Median reliabilities for the affective, continuance, and normative commitment scale, respectively, are .85, .79, and .73 (Allen & Meyer, 1996). With few exceptions, reliability estimates exceeded .70 (Meyer & Allen, 1997).

Temporal stability was evaluated by correlating measures of commitment obtained at different times (test-retest reliability). Relatively few published studies have reported test-retest reliability estimates; some of the published studies have typically collected data from newcomers at various points during their first year of employment. Temporal stability tends to be lower when commitment is measured very early in employees' careers. Vandenberg and Self (1993), for example, found test-retest reliabilities as low as .38 for affective commitment and .44 for continuance commitment when commitment measured on the first day of work was correlated with commitment six months later. Meyer, Bobocel, and Allen (1991) and Meyer, Allen, and Smith (1993) found reliability estimates above .60 when the measures of affective, continuance, and normative commitment included in the correlation were obtained after at least one month on the job. Blau, Paul, and St. John (1993) found a test-retest reliability coefficient of .94 for the affective commitment scale when administered seven weeks apart to a sample of employees with an average tenure of more than five years. Collectively, these findings suggest that commitment is in a state of flux in the early period of employment but quickly begins to stabilize.

The factor structure of the commitment measures has been examined in several studies using both exploratory and confirmatory analyses. Some analyses included items from all three measures; others included only affective commitment scale and/or continuance comment scale items. For the most part, the results of both the exploratory (Allen & Meyer, 1990b; McGee & Ford, 1987; Reilly & Orsak, 1991) and confirmatory (Meyer, Allen, & Gellatly, 1990; Shore & Tetrick, 1991; Somers, 1993; Vandenberghe, 1996) studies provided evidence to suggest that affective, continuance, and normative commitment are indeed distinguishable constructs (Allen

& Meyer, 1996). Total scores ranged from 23 to 161 with higher scores indicating more perceived job insecurity (Cheng & Stockdale, 2003; Feather & Rauter, 2004).

Job Satisfaction. This independent variable was measured by a 20 item index called Minnesota Satisfaction Questionnaire (MSQ) short-form, developed by Weiss, Dawis, England, & Lofquist (1967) (Appendix B, Section C) with an estimated Cronbach's alpha .91 (Ben-Bakr, Al-Shammari, & Jefri, 1994). The MSQ, a self-reported instrument that consists of 20 items that sample job satisfaction on 20 scale areas, is an often used and widely researched job satisfaction measure (DeMato & Curcio, 2004; Hancer, 2003; Hirschfeld, 2000; Pool, 1997; Scarpello & Campbell, 1983; Spector, 1997). It was derived from the Minnesota Studies in Vocational Rehabilitation in 1967 and was revised in 1977. The MSQ provides an overall index of job satisfaction and assesses the following job satisfaction facets through the following 20-scale areas: ability utilization, achievement, activity, advancement, authority, company policies and practices, compensation, co-workers, creativity, independence, moral values, recognition, responsibility, security, social service, social status, supervision-human relations, supervision-technical, variety, and working conditions. Each of the 20 scales has a total of one item, and respondents were asked to rate their satisfaction according to five categories that include very dissatisfied, dissatisfied, neutral, satisfied, and very satisfied. Response weights for each of the 20 items were summed to determine overall job satisfaction scores for respondents. The scores ranged from 20 to 100, with higher scores indicating respondents were very satisfied and lower scores indicating they were very dissatisfied.

Data on the internal consistency reliability of the MSQ as estimated by Hoyt's analysis-of-variance method showed that Hoyt's reliability coefficients for the MSQ scales were high (DeMato & Curcio, 2004). Weiss, Dawis, England, & Lofquist (1967) found that on the intrinsic satisfaction scale, the coefficients ranged from .84 (for the two assembler groups) to .91 for engineers. For the extrinsic satisfaction scale, the coefficients varied from .77 (for electronics assemblers) to .82 (for engineers and mechanics). On the general satisfaction scale, the coefficients varied from .87 (for assemblers) to .92 (for engineers). Median reliability coefficients were .86 for intrinsic satisfaction, .80 for extrinsic satisfaction and .90 for general satisfaction (Weiss, Dawis, England, & Lofquist, 1967). Stability coefficients for test-retest correlations for one-week interval ranged from .66 for the co-workers scale to .91 for the working conditions scale. Test-retest reliability for a one-year period ranged from .35 for the independence scale to .71 for the ability utilization scale (DeMato & Curcio, 2004). Previous studies have shown that Cronbach's alpha coefficients have ranged from .73 to .94 for the scales and .97 for the overall satisfaction scale (Anderson, Hohenshil, & Brown, 1984; Brown, Hohenshil, & Brown, 1988; Levinson, Fetchkan, & Hohenshil, 1988).

Much of the evidence supporting construct validity for the MSQ is derived indirectly from construct validation studies of the Minnesota Importance Questionnaire (MIQ), based on the Theory of Work Adjustment (Weiss, Dawis, England, & Lofquist, 1964, 1965). In one set of studies, the separate scales of the MSQ were the dependent variables to be predicted from the relationship between vocational needs, measured by the MIQ (Weiss, Dawis, England, & Lofquist, 1964). The hypothesis under investigation was that satisfaction was a function of the correspondence between the individual's needs and the reinforcer system of the job. The major prediction was that the high-need-high-reinforcement group would express the most satisfaction and the high-need-low-reinforcement group would express the least satisfaction. Although there exists empirical evidence involving the MSQ short-form subscales that is consistent with the theoretical distinction between intrinsic and extrinsic job satisfaction (Arvey, Bouchard, Segal, &

Abraham, 1989; Arvey, McCall, Bouchard, Taubman, & Cavanaugh, 1994; Day & Bedeian, 1991), many researchers have suggested that assigning MSQ short-form items to intrinsic and extrinsic subscales as specified by the MSQ manual (Weiss, Dawis, England, & Lofquist,1967) results in a lower-than-optimal level of construct validity (Arvey, Dewhirst, & Brown, 1978; Cook, Hepworth, Wall, & Warr, 1981; Schriesheim, Powers, Scandura, Gardiner, & Lankau, 1993; Spector, 1997).

Perceived Organizational Support. Employees' perceptions of the amount of support they felt they received from their organization were examined via a 16-item questionnaire called Survey of Perceived Organizational Support (SPOS) scale, developed by Eisenberger, Huntington, Hutchison, and Sowa (1986) (Appendix B, Section D). The SPOS scale was composed of sixteen items for which the participants used a 7-point likert scale (1 = strongly disagree, 7 = strongly agree) to indicate the extent of their agreement with each item. In order to control for an agreement response bias, Eisenberger and his colleagues (1986) phrased some of the statements in the survey positively, while others were worded negatively. Positively worded items in this questionnaire tap the extent to which respondents believe their organization values their contribution, considers their goals and interests, makes help available to solve problems, and cares about their general work satisfaction. Negatively worded items examine beliefs that the organization would disregard employee interests, fail to notice their efforts and contribution, and would take advantage of them if the opportunity arose. The scores ranged from 16 to 112, with higher scores indicating higher perceived organizational support. The Cronbach's alpha for these items was found to be reliable at .75 (Yoon & Thye, 2002). A total of 361 employees from nine organizations participated in the study with a return rate of the responses averaged 52%, from a low of 40% for the credit bureau to a high of 80% for the telephone company. The validity of the item analysis results indicated that each item had a positive correlation with a total score for the SPOS ranging from .43 to .84 and a median correlation of .63 (Eisenberger, Huntington, Hutchison, & Sowa,1986). The analysis reflected a reliability coefficient (Cronbach's alpha) of .97, with an item-total correlation ranging from .42 to .83. The mean and median item-total correlations were .67 and .66 respectively (Eisenberger, Huntington, Hutchison, & Sowa, 1986). Eisenberger, Fasolo, and Davis-LaMastro (1990), O'Driscoll and Randall (1999), Settoon, Bennett, and Liden (1996) reported that the internal consistency for the scale is .94.

