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Selected Predictors of Empowerment Among Nurse Managers

Deborah S. Clarke

SELECTED PREDICTORS OF EMPOWERMENT AMONG NURSE MANAGERS

DISSERTATION

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Deborah S. Clarke

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by

Deborah S. Clarke

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APPROVED BY:

_____

Jessie M. Colin, PhD, RN, FRE, FAAN
Chairperson, Dissertation Committee

_____

Claudette Spalding, PhD, ARNP, CNAA
Member, Dissertation Committee

_____

Edward Bernstein, EdD
Member, Dissertation Committee

_____

Claudette Spalding, PhD, ARNP, CNAA
Chair, Division of Nursing

_____

John McFadden, PhD, CRNA
Interim Dean, College of Health Sciences

Abstract

Background: Extensive healthcare transitions have resulted in a larger span of control for nurse executives, and in a trickle-down effect, nurse managers are susceptible to broader responsibilities. In a role already considered complex, ambiguous, and demanding, work factors less conducive to motivation reduce an individual's perceptions of effectiveness. For managers, reduced perceptions of motivation can threaten the critical link they play in sustaining organizational efficiencies and work environments that foster professional nursing practice and quality outcomes.

Purpose: The purpose of this study was to test four hypotheses that measured the propositions of the Interpretive Model of Intrinsic Motivation to determine whether the selected variables were effective predictors of empowerment among the nurse managers.

Theoretical Framework: The Interpretive Model of Intrinsic Motivation provided the framework and lens to study the nurse manager population.

Methods: A descriptive, predictive design was used to examine the relationships among the study variables: leader-member exchange, participative decision-making, role ambiguity, perceived organizational support, core-self evaluation, and psychological empowerment. Data were analyzed using descriptive, correlation, and multiple regression statistics. The sample consisted of 115 nurse managers employed in hospitals in Southeast Florida.

Results: Four hypotheses were tested for relationships among the variables. Perceived organizational support, leader-member exchange, participative decision-making, and core self-evaluation had a significant positive relationship, while role ambiguity had a

significant negative relationship. Further, examination revealed that leader-member exchange, participative decision-making, role ambiguity, and core self-evaluation collectively contributed to psychological empowerment; perceived organizational support was not significant in the model.

Conclusion: The findings from this study will increase the knowledge regarding those factors that influence empowerment among nurse mangers. As a result, nurse executives and nurse managers will have more insight into the strategies that are likely to positively impact nurse manager empowerment perceptions.

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I thank God for blessing me with the knowledge, strength, perseverance, and faith to journey through this life-altering process. This transformation only occurred in my life because He renewed my mind, encouraged my soul, protected me, and aligned me with those individuals who have contributed to my success.

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DEDICATION

First and foremost, I dedicate this dissertation to God who planted the PhD in my mind and heart as a mustard seed. I dedicate this dissertation to my mother, Joyce Clarke, who tirelessly prayed and probed everyday for a status update about school. Finally, to my other relatives and close friends who provided continuous encouragement, support, and prayers. You each inspired me to throughout this journey that has transformed me personally and professionally. I look forward to closing this chapter and beginning on the new journey that lies ahead with countless opportunities to enhance healthcare.

"…. For everyone to whom much is given, from him much will be required; and to whom much has been committed, of him they will ask the more." Luke 12:48 (KJV)

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

The healthcare industry is experiencing extensive transitions resulting in a turbulent work environment with increased organizational intricacies, instability, and unpredictable events (Anthony et al., 2005). Healthcare focuses are centered on controlling costs, utilization, and securing profits (Tarrant & Sabo, 2010). Though executives remain committed to safeguarding their institutions, continual changes in this sector are evident due to tightened regulatory requirements, decreased reimbursements, and technological advancements. The situation is further challenged with staffing complexities, skilled personnel recruitment and retention, and high patient acuity levels, which make working in the healthcare sector a complex task. Some hospitals have gone out of business, while others have merged to maintain a competitive advantage. Faced with economic challenges, hospitals have streamlined business practices in an attempt to maintain profit margins and market share. As a result, nurses, who represent the largest numbers of employees in healthcare institutions, have recognized changes to their professional practice role.