Transformational Leadership. To evaluate the nurses' perceptions of their administrators' transformational leadership behavior, study participants were asked to respond to 12 descriptive elements of transformational leadership behavior (Appendix B, Section E) developed by Bass and Avolio (1992). The Multifactor Leadership Questionnaire (MLQ) Form 6S (Bass & Avolio, 1992) included 12 items to measure the four factors of transformational leadership. It contains three items each for idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration. Respondents were requested to answer the MLQ by rating how frequently their current immediate supervisor had displayed the behaviors described, using a five-point scale (1 = not at all; 2 = once in a while; 3 = sometimes; 4 = fairly often; 5 = frequently, if not always). The mean rating on the three items comprising a factor was taken as the score of that factor. The mean of the scores for the four factors was taken as the score for transformational leadership (Krishnan, 2004; Whittington, Goodwin, & Murray, 2004).

The scores ranged from 12 to 60, with higher scores indicating whether the leader holds subordinates' trust, maintains their faith and respect, shows dedication to them, appeals to their hopes and dreams, acts as their role model, provides vision, uses appropriate symbols and images to help others focus on their work, and tries to make others feel their work is significant. Also, the higher scores indicate the leader creates an environment that is tolerant of seemingly extreme positions, shows interest in others' well-being, assigns projects individually, and pays attention to those who seem less involved in the group (Northouse, 2004).

The MLQ has been the primary measurement tool used in research on Multifactor Leadership Theory. As noted by Yukl (1994), "most of the research on the theory has involved the use of a questionnaire called the Multifactor Leadership Questionnaire to measure various aspects of transformational and transactional leadership" (p. 353). A number of studies using the measure have related the MLQ dimensions of leader behavior to leader effectiveness (Burke & Collins, 2001; Krishnan, 2004; Ozaralli, 2003; Pillai & Williams, 2004). Transformational leadership has been more highly correlated with performance and motivation of subordinates than transactional leadership (Howell & Avolio, 1993). However, significant relationships between the transactional components of the MLQ and leader effectiveness have been obtained as well (Avolio & Howell, 1992; Bass, Avolio, & Goodheim, 1987; Yammarino & Bass, 1990).

An earlier version of the MLQ was originally developed by Bass (1985), based on a series of interviews the author conducted with 70 senior executives in South Africa; the executives were asked to recall leaders within their experiences who had raised their awareness to boarder goals, moved them to higher motives, or inspired them to put others' interests ahead of their own. The executives were then asked to describe how their supervisors' leadership behaviors affect changes through their organizations. From these descriptions and from numerous other interviews with both junior and senior executives, Bass (1985) constructed the questions that make up the MLQ. Since it was first designed, the MLQ has gone through many revisions, and it continues to be refined to strengthen its reliability and validity (Bass & Avolio, 1993).

Based on a summary analysis of a series of studies that used the MLQ to predict how transformational leadership relates to outcomes such as effectiveness, Bryman (1992) and Bass and Avolio (1994) have suggested that the charisma and motivation factors on the MLQ are the most likely to be related to positive effects. Individualized consideration, intellectual stimulation, and contingent reward are the next most important factors (Northouse, 2004). A recent meta-analysis conducted by Lowe, Kroeck, and Sivasubramaniam (1996) supported the predictions of Multifactor Leadership Theory. Consistent with Bass (1985), the study suggested that the same leader may exhibit both transactional and transformational leadership. In addition, the author stated that both leadership styles are associated with leader effectiveness. A review of literature on Multifactor Leadership Theory demonstrated the proliferation of different measures of MLQ constructs (Yukl, 1994). This has both fueled recent debates on the theory, and potentially limited the development of a cumulative body of research findings on the theory. Although most research has used MLQ, some studies have developed new measures, employed modifications of the MLQ, or various forms of the MLQ itself (Bass & Avolio, 1993). For example, Howell and Avolio (1993) employed a shorter form of the MLQ (Form 10) which contains "…….only behavioral items…." (Bass & Avolio, 1993, p. 57).

While these reduced measures may represent an improvement in the measurement of Bass' construct (1985), such modifications make it more difficult to compare the results of previous research. Further, such measurement practices, while common because of practical limitations on research, nevertheless pose serious problems in terms of content validity of measures and may be harmful to the development and accumulation of knowledge (Bobko & Stone-Romero, 1998; Newman & Tejeda, 1999; Schriesheim, Powers, Scandura, Gardiner, & Lankau, 1993; Sridhar, Valecha, & Sridhar, 1994).

Tepper and Percy (1994) examined a reduced version of Bass and Avolio's (1990) 72-item MLQ. The authors employed the maximum likelihood confirmatory factor analysis (CFA) to examine the hypothesized structure of the MLQ using a reduced set of items from the MLQ Form X. Using 290 undergraduates and 95 managers, Tepper and Percy found none of the hypothesized models were confirmed . In subsequent exploratory analysis, Tepper and Percy reported that the charismatic and inspirational leadership scales converged to a single construct and that the management-by-exception scales may require improvement or reinterpretation because of their relationships to the contingent reward scale.

Despite the relatively wide range of outcomes that have been related to various forms of MLQ, little research has been devoted to the underlying psychometric characteristics of the questionnaire. As Bass (1985) noted, for example, there is a need to replicate the MLQ factor structure with diverse samples and occupations. Moreover, Bass' (1985) original analysis did not allow for the possibility that the factors were interrelated, despite his contention that leaders are capable of being both transactional and transformational. Howell and Avolio (1993) have studied the MLQ factor structure in a way that allowed the facets to be correlated. Using MLQ-10 responses from a relatively small group of managers, 78 leaders as rated by 322 followers, the authors conducted a partial least squares analysis that revealed low to moderate correlations among the six target dimensions. Obviously, the extent to which transactional and transformational leadership are correlated is of theoretical interest because Burns (1978) originally viewed them as representing opposite ends of the same continuum.

In the recent study conducted by Zhu, Chew, and William (2005), testing an integrated theoretical model relating chief executive officers' transformational leadership, the authors found that human-capital-enhancing human resource management fully mediates the relationship between chief executives' transformational leadership and subjective assessment of organizational outcomes and partially mediates the relationship between chief executives' transformational leadership and absenteeism. The authors administered a total of 1,050 questionnaires to senior human resources executives and chief executives of selected firms drawn from the Singapore exchange listing. Zhu and colleagues (2005) reported that the six items of idealized influence alpha = .84, the four items of individualized consideration alpha = .84, the four items of intellectual stimulation = .85, the two items of contingent rewards alpha = .85, the two items of management by exception active alpha = .82, and the two items of management by exception passive alpha = .79.

Method of Analysis

The data from the surveys were analyzed using the Statistical Package for the Social Sciences (SPSS for Windows 11.5.0) (SPSS Inc., 2002). The statistical procedure of multiple regression was used to analyze the multiple influences of the independent variables job satisfaction, perceived organization support, transformational leadership, and level of education on nurses' organizational commitment. A correlation is defined as a statistical test to determine the tendency or pattern for two or more variables or two sets of data to vary consistently (Creswell, 2002; Cronk, 2004; Fraenkel & Wallen, 2003; Hulley, Cummings, Browner, Grady, et al., 2001; Isaac & Michael, 1997; Salkind, 2003; Weinberg & Abramowitz, 2002). According to Voelker, Orton, and Adams (2001), this means that two variables share common variance, or they co-vary together.

The Pearson product-moment correlation coefficient (r), also called bivariate correlation, was used to indicate the degree that the independent variables and the dependent variable are linearly related (Cronk, 2004; Green, Salkind, & Askey, 2000; Weinberg & Abramowitz, 2002).

The Pearson product-moment correlation coefficient was used to detect the magnitude of association between variables and to determine the direction of the relationships (Creswell, 2002). It varies between -1 and +1. Negative values indicate that as one variable increases, the other decreases. The closer the absolute value of r is to 1, the stronger the association; the closer to 0, the weaker the association (Hulley, Cummings, Browner, & Grady, 2001).

The statistical procedure of multiple regression was utilized to determine the combined relationship of the independent variables on a single dependent variable (Creswell, 2002; Salkind, 2003). There were several procedures available to determine relationships; however, multiple regression analysis was selected because of its strength in providing the efficient degree of multiple correlations. It is a technique that enables researchers to determine a correlation between a criterion variable and the best combination of two or more predictor variables (Fraenkel & Wallen, 2003). Additionally, multiple regression techniques have been widely employed in the business industry, health care industry, and education services and used effectively in decision making (Isaac & Michael, 1997; Kerlinger, 1986; Norusis, 1993).

Multiple regression was utilized to examine the strength between the independent variables of job satisfaction (X1), perceived organizational support (X2), transformational leadership behavior (X3), and level of education (X4), and the dependent variable of organizational commitment (Y1). The regression equation utilized in this study was
Predicted organizational commitment score (Y1) = constant (a) + job satisfaction (b1X1) + organizational support (b2X2) + transformational leadership (b3X3) + level of education (b4X4). The regression weights are referred by each b and the constant (a) is the value of the predicted Y score when X = 0 (Creswell, 2002; Munro, 2005; Salkind, 2003). The alpha significant level of .05 was used for all statistical analysis. The data file, backup copies of the data file, and all the

data will be stored for safekeeping. All returned questionnaires will be kept in the researcher's office for five years under lock and key, and after this period of time, all data will be shredded.

CHAPTER IV

ANALYSIS OF THE DATA

This study examined the predictive values of job satisfaction, perceived organizational support, transformational leadership behavior, and level of education on nurses' organizational commitment in health care organizations, measured by five scales of the Minnesota Satisfaction Survey-Short Form, Perceived Organizational Survey, Multifactor Leadership Behavior Survey, Demographic Survey, and Organizational Commitment Survey. The results of the data analysis and the research findings are presented in this chapter. This chapter includes the research question, descriptive data for demographic information, and research findings.

Research Question

In order to determine the multiple correlations between the four predictors (job satisfaction, perceived organizational support, transformational leadership behavior, and level of education) on the degree of organizational commitment among registered and licensed practical nurses in South Florida's long-term facilities, an answer was sought to the following research question:

What is the multiple correlation between the four predictors (job satisfaction, perceived organization support, transformational leadership behavior, and level of education) and the nurses' organizational commitment?

Descriptive Data for Demographic Information

The data analyzed were based on surveys completed by 55 nurses employed by Miami-Dade County nursing homes. A total of 60 questionnaires were distributed by simple random sample. Fifty five or 92% completed surveys were returned to the researcher. The demographic data collected include gender, race, education, facility experience, and years of nursing experience. Of the study sample, 85.5% (n = 47) of the nurses were women and 14.5% (n = 8) were men. 10.9% (n = 6) were Caucasian, 54.5% (n = 30) were African American, 21.8% (n = 12) were Hispanic, and 12.7% (n = 7) were Asian (Table 1).

Table 1.

Demographic Characteristics: Frequencies and Percentages

Demographic	Variables	Frequency	Percent
Gender	Female	47	85.5
	Male	8	14.5
Race	Caucasian	6	10.9
	African American	30	54.5
	Hispanic	12	21.8
	Asian	7	12.7

Respondents were requested to report their level of education. Nearly two thirds of the nurses were licensed practical nurses (n = 33), followed by 20% (n = 11) registered nurses with bachelor degrees, 16.4% (n = 9) registered nurses with associate degrees, and 3.6% (n = 2) registered nurses with master degrees (Table 2).

Table 2.

Education Level: Frequencies and Percentages

Level of Education	Frequency	Percent
Licensed Practical Nurse	33	60.0
Registered Nurse with AA/AS	9	16.4
Registered Nurse with BSN	11	20.0
Registered Nurse with MSN	2	3.6

The duration of the work experience of nurses with their organizations varied from one year to more than 20 years. 60% of the nurses reported that they had been employed in their nursing homes between one to five years. More than 27% worked between six and nine years, and seven nurses (12.7%) reported that they have been working more than 10 years (Table 3).

Table 3.

Frequencies and Percentages of Nurses' Number of Years Employed at Nursing Homes

Number of Years	Frequency	Percent
1-5	33	60.0
6-9	15	27.3
10-20	6	10.9

Table 3 (cont.).

Frequencies and Percentages of Nurses' Number of Years Employed at Nursing Homes

Number of Years	Frequency	Percent
20 +	1	1.8

Nursing experience among participants was reported. 21.8% (n = 12) of the respondents reported that they have one to five years of nursing experience, while 25.5% (n = 14) reported that they have six to nine years of experience, and more than 52.8% worked more than 10 years (Table 4).

Table 4.

Frequencies and Percentages of Nurses' Number of Years Employed Nursing

Number of Years	Frequency	Percent
1-5	12	21.8
6-9	14	25.5
10-20	20	36.4
20 +	9	16.4

Research Findings

Pearson product-moment correlations coefficients (r) were conducted to determine whether a relationship existed between the dependent variable organizational commitment and the independent variables, job satisfaction, organizational support, transformational leadership behavior, and level of education. In addition, a multiple regression analysis was conducted to evaluate the predictive values of job satisfaction, perceived organizational support, transformational leadership behavior, and level of education on the nurses' organizational commitment in health care organizations. All analyses were conducted at the .05 significance level.

Pearson correlation coefficients were computed to determine the relationship between organizational commitment, job satisfaction, perceived organizational support, transformational leadership, and level of education. In table five, the correlation matrix depicts a significant correlation of, $r\ (55) = .93$, $p \leq .05$, between the job satisfaction scores and organizational commitment scores. The correlation coefficient suggests that higher job satisfaction scores are related to higher organizational commitment scores, and the correlation .93 indicated that approximately 87% of variance of organizational commitment was accounted for by the predictor, job satisfaction. Table five, demonstrates that the perceived organizational support and transformational leadership scores positively correlated with organizational commitment scores ($r = .92$, $p \leq .05$, $r = .71$, $p \leq .05$, respectively). This finding suggests that higher scores in perceived organizational support and transformational leadership are associated with increased organizational commitment. Correlational analysis of level of education and organizational commitment revealed a significant positive correlation, $r = .30$, $p \leq .05$, and indicated that approximately 9% of variance of organizational commitment was accounted for by the predictor, level of education. Table five also depicts positive correlations between the independent variables of job satisfaction, perceived organizational support, transformational leadership, and level of education.

Table 5.

Pearson Correlation of Organizational Commitment, Job Satisfaction, Organizational Support, Transformational Leadership, and Level of Education

		OC	JS	OS	TL	LE
OC	Pearson Correlation	1				
	Sig. (2-tailed)	.				
	N	55				
JS	Pearson Correlation	.935**	1			
	Sig. (2-tailed)	.000	.			
	N	55	55			
OS	Pearson Correlation	.920**	.931**	1		
	Sig. (2-tailed)	.000	.000	.		
	N	55	55	55		
TL	Pearson Correlation	.717**	.717**	.681**	1	
	Sig. (2-tailed)	.000	.000	.000	.	
	N	55	55	55	55	
LE	Pearson Correlation	.307*	.196	.165	.251	1
	Sig. (2-tailed)	.023	.151	.229	.064	.
	N	55	55	55	55	55

* .Note Correlation is significant at the 0.05 level (2-tailed). ** Correlation is significant at the 0.01 level (2-tailed). (JS = Job Satisfaction; OS = Organizational Support; TL = Transformational Leadership; LE = Level of Education; OC = Organizational Commitment)

A regression analysis was performed between the dependent variable, organizational commitment, and the independent variable, job satisfaction. The results are provided in table 6.

Table 6.

Correlational Analysis of Organizational Commitment and Job Satisfaction

R	R Square	Adjusted R Square	Std. Error of the Estimate
.93	.87	.87	3.87

The R value is .93 which is the simple correlation between organizational commitment and job satisfaction. In contrast, the number represented by squaring R, the R square of .87, is said to represent the proportion of the total variance of organizational commitment, or explained by job satisfaction.

The model that results from performing a regression on the data is as follows:

Table 7.

Regression Model for Organizational Commitment and Job Satisfaction

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
Constant	8.39	4.85		1.23	.089
Job Satisfaction	1.10	.058	.93	19.24	.000

This states that the regression line is as follows:

Predicted organizational commitment score = 8.39 + 1.10 (job satisfaction). The standard error of the estimate for B equal 4.85 and the standard error for the regression line is .058. The standard error of the estimate for B is less than the standard deviation of the job satisfaction, which was 9.15 (Table 8).