Economic trends have had a tumultuous effect on financial outcomes, which has caused healthcare executives to revamp organizational strategies to maintain organizational viability (Tarrant & Sabo, 2010). Nurse executives are no longer providing oversight strictly to nursing units; rather, their scope has evolved to include patient care services throughout the continuum of care. Consequently, there have been changes in the depth and breadth of the nurse manager role with less support from busy nurse executives (Shirey, McDaniel, Ebright, Fisher, & Doebbling, 2010; Tulgan, 2007).

Yet, nurse manager leadership is increasingly vital for effective unit functioning, quality care, and retention because the role is central to managing core values, maintaining consistency, and influencing staff nurses towards goal achievement (Anthony et al., 2005). While the significance of the nurse manager role is clearly understood, researchers have continually identified that the expanding role is overwhelming and stressful (Anthony et al., 2005; Laschinger, Purdy, & Almost, 2007; McCallin & Frankson, 2010; Paliadelis, Cruickshank, & Sheridan, 2007; Shirey, Ebright, & McDaniel, 2008; Shirey et al., 2010). Though the nurse manager serves as the liaison between executive leadership and staff nurses, little research has been conducted that examines the factors that influence motivation perceptions within this population. As such, the intrinsic model of motivation was used to guide this study into the examination of selected predictors of empowerment among nurse managers.

Background of the Study

The nurse manager role is considered complex, ambiguous, and demanding (McCallin & Frankson, 2010; Shirey et al., 2008). Researchers consistently identify that nurse managers play a key role in the work environment because their decisions and actions are the foundation for building and sustaining safe and healthy workplaces (Shirey et al., 2010). Managers shape the professional practice environment with a notable impact on satisfaction, retention, patient outcomes, and organizational performance (Sherman & Pross, 2010; Shirey, 2009). However, nurse managers face an uphill battle in tackling organizational expectations geared towards performance-driven initiatives coupled with the responsibility for safe patient care (McLarty & McCartney, 2009).

Nurses who have been clinical experts are often top choices for vacant managerial positions, and with limited training, they are confronted with complicated operational challenges (DeCampli, Kirby, & Baldwin, 2010; McLarty & McCartney, 2009). The role challenges manifest into conflicting demands related to budgets, patient acuity, nursing shortages, staff development, quality patient care delivery, and organizational pressures. Even experienced nurse managers have difficulty balancing the overwhelming workload. Managers generally have unclear role definitions due to fluctuating business priorities, leading to an inability to identify with organizational initiatives.

Today's healthcare environment continues to increase in complexity and uncertainty with organizations described as stressful and fast paced. Currently, the business sector calls for knowledge, ideas, energy, and creativity from each and every employee, from frontline workers to the top-level managers in the executive suite. The best organizations achieve success through empowering employees to take initiative to serve the organization's interests without feeling micro-managed (O'Toole & Lawler, 2006). The barometer for organizational success may be centered on promoting employee effectiveness, through enhancing perceptions of empowerment.

Healthcare organizations are pressured to improve performance and be competitive. As a result, empowerment has generated substantial research in the business sector, particularly in environments where stress and change are considered as constants. As such, empowerment has become an important concept when the goal is improving performance within chaotic work environments (Spreitzer, 1995). Empowered

employees tend to feel that the job requirements align with their own belief and values, which results in the job having greater personal meaning (Spreitzer, 1996).

Researchers have found that empowerment has been effective in neutralizing stressful work conditions (Kanter, 1993; Spreitzer & Doneson, 2007). Similarly, nurse managers have identified that stress is related to workplace complexities and perceptions that the work environment lacked empowering structures (Shirey et al., 2008). This information is useful because nurse managers are a key aspect in connecting the organization's vision and strategic plan with unit-level clinical practices, which might be a challenge in stressful situations (Sherman, Bishop, Eggenberger, & Karden, 2007). Furthermore, due to their proximity with staff nurses, managers are best poised to model positive behaviors that impact the organization's performance and patient outcomes.