Table 8.

Standard Deviation for Job Satisfaction, Perceived Organizational Support, Transformational Leadership Behavior and Level of Education

Variable	Standard Deviation
Job Satisfaction	9.15
Organizational Support	10.42
Leadership Behavior	5.95
Education	.89

This suggests that the regression equation using job satisfaction is a better predictor of organizational commitment than just using the mean of organizational commitment to predict commitment.

The following table provides the F statistic which tests the probability of the slope of the regression line being zero.

Table 9.

ANOVA Table Providing F Statistics for Regression Model

	Sum of Squares	df	Mean Square	F	Sig.
Regression	5556.43	1	5556.43	370.38	.000
Residual	795.09	53	15.00		
Total	6351.52	54			

With the F statistic 370.38 shown in table 9, one can reject with a high degree of certainty the hypothesis that the slope of the regression line is zero; this confirms the usefulness of the regression model for this independent variable.

The regression analysis between organizational commitment and organizational support yielded an R value of .92 (Table 10). The number represented by squaring the R, the square R of .84, is said to represent the proportion of the total variance explained by perceived organizational support.

Table 10.

Correlational Analysis of Organizational Commitment and Organizational Support

R	R Square	Adjusted R Square	Std. Error of the Estimate
.92	.84	.84	4.29

The model that results from performing a regression on the data is as follows:

Table 11.

Regression Model for Organizational Commitment and Organizational Support

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
Constant	4.91	4.70		1.04	.301
Organ. Support	.95	.056	.92	17.48	.000

The above table indicates that the equation for the regression line is as follows: Predicted organizational commitment score = 4.91 + .95 (perceived organizational support). The standard error of the estimate for B is 4.70 and the standard error for the regression line slope is .05. Since the standard error of the estimate (4.70) is less than the standard deviation of the perceived organizational support (10.42), this suggested that the regression equation using perceived organizational support is a better predictor of organizational commitment than just using the mean of organizational commitment to predict the commitment.

The following table provides the F statistics that test the chance of the slope of the regression line being zero.

Table 12.

ANOVA Table Providing F Statistics for Regression Model

	Sum of Squares	df	Mean Square	F	Sig.
Regression	5371.89	1	5371.89	290.63	.000
Residual	979.63	53	18.48		
Total	6351.52	54			

With the F statistic of 290.63 shown in table 12, one can reject with a high degree of certainty the hypothesis that the slope of the regression line is zero and thus provides additional justification regarding the usefulness of the regression model of this analysis.

The regression analysis between organizational commitment and transformational leadership behavior yielded an R value of .71 (Table 13). The square R of .51 is said to represent the proportion of the total variance of organizational commitment which is accounted for, or explained by transformational leadership behavior.

Table 13.

Correlational Analysis of Organizational Commitment and Leadership Behavior

R	R Square	Adjusted R Square	Std. Error of the Estimate
.71	.51	.55	7.63

The model that results from performing regression of the data is as follows:

Table 14.

Regression Model for Organizational Commitment and Leadership Behavior

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
Constant	20.94	8.54		2.45	.01
Leadership	1.30	.17	.71	7.48	.00

The equation for the regression line is follows:

Predicted organizational commitment score = 20.94 + 1.30 (transformational leadership). The standard error of the estimate for B equals 8.54 and the standard error for the regression line's slope is .17. Since the standard error of the estimate (8.54) is less than the standard deviation of the transformational leadership behavior (10.49), this suggests that the regression equation using leadership behavior is a better predictor of organizational commitment than just using the mean of the organizational commitment to predict one's commitment.

The following table provides the F statistics that test the chance of the slope of the regression line being zero.

Table 15.

ANOVA Table Providing F Statistics for Regression Model

	Sum of Squares	df	Mean Square	F	Sig.
Regression	3265.73	1	3265.73	56.09	.000
Residual	3085.79	53	58.22		
Total	6351.52	54			

Since the F statistics is 56.09, one can reject with a high degree of certainty the hypothesis that the slope of the regression line is zero. This supports the usefulness of the regression model for this analysis.

A regression analysis was performed between organizational commitment and level of education. The results yielded an R value of .30, and the number obtained by squaring the R, the square R value of .09 (Table 16), represent the proportion of the total variance in organizational commitment as accounted for, or explained by level of education.

Table 16.

Correlational Analysis of Organizational Commitment and Level of Education

R	R Square	Adjusted R Square	Std. Error of the Estimate
.30	.09	.07	10.41

The model that results from performing a regression on the data is as follows:

Table 17.

Regression Model for Organizational Commitment and Level of Education

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
Constant	78.48	2.90		27.06	.00
Education	3.71	1.58	.30	2.34	.02

This table shows that the regression line equation is as follows:

Predicted organizational commitment score = 78.48 + 3.71 (level of education). The standard error of the estimate for B equal 2.68 and the standard error for the regression line's slope is 1.58.

The following provides the F statistics that test the chance of the slope of the regression line being zero.

Table 18.

ANOVA Table Providing F Statistics for Regression Model

	Sum of Squares	df	Mean Square	F	Sig.
Regression	597.04	1	597.04	5.49	.023
Residual	5754.48	53	108.57		
Total	6351.52	54			

Since the F statistics is 5.49, one can reject with a high degree of certainty the hypothesis that the slope of the regression line is zero. Therefore, the regression line is useful in estimating organizational commitment based on level of education.

To view overall nurses' organizational commitment, a multiple regression analysis was conducted to predict the organizational commitment. The model analysis included the four independent variables of job satisfaction, perceived organizational support, transformational leadership, and level of education. The linear combination of the four independent variables was significantly related to the dependent variable (organizational commitment), R squared = .91, adjusted R squared = .90, F (4, 50) = 129.35, P = .000 (Table 19). An estimated 91% of variance of the organizational commitment index can be accounted for by the linear combination of predictors, job satisfaction, perceived organizational support, transformational leadership, and level of education.

Table 19.

Multiple Linear Regressions for a Single Set of Predictors: Model Summary and ANOVA

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.955	.912	.905	3.345

ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Regression	5791.851	4	1447.963	129.357	.000
Residual	559.676	50	11.194		
Total	6351.527	54			

Predictors: Transformational Leadership, Level of Education, Organizational Support, and Job Satisfaction.
Dependent Variable: Organizational Commitment.

As indicated in table 20, the three measures of predictors, job satisfaction, perceived organizational support, and level of education were most strongly related to organizational commitment. Supporting this conclusion was the strength of the bivariate correlation between job satisfaction and organizational commitment, which was .93 and perceived organizational support, which was .92, $p \leq .001$. Transformational leadership behavior was found not to be a significant predictor of organizational commitment when entered with the other independent variables.

Table 20.

Multiple Linear Regressions for a Single Set of Predictors: Coefficients

Independent Variables	Unstandardized Coefficient		Standardized Coefficient		
	B	Std. Error	Beta	t	Sig.
(Constant)	7.120	4.386		1.623	.111
Level of Education	1.558	.527	.129	2.957	.005
Job Satisfaction	.613	.143	.517	4.277	.000
Organizational Support	.395	.120	.379	3.296	.002
Leadership	.102	.111	.056	.911	. 366

Dependent Variable: Organizational Commitment.

The results from the regression equation for the standardized variables were as follows: Predicted organizational commitment score = 7.120 + 1.558 (level of education) + .613 (job satisfaction) + .395 (organizational support) + .102 (transformational leadership) (shown in Table 20). Based on the findings, the null hypothesis was rejected.

Summary of Results

In summary, the null hypothesis that predicted no multiple correlations between the four predictors (job satisfaction, perceived organization support, transformational leadership behavior, and level of education) and the nurses' organizational commitment was rejected. Correlational and multiple regression analyses indicated that all independent variables were significantly associated with the nurses' organizational commitment except transformational leadership behavior.

Three predictors, job satisfaction, perceived organization support, and level of education were most strongly related to organizational commitment. Supporting this result was the strength of the bivariate correlation between job satisfaction and organizational commitment, which was .93 and perceived organizational support, which was .92, $p \leq .001$.

CHAPTER V

CONCLUSIONS, DISCUSSION, LIMITATIONS, IMPLICATIONS AND RECOMMENDATIONS

Few investigations have explored the impact of job satisfaction, perceived organizational support, and level of education on nurses' levels of organizational commitment, particularly studies that attempt to consider the potential effects of transformational leadership behavior. The present study has attempted to contribute to the general body of knowledge regarding nurses' organizational commitment. Pearson product-moment correlations were conducted to determine whether relationships existed between the nurses' organizational commitment and job satisfaction, perceived organizational support, transformational leadership, and level of education. The information gathered from 55 nurses was sought to determine whether relationships existed between the dependent and independent variables in the nursing homes that participated in this study. Data procured by surveying registered and licensed practical nurses working in the four nursing homes in Miami-Dade County provided answers to the following research question:

What is the multiple correlation between a set of four predictors (job satisfaction, perceived organization support, transformational leadership behavior, and level of education) and the outcome, the nurses' organizational commitment?

Data for this study was obtained through a questionnaire given to 60 nurses (24 registered nurses and 36 practical nurses) working in long-term nursing homes. The Nurses' Organizational Commitment Questionnaire (NOCQ) served as the instrument in this study to assess the extent to which nurses expressed their levels of agreement regarding five constructs, organizational commitment, job satisfaction, perceived organizational support, transformational leadership behavior, and level of education. The NOCQ was developed in five parts. Part A contained five items designed to obtain participants' demographic information. Although the survey of Nurses' Organizational Commitment Questionnaire consisted of questions measuring demographics such as gender, ethnicity, level of education, age, years in career and years with the present organization. This study used only the level of education as a predictor of organizational commitment. According to the literature review, it is believed that the level of education is considered an important factor of organizational commitment. Respondents were asked if they are: LPN, RN with an associate degree, RN with a baccalaureate degree, and RN with a master's degree.

Part B the dependent variable, organizational commitment, was measured by a 23 item index called Organizational Commitment Questionnaire (OCQ) developed by Meyer, Allen, and Smith (1993) with an estimated Cronbach's alpha .85 (Feather & Rauter, 2004). Development of the affective, continuance, and normative commitment scales were based on the scale construction principles outlined by Jackson (1970) and described in detail by Allen and Meyer (1990b). Briefly, definitions of the three constructs were used to develop an initial pool of items that were then administered to a sample of men and women working in various occupations and organizations. Items were selected for inclusion in the scales on the basis of a series of decision rules that took into account the distribution of responses on the 7-point agree-disagree scale for each item, item-scale correlations, content redundancy, and the desire to include both positively and negatively keyed items.

Part C the independent variable, job satisfaction, was measured by a 20 item index called Minnesota Satisfaction Questionnaire (MSQ) short-form, developed by Weiss, Dawis, England, & Lofquist (1967) (Appendix B, Section C) with an estimated Cronbach's alpha .91 (Ben-Bakr, Al-Shammari, & Jefri, 1994). The MSQ, a self-reported instrument that consists of 20 items that sample job satisfaction on 20 scale areas, is an often used and widely researched job satisfaction measure (DeMato & Curcio, 2004; Hancer, 2003; Hirschfeld, 2000; Pool, 1997; Scarpello & Campbell, 1983; Spector, 1997). It was derived from the Minnesota Studies in Vocational Rehabilitation in 1967 and was revised in 1977. The MSQ provides an overall index of job satisfaction and assesses the following job satisfaction facets through the following 20-scale areas: ability utilization, achievement, activity, advancement, authority, company policies and practices, compensation, co-workers, creativity, independence, moral values, recognition, responsibility, security, social service, social status, supervision-human relations, supervision-technical, variety, and working conditions. Each of the 20 scales has a total of one item, and respondents were asked to rate their satisfaction according to five categories that include very dissatisfied, dissatisfied, neutral, satisfied, and very satisfied. Response weights for each of the 20 items were summed to determine overall job satisfaction scores for respondents. The scores ranged from 20 to 100, with higher scores indicating respondents were very satisfied and lower scores indicating they were very dissatisfied.

Part D was the Survey of Perceived Organizational Support (SPOS) scale. Employees' perceptions of the amount of support they felt they received from their organization were examined via a 16-item questionnaire called Survey of Perceived Organizational Support (SPOS) scale, developed by Eisenberger, Huntington, Hutchison, and Sowa (1986). The SPOS scale was composed of sixteen items for which the participants used a 7-point likert scale (1 = strongly disagree, 7 = strongly agree) to indicate the extent of their agreement with each item. In order to control for an agreement response bias, Eisenberger and his colleagues (1986) phrased some of the statements in the survey positively, while others were worded negatively. Positively worded items in this questionnaire tap the extent to which respondents believe their organization values their contribution, considers their goals and interests, makes help available to solve problems, and cares about their general work satisfaction. Negatively worded items examine beliefs that the organization would disregard employee interests, fail to notice their efforts and contribution, and would take advantage of them if the opportunity arose. The scores ranged from 16 to 112, with higher scores indicating higher perceived organizational support. The Cronbach's alpha for these items was found to be reliable at .75 (Yoon & Thye, 2002).

Part E was the Multifactor Leadership Questionnaire (MLQ) Form 6S. To evaluate the nurses' perceptions of their administrators' transformational leadership behavior, study participants were asked to respond to 12 descriptive elements of transformational leadership behavior (Appendix B, Section E) developed by Bass and Avolio (1992). The Multifactor Leadership Questionnaire (MLQ) Form 6S (Bass & Avolio, 1992) included 12 items to measure the four factors of transformational leadership. It contains three items each for idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration. Respondents were requested to answer the MLQ by rating how frequently their current immediate supervisor had displayed the behaviors described, using a five-point scale (1 = not at all; 2 = once in a while; 3 = sometimes; 4 = fairly often; 5 = frequently, if not always). The mean rating on the three items comprising a factor was taken as the score of that factor. The mean of the scores for the four factors was taken as the score for transformational leadership (Krishnan, 2004; Whittington, Goodwin, & Murray, 2004). The scores ranged from 12 to 60, with higher scores indicating whether the leader holds subordinates' trust, maintains their faith and respect, shows dedication to them, appeals to their hopes and dreams, acts as their role model, provides vision, uses appropriate symbols and images to help others focus on their work, and tries to make others feel their work is significant. Also, the higher scores indicated the leader creates an environment that is tolerant of seemingly extreme positions, shows interest in others' well-being, assigns projects individually, and pays attention to those who seem less involved in the group (Northouse, 2004).

The data analyzed were based on surveys completed by 55 nurses employed by Miami-Dade County nursing homes. A total of 60 questionnaires were distributed by a simple random sample. Fifty five or 92% completed surveys were returned to the researcher. The demographic data collected include gender, race, education, facility experience, and years of nursing experience. Of the study sample, 85.5% (n = 47) of the nurses were women and 14.5% (n = 8) were men. Six respondents (10.9%) were Caucasian, 54.5% (n = 30) were African American, 21.8% (n = 12) were Hispanic, and 12.7% (n = 7) were Asian. Respondents were requested to report their level of education. Nearly two thirds of the nurses were licensed practical nurses (n = 33), followed by 20% (n = 11) registered nurses with a bachelor's degree, 16.4% (n = 9) registered nurses with associate's degree, and 3.6% (n = 2) registered nurses with a master's degree.

Conclusions

This study provides new support to previous research about the importance of nurses' commitment and satisfaction for organizational effectiveness and performance. It also provides further evidence that the more committed they are to their organizations, the more they will be productive and effective in their organizations. This gives a clear message to all nursing home administrators and nursing directors to pay considerable attention to the issues of organizational commitment and job satisfaction for nurses and other employees in their institutions.

The findings indicated that there was a strong correlation between nurses' organizational commitment and job satisfaction, $r\ (55) = .61,\ p \leq .05$, nurses' organizational commitment and perceived organizational support, $r\ (55) = .39,\ p \leq .05$, nurses' organizational commitment and transformational leadership, $r\ (55) = .10,\ p \geq .05$, and nurses organizational commitment and level of education, $r\ (55) = 1.55,\ p \leq .05$. Multiple regression analysis indicated that 91% of the variance in nurses' organizational commitment was explained with all of the principal independent variables.