In a healthcare arena exacerbated by a nursing shortage and growing expectations to provide excellent patient care, strategies to improve nursing retention and patient quality are paramount (Anthony et al., 2005). Healthy work environments have been noted as the best action to support retention and quality outcomes. In a recent study, nurses identified reasons for departing from the profession was related to burnout, stressful work environments, and poor management (USDHHS, 2010). The researchers reported that there are growing numbers of managers who will reach retirement age within three to five years. Findings also noted that between 2004 and 2008, nurses in management positions decreased from 14.6% to 12.5%. Parsons and Stonestreet (2003) identified that successful nurse manager retention strategies included relationship building, participative decision-making, empowering managers in their role, developing

supportive resources, supporting life-work balances, recognizing quality of care in nursing units, and rewarding nurse manager retention. According to Elele and Fields (2010), employees that are able to engage in organizational decision-making perform better at work and were more committed to the organization through providing a greater sense of purpose in relation to organizational outcomes.

Empowerment research within the nursing discipline has been focused on staff nurses who provide direct patient care. Ironically, researchers continue to identify the nurse manager as pivotal to making decisions that maintain a healthy and safe work environment and modeling positive behaviors. Yet, research studies have not been performed to investigate those factors that contribute to managers' empowerment level, in as much as the motivation for achieving organizational goals and performance expectations.

Problem Statement

Nurse executives have larger span of control, and in a trickle-down effect, nurse managers are saddled with broader responsibilities and fewer resources, leaving them challenged to balance an overwhelming performance-driven workload. The combination of a stressful work environment, limited support, misaligned experiences, inadequate role preparation, and a position sandwiched in the hierarchical structure compounds the nurse manager's ability to effectively manage competing clinical and administrative priorities, thereby fostering low morale (DeCampli et al., 2010; McLarty & McCartney, 2009; Shirey et al., 2010). As such, work factors less conducive to motivation reduce an individual's perceptions of effectiveness (Laschinger et al., 2007; Wallach & Mueller,

2006). Decreased motivation perceptions among nurse managers threaten the critical link managers play in sustaining organizational efficiencies and work environments that foster professional nursing practice and quality outcomes.

Purpose of the Study

The purpose of the study was to use a descriptive, predictive design to test four hypotheses that measure the propositions of Thomas and Velthouse's (1990) model of intrinsic motivation to determine whether selected variables are effective predictors of psychological empowerment among the sample of nurse managers. The predictor (independent) variables that were utilized in the study included leader-member exchange, participative decision-making, role ambiguity, perceived organizational support, and core-self evaluation. The criterion (dependent) variable for the study was psychological empowerment.

Research Question and Hypotheses

Based on the interpretive intrinsic motivation model and the review of the literature, four research questions emerged that guided this study. Herein they are described, and the corresponding hypotheses that were used are listed.

Research Question and Hypothesis 1

Question. Is there a significant positive relationship between contextual factors (perceived organizational support, leader-member exchange, participative decision-making) on psychological empowerment among nurse mangers?

Hypothesis. There will be a significant positive relationship between contextual factors (perceived organizational support, leader-member exchange, participative decision-making) on psychological empowerment among nurse managers.

Research Question and Hypothesis 2

Question. Is there a significant positive relationship between the individual characteristic (core self-evaluations) and psychological empowerment among nurse managers?

Hypothesis. There will be a significant positive relationship between the individual characteristic (core self-evaluation) and psychological empowerment among nurse managers.

Research Question and Hypothesis 3

Question. Is there a significant negative relationship between contextual factor (role ambiguity) and psychological empowerment among nurse mangers?

Hypothesis. There will be a significant negative relationship between contextual factor (role ambiguity) and psychological empowerment among nurse managers.

Research Question and Hypothesis 4

Question. Is there a unique or combined significant effect among contextual factors (perceived organizational support, leader member exchange, participative decision-making, role ambiguity) and individual characteristic (core-self evaluation) on psychological empowerment among nurse managers?

Hypothesis. There will be a unique or combined significant effect on four contextual factors (perceived organizational support, leader member exchange,

participative decision-making, role ambiguity) and one individual characteristic (core self-evaluation) on psychological empowerment among nurse managers.