Discussion

Although there remains a plethora of research on organizational commitment, there remains a scarcity of studies that have focused on organizational commitment and nurses in the long-term care industry. The results in this study revealed that a positive correlation existed between the dependent variable, organizational commitment, and all independent variables, job satisfaction, perceived organizational support, transformational leadership behavior, and level of education. Job satisfaction reflected the strongest correlation, followed by perceived organizational commitment, level of education, and transformational leadership behavior, respectively. The multiple regression performed in this study indicated 91% of the variance in organizational commitment was accounted for by the linear combinations of job satisfaction, organizational support, transformational leadership behavior, and level of education. Job satisfaction was determined to be the strongest predictor of the four variables and transformational leadership behavior was the weakest predictor of organizational commitment.

Relationships among nurses' organizational commitment, job satisfaction, perceived organizational support, transformational leadership behavior, and level of education are numerous and varied in the literature (Lok & Crawford, 2001; Mathiew & Zajac, 1990;

McNeese-Smith, 2001; Price & Mueller, 1981, Williams & Hazer, 1986). Significant positive correlation between organizational commitment and job satisfaction, ($r = .61$, $p \leq .05$), was consistent with a number of studies (Gilsson & Durick, 1988; Savery, 1994; Wilson, 1995; Yousef, 2000). The findings of significant correlations between organizational commitment and perceived organizational support ($r = .39$, $p \leq .05$), transformational leadership behavior ($r = .10$, $p > .05$), and educational level ($r = 1.55$, $p \leq .05$) were also consistent with the results of previous studies (Bateman and Strasser, 1984; Casper & Buffardi, 2004; Chen, Aryee, & Lee, 2005; Cheung, 2000; Eisenberger, Fasolo, & Davis-LaMasto, 1990; Eisenberger, Huntington, Hutchison, & Sowa, 1986; Lok & Crawford, 1999; Mueller and Price, 1990; Naumann, Bennett, Bies, & Martin, 1998; Settoon, Bennett, & Liden, 1996; Yoon & Thye, 2002). Furthermore, the results that the relationships between organizational commitment and job satisfaction, perceived organizational support, transformational leadership behavior, and level of education are positive and significant indicate that those who are committed to their organizations are more satisfied with their job and their performance is high.

It was very surprising to discover that perceived organizational support was one of the most salient independent variable, considering the different conclusions stated in the literature. According to Wynd (2003), nurses received virtually little attention and no effort was made to make them feel as if they were important parts of the building organization and management team. These feelings led to problems that caused low morale, lack of job satisfaction, and the perception of very little or no organizational support. This study provided contrary results. Most of the nurses felt that their employers supported them.

The study also indicated that there was a positive relationship between job satisfaction and organizational commitment. Job satisfaction has been mostly concerned with the intrinsic and/or extrinsic feelings employees had about their job. Research has provided several findings regarding the relationship between job satisfaction and organizational commitment. Bateman and Strasser (1984) found a causal correlation between the two variables. Price and Mueller (1986) concluded that the relationship between job satisfaction and organizational commitment did not exist. Mueller and Price (1990) determined that job satisfaction was the strongest predictor of organizational commitment and organizational support was the second strongest. This study, however, produced similar results indicating that job satisfaction was the stronger predictor of organizational commitment, than perceived organizational support.

Transformational leadership behavior also influenced organizational commitment in this study and it is consistent with the earlier research (Bass, 1995; Pillai & Wiliams, 1998). Transformational leadership elicits support from members of the organization through their acceptance of the organization’s values, goals, and behaviors based on interaction with the transformational leader (Bass, 1985). In the past, researchers like, Podsakoff, Mackenzie, and Bommer (1996), Pillai & Wiliams (2004), believed that there was a link between organizational commitment and transformational leadership behavior.

Consistent with the idea that transformational leadership behavior can influence nurses’ organizational commitment, the results of this study helped clarify the relative importance of leadership in determining how nursing staff feel about their jobs. This is an important finding because leadership has not been included in most recent studies of health care organizational commitment. Therefore, although job satisfaction has a significant influence on the satisfaction of nursing staff, the impact of transformational leaders can be significantly greater in scope.

In addition, education emerged as the third significant predictor of organizational commitment. Contrary to the literature, more educated staff members tended to report higher levels of commitment, regardless of their perceptions of perceived organizational support and job satisfaction. This positive relationship between education and commitment might be due to the fact that staff members who had more education occupied higher status positions and were more involved in decision making in the organization. Research has shown that greater participation in decision making is strongly associated with higher levels of job satisfaction and organizational commitment (Laschinger, Finegan, Shamian, & Casier, 2000; Laschinger, Shamian, & Thomson, 2001). In nursing homes, staff members who occupy higher status positions, which provide more opportunities for involvement in decision making, report higher job satisfaction and greater commitment than the less educated paraprofessional staff (Kiyak, Namazi, & Kahana, 1997; Sikorska-Simmons, 2005).

Academic education has a negative effect on organizational commitment (Freund, 2005). Freund found that the higher the worker's education, the greater the worker's intent to leave the organization. A high-level of education is reported in the research as influencing occupational mobility. Freund's (2005) findings did not coincide with other studies that suggest that employees with a high level of education have higher professional expectations than non-professional employees. In cases in which the employee feels that the organization fails to fulfill these high expectations, the performance is to leave the organization and to realize one's professional potential elsewhere (Angle & Perry, 1981).

Limitations

The present study has several limitations, some of which relate to all leadership research.

1. The information obtained for this study was dependent on the participants' self reported responses. This limitation may have influenced the responses if the nurses

felt an obligation to support their directors based on their administrative position and future work relations.

2. Survey research requires the use of standardized questionnaires which can “result in fitting of round pegs into square holes” (Bebbie, 1986, p. 232). Additionally, the nature of non-experimental research design such as a survey does not provide conclusive evidence of causality. Surveys are only able to “collect self-reports of recalled past action” (Babbie, 1986, p. 233) and are, therefore, subject to contamination by mood, attitude, antecedent or intervening variables. Babbie (1986) suggested that survey responses tend to be artificial and only approximate measures of what a respondent is thinking. This limitation results in questions of validity.
3. This study included a larger number of females than males. A study involving other registered and licensed practical nurse positions may produce different results.
4. Respondents to the various measures in this study participated voluntarily. As such, the effects of potential systematic bias in non-responses are unknown.
5. The sample the researcher used for this study was from four small nursing home corporations. Results of the study may not be generalizable to other populations.
6. The simple random sampling technique, though appropriate for the present study, assumes that the population is typical and may, therefore, have selection bias. Voluntary participation of respondents also may contribute to selection bias.

Implications

A serious nursing shortage is creating a crisis in the nation’s health care system. Many experienced nurses are leaving the field and younger people are not selecting nursing as a potential career (Wynd, 2003). Therefore, health care administrators must work harder to promote and develop methods for building organizational commitment among nurses, and among other clinicians, before that imminent shortage occurs. Traditionally nursing has been concerned with clients' health, sickness, stress, and their ability to cope with it. Research has suggested that nurses are an integral part of the health care system (Monroe & Deloach, 2004; Wright, 1999). They are advocates and health educators for patients, families, and communities. When providing direct patient care, they observe, assess, and record symptoms, responses, and progress, assist physicians during treatments and examinations, administer medications, and assist in convalescence and rehabilitation. Nurses also develop and manage nursing care plans, instruct patients and their families in proper care, and help individuals and groups take steps to improve or maintain their health (Kaye & Davitt, 1998; Kulys & Davis, 1986; Munley, 1983; Potter & Perry, 2005). Since nurses perform important functions in long-term facilities and are vital members of the health care team, it is critical for health care administrators to become aware of these practitioners' attitudes and behaviors. Ensuring adequate staffing in long-term facilities is an ongoing challenge which requires creative problem solving that focuses on work motivation and job satisfaction. By finding ways to improve salaries of the nursing staff and to create an attractive work place environment, health care administrators will help to ensure that they continue to attract and retain these essential care providers.

The shortage of nurses nationwide and locally has been well documented and extended to the long-term care industry (Fletcher, 2001; Mark, 2002; Mitchell, 2003). As a growing segment of the population ages and strains the capacity of these institutions, most are having difficulties in finding and retaining qualified nursing staff (Fenleib, Gunningham, & Short, 1994; Gohen & Van Nostrand, 1995; Kassner & Bertel, 1998; LaPlante, 1993). In order to alleviate the captioned shortage, the health care administrators are requested to go to great efforts to achieve more progress toward promoting and developing methods for building organizational commitment among nurses and other health care practitioners (McNeese-Smith, 2001).

One of the major implications that a study of this nature raises is the manner in which health care administrators monitor the work climate, and observe and identify factors that may increase or decrease job satisfaction and the work commitment of nursing staff. Even though the findings were positive toward organizational commitment, continued consideration should be given to the fact that nurses and other health care professional remain committed. The cost associated with leaving is high. Nurses have identified behaviors and conditions that promote job satisfaction, perceived organizational support, and organizational commitment. They are more likely to be more committed to the organization when they are provided an appropriate amount of support. The perception that the organization also focuses on transformational leadership behavior may also contribute to employee commitment.

Another implication is that health care administrators should stay abreast of the current trends and factors that contribute to organizational commitment. Issues related to job satisfaction and organizational support, such as unfair work conditions, salary inequities, lack of employee support, should be addressed promptly and justly.

Health care administrators should bear in mind that any action to improve nurses' organizational commitment with their organizations should take into account the fact that job satisfaction, perceived organizational support, and transformational leadership behavior interact together in their influences on organizational commitment. Improving employees' satisfaction with and performance in their job requires the adoption of the appropriate leadership behavior in order to improve the level of organizational commitment and in turn the level of job satisfaction.

Recommendations

The present study explored many aspects of nurses' organizational commitment. It is important to note that this sample of relatively well-educated respondents from South Florida may not be representative of the larger national population of professional nurses. Future research is needed to investigate these relationships among a larger and more highly educated population.

This study used the likert questionnaires to measure organizational commitment, job satisfaction, perceived organizational support, and transformational leadership behavior. It would be interesting to test the sensitivity of the results by using other measures of organizational commitment, job satisfaction, perceived organizational support, and transformational leadership behavior or to utilize more than one measure. This study has concentrated only on the impact of job satisfaction, perceived organizational support, transformational leadership, and level of education on the nurses' organizational commitment. Therefore, looking into the impact of transactional leadership behavior and organizational culture on such relationships appears worthy of future research.

Qualitative research is needed to gain insight into the feelings of registered and licensed practical nurses regarding retention and recruitment. According to Borda and Norman (1997) and Lu, While, and Barriball (2005), the retention and recruitment of nurses has shown that low wages and poor job satisfaction are the primary reasons why nurses leave their positions. Their dissatisfaction is often attributed to heavy workloads, leadership styles, motivation, inadequate training, and lack of respect (Lu, While, & Barriball 2005). Compared to their counterparts in other health care settings, such as those who work for home health care, staffing agencies, and acute care facilities, nursing home facility employees are often underpaid (Lu, While, &

Barriball 2005). Wilson (2005) stated that recruitment and retention efforts need to concentrate on increasing financial incentives for these staff members and creating a desirable work place that will lead to greater job satisfaction because the expertise required of direct care givers and the heavy workload they are assigned often far exceed the financial compensation they receive. One of the possible solutions to reduce turnover mentioned by Lu, While, & Barriball (2005) is to encourage registered nurses to further their education and to pursue advanced degrees. Mitchell (2003) points out what may be most threatening to nurses is not a lack of higher education but rather the fact that nursing education is not providing that inherent nursing know-how crucial to the art of the profession.

Since nursing research has an impact on health care and society in general, findings will be disseminated through local organizations that serve elderly and in poster or paper submissions at conferences and in workshops. Both professional and lay journals and many aspects of media will be used for wider dissemination of these findings and recommendations. The definitive efforts of the study will be disseminated among multiple agencies and organizations whose mission is to increase nurses' organizational commitment. The Healthcare Improvement Association, Incorporated (HIA) will collaborate with the Florida Department of Health- Board of Nursing to allow for timely submission of the results of the project to be incorporated into their major publications. Among the journals to be targeted are the American Journal of Public Health, Geriatric Nursing, Gerontologist, Journal of Advance Nursing, Journal of Healthcare Management, Journal of Nursing Administration, Journal of Vocational Behavior, and Journal of the American Medical Association (JAMA).

Summary

In closing, much remains to be learned about nurses' organizational commitment in health care organizations. Although four variables were examined in this research, a great amount of variance remains unaccounted for in predicting commitment. Thus, it is hoped that this study will stimulate further research in the field of organizational commitment and job satisfaction, as well as promote greater attention to preventing turnover in the profession of nursing and allied health.

Overall, the findings of this study provided support for the hypothesis proposed. The results show a significant positive relationship between nurses' organizational commitment and job satisfaction, perceived organizational support, transformational leadership behavior, and level of education. The present investigation addresses a dearth in the organizational commitment literature by attempting to study the four predictors of nurses' organizational commitment in health care organizations. Since nurses conduct important functions in the health care organizations and are vital members of the health care team, it is very important for health care administrators to become aware of research findings that may positively or negatively affect the workplace. Today there is a growing concern regarding the type of treatment that nurses receive at their jobs. According to the literature, nurses and allied health care employees have complained about unfair or unequal treatment, feeling that they are not appreciated for their contributions to health care industry (Monroe & Deloach, 2004; Wright, 1999). Research has shown that nurses feel that they are not receiving the recognition and attention that medical personnel receive (Wynd, 2003).

The study findings have practical implications for nursing home administrators and nursing managers who want to improve staff commitment and increase their retention. Because job satisfaction and perceived organizational support were strong predictors of commitment, interventions aimed at increasing job satisfaction and perceived organizational support could be most effective in producing higher levels of organizational commitment. Such interventions should concentrate on bolstering nursing staff interpersonal skills, building nurses' group support, and fostering meaningful participation in resident nursing care planning and health care decision making (Harahan, Kiefer, and Johnson, 2003). Research suggests that good interpersonal skills and participation in decision making encourage nursing team work, which in turn increases staff organizational commitment and reduces turnover (Banaszak-Holl & Mines, 1996; Sikorska-Simmons, 2005). Furthermore, efforts to increase staff commitment should focus on perceived organizational support and transformational leadership behavior that values and respects nursing staff.

Organizational commitment is an important indicator of the quality of staff in nursing homes and other health care settings. With the projected nursing staff shortage and the increasing need for services related to the growing elderly population, a better understanding of factors that influence staff commitment is critically needed for nursing home administrators. The lack of stable and committed nursing staff could be especially detrimental to nursing homes because resident relationships with staff are central to the provision of good-quality care. The success of the administrators and nursing managers in nursing homes will depend greatly on their ability to attract and retain committed staff members who identify with the mission of nursing homes and are willing to exert considerable effort to translate resident-centered philosophy into their daily work with residents. To conclude, although much research has been accumulated in the area of organizational commitment, most studies of health care settings tend to focus on nurses and other medical personnel in acute care settings resulting in a major gap in the literature on issues and concerns of health professionals in long-term care settings. It is believed that more experimental research will also contribute to a clarification of some of the processes underlying employee commitment.

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APPENDICES

APPENDIX A

COVER LETTER

December 10, 2006

Dear Research Participant:

Your participation in a research project is requested. The research is being conducted by Mahmoud Al-Hussami, a doctoral student at Barry University. The purpose of this research is to focus on the predictive effects of job satisfaction, perceived organizational support, certain leadership behaviors, and level of education on the degree of organizational commitment among registered and licensed practical nurses in South Florida's nursing home facilities. While there may be no direct benefit to you, and there are no known risks, it is hoped that the study will help us better understand the predictors of nurses' organizational commitment. In accordance with these purposes, the following procedures will be used: first, to recruit participants for the research study; second, to collect data from the participants using questionnaire surveys, and third, to provide feedback of the research findings.

If you decide to participate in this study, you will be asked to fill out a questionnaire that will take about 30 to 45 minutes. Some of the questions are about the organizational commitment and others ask about job satisfaction, perceived organizational support, leadership behaviors, and demographic variables. Your consent to participate in this research study is strictly voluntary and, should you decline to participate, there will be no adverse effects on your employment. You do not have to answer question(s) if they make you uncomfortable.

Information you will provide will be kept entirely anonymous, that is, no names or other identifiers will be collected on any of the instruments used. Any published results of the research will refer to group average only. Data will be kept in the researcher's office for five years in a locked drawer. After this period of time, all data will be shredded. By completing and returning this survey you have shown your agreement to participate in the study.

If you are satisfied with the information provided to you, and are willing to participate in this study, please complete the attached questionnaire. Do not put your name or address on any of the forms. If you have any questions or concerns regarding the study or your participation in the study, you may contact Mahmoud Al-Hussami, at (954)274-1499, Dr. Edward Bernstein, faculty sponsor, at (305)899-3861, or the Institutional Review Board point of contact, Ms. Nildy Polanco, at (305) 899-3020.

Thank you for your participation.

Sincerely,

Mahmoud Al-Hussami

APPENDIX B

NURSES QUESTIONNAIRE SURVEY

Part A: Demographic Information
Directions: The following questions are about yourself. Please check the appropriate responses.

1. What is your gender?
   a. Female____________ b. Male____________
2. What is your ethnicity?
   a. Caucasian____________ b. African American___________
   c. Hispanic_____________ d. Native American____________
   e. Asian_______________ f. Others (please indicate)____________
3. Are you a (an)?
   a. LPN_______________ b. RN with Associate Degree___________
   c. RN with Baccalaureate Degree ______ d. RN with Master Degree____________
4. What is your age range?
   a. Under 21____________ b. 21-29_____________
   c. 30-39_______________ d. 40-49_____________
   e. 50-59_______________ f. 60-69_____________
   g. over 70______________
5. How many years have you been working in nursing?
   a. 1-5______ b. 6-10_______ c. 10-20_________ d. More than 20________
6. How many years have you been employed at this nursing home?
   a. 1-5______ b. 6-10_______ c. 10-20_________ d. More than 20________

Part B: Organizational Commitment
Directions: Using the rating scale below, please mark a number on the blank line before each statement that best describes your feelings to indicate how strongly you agree or disagree with it.

1	2	3	4	5	6	7
STONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	NEITHER AGREE NOR DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE

_____ 1. I would be very happy to spend the rest of my career in this organization.
_____ 2. I enjoy discussing my organization with people outside it.
_____ 3. I really feel as if this organization's problems are my own.
_____ 4. I think I could become as attached to another organization as I am to this one.
_____ 5. I do not feel like "part of the family" at my organization.
_____ 6. I do not feel "emotionally attached" to this organization.
_____ 7. This organization has a great deal of personal meaning for me.
_____ 8. I do not feel a strong sense of belonging to my organization.
_____ 9. I am afraid of what might happen if I quit my job without having another one lined up.
_____ 10. It would be very hard for me to leave my organization right now, even if I wanted to.
_____ 11. Too much of my life would be disrupted if I decided I wanted to leave my organization right now.

_____ 12. It wouldn't be too costly for me to leave my organization in the near future.
_____ 13. Right now, staying with my organization is a matter of necessity as much as desire.
_____ 14. I believe that I have too few options to consider leaving this organization.
_____ 15. One of the few negative consequences of leaving this organization would be the scarcity of available alternatives.
_____ 16. One of the major reasons I continue to work for this organization is that leaving would require considerable personal sacrifice; another organization may not match the overall benefits I have here.
_____ 17. If I had not already put so much of myself into this organization, I might consider working elsewhere.
_____ 18. I do not feel any obligation to remain with my current employer.
_____ 19. Even if it were to my advantage, I do not feel it would be right to leave my organization now.
_____ 20. I would feel guilty if I left my organization now.
_____ 21. This organization deserves my loyalty.
_____ 22. I would not leave my organization right now because I have a sense of obligation to the people in it.
_____ 23. I owe a great deal to my organization.

Part C: Job Satisfaction
Directions: Using the rating scale below, please mark a number on the blank line before each statement that best describes your feelings to indicate how satisfied you feel about that aspect of your job.

1	2	3	4	5
VERY DISSATISFIED	DISSATISFIED	NEUTRAL	SATISFIED	VERY SATISFIED

On my present job, this is how I feel about……….

_____ 1. Being able to keep busy all the time.
_____ 2. The chance to work alone on the job.
_____ 3. The chance to do different things from time to time.
_____ 4. The chance to be "somebody" in the community.
_____ 5. The way my boss handles his/her workers.
_____ 6. The competence of my supervisor in making decisions.
_____ 7. Being able to do things that don't go against my conscience.
_____ 8. The way my job provides for steady employment.
_____ 9. The chance to do things for other people.
_____ 10. The chance to tell people what to do.
_____ 11. The chance to do something that makes use of my abilities.
_____ 12. The way company policies are put into practice.
_____ 13. My pay and the amount of work I do.
_____ 14. The chances for advancement on this job.
_____ 15. The freedom to use my own judgment.
_____ 16. The chance to try my own methods of doing the job.

_____ 17. The working conditions.
_____ 18. The way my co-workers get along with each other.
_____ 19. The praise I get for doing a good job.
_____ 20. The feeling of accomplishment I get from the job.

Part D: Perceived Organizational Support
Directions: Using the rating scale below, please mark a number on the blank line before each statement that best describes your feelings to indicate how strongly you agree or disagree with each statement by checking one of the seven alternatives next to each statement.

1	2	3	4	5	6	7
STONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	NEITHER AGREE NOR DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE

_____ 1. The organization values may contribution to its well-being.
_____ 2. If the organization could hire someone to replace me at a lower salary it would do so.
_____ 3. The organization fails to appreciate any extra effort from me.
_____ 4. The organization strongly considers my goals and values.
_____ 5. The organization would ignore any complaint from me.
_____ 6. The organization disregards my best interests when it makes decisions that affect me.
_____ 7. Help is available from the organization when I have a problem.
_____ 8. The organization really cares about my well-being.
_____ 9. Even if I did the best job possible, the organization would fail to notice.
_____ 10. The organization is willing to help me when I need a special favor.
_____ 11. The organization cares about my general satisfaction at work.
_____ 12. If given the opportunity, the organization would take advantage of me.
_____ 13. The organization shows very little concern for me.
_____ 14. The organization cares about my opinions
_____ 15. The organization takes pride in my accomplishment at work.
_____ 16. The organization tries to make my job as interesting as possible.

Part E: Leadership Behavior
Directions: Using the rating scale below, please mark a number on the blank line before each statement that best describes your superior leadership style.

1	2	3	4	5
NOT AT ALL	ONCE IN A WHILE	SOMETIMES	FAIRLY OFTEN	FREQUENTLY

_____ 1. Makes me feel good to be around him/her.
_____ 2. Express with a few simple words what I could and should do.
_____ 3. Enables me to think about problems in new ways.
_____ 4. Helps me to develop myself.
_____ 5. Tells me what I should do if I want to be rewarded for my efforts.
_____ 6. Is satisfied when I meet the agreed-upon standards for good work.
_____ 7. Is content to let me continue doing my job in the same way as always.

_____ 8. I have complete faith in him/her.
_____ 9. Provides appealing images about what I can do.
_____ 10. Has provided me with new ways of looking at things which used to be a puzzle for me.
_____ 11. Has let me know how he/she thinks I am doing.
_____ 12. Provides recognition/rewards when I reach my goals.
_____ 13. As long as things are going all right, he/she does not try to change anything.
_____ 14. Whatever I want to do is OK with him/her.
_____ 15. Makes me proud to be associated with him/her.
_____ 16. Has helped me find meaning in my work.
_____ 17. His/her ideas have forced me to rethink some of my own ideas which I had never questioned before.
_____ 18. Gives personal attention to members who seem neglected.
_____ 19. Calls attention to what others can get for what they accomplish.
_____ 20. Tells me the standards I have to know to carry out my work.
_____ 21. Asks no more of me than what is absolutely essential to get the work done.

Comments