Theoretical Framework

The study was based on the theoretical framework of intrinsic motivation that was developed in 1990 by Thomas and Velthouse. Empowerment began to emerge over the last two decades in the organizational sciences with roots in management and organizational sciences, psychology, and sociology. As foreign competition entered the market, there was a need for management that encouraged commitment, risk-taking, and innovation (Kanter, 1979). Subsequently in the 1980s, the concept of empowerment became a growing interest within the management sector because of the conceptual link to organizational effectiveness (Conger & Kanungo, 1988; Kanter, 1979). Up until this time, empowerment had been viewed as a managerial practice that was equated to sharing or delegating power with no further explanation. Social scientists used the concept in issues of powerlessness within minority groups to level the playing field for the disadvantaged.

In the early stages, empowerment was widely used with no agreed-upon definition, and minimal attention was focused on understanding the nature and underlying processes associated with empowerment (Conger & Kanungo, 1988; Thomas & Velthouse, 1990). As a result, Conger and Kanungo (1988) realized the gap in the management theories that interpreted empowerment too narrowly, and they sought to clarify the concept and demonstrate the relevance to management theory and practice. The authors questioned whether empowerment defined through sharing power provided

wholesome answers for understanding the concept and further argued if delegating and sharing resources always induced empowerment among subordinates. Today, empowerment continues to be an important concept because of the notion that there is a possibility to influence outcomes that benefit both the individual and the organization (Liden & Tewksbury, 1995).

Conger and Kanungo (1988) were the first to identify empowerment as motivational process and defined the concept as a process that enhances self-efficacy through identifying conditions that foster powerlessness. Strategies were then initiated that aimed at removing both formal organizational practices and informal techniques of providing efficacy information (Conger & Kanungo, 1988). In 1990, Thomas and Velthouse expanded Conger and Kanungo's (1988) work with the development of a theoretical framework articulating empowerment as intrinsic task motivation. Both authors sought to build a more complex cognitive model. Thomas and Velthouse (1990) argued that their work improved on Conger and Kanungo's body of work in the following ways: 1) the type of motivation was identified and noted as being from an intrinsic source, 2) an inclusive set of terms were recognized to represent the essence of intrinsic motivation through four psychological states, and 3) an interpretive process was outlined to better understand what influences personal thoughts and decisions.

These authors emphasized that empowerment could not be defined as a single dimension; rather, they described empowerment as multi-dimensional (Thomas & Velthouse, 1990). Empowerment was defined as a series of states that were influenced by the work environment and served to create active feelings and responses towards an

individual's job (Spreitzer, 2007; Thomas & Velthouse, 1990). Thomas and Velthouse (1990) stressed that there are four states that comprise psychological empowerment: impact, competence, meaningfulness, and choice. Impact is performance driven to the degree in which behavior makes a difference in accomplishing a task and produces an intended effect in the work environment. Meaningfulness is an anticipated outcome and is the value placed on the purpose of the task, judged in relation to the individual's own ideas or standards and involves intrinsic caring. Choice represents a perceived opportunity and is the casual responsibility for one's actions. Competency is an effort-performance expectancy and is the degree to which a person can perform task activities skillfully. Using Thomas and Velthouse's work as a theoretical foundation, Spreitzer (1995) developed a four-dimensional instrument that continues to serve as a valid and reliable tool that measures the four psychological states: meaningfulness, impact, competence, and choice.

In Spreitzer's quest to capture the essence of empowerment, she condensed the interdisciplinary literature on empowerment that stemmed from psychology, sociology, social work, and education (Spreitzer, 1995; Spreitzer, Kizolos, & Nason, 1997). Wide support was found for the four dimensions across the literature, and as a result, meaningfulness was renamed as meaning, and choice was replaced with self-determination. However, the essence of the meanings remained the same with the four dimensions combined to create an overall psychological empowerment measure, an active process that occurs when individuals feel they have the ability to shape their work role (Spreitzer, 1995). If one dimension is missing, then the experience of empowerment will

be limited. So, when an individual has the ability to make decisions due to self-determination but does not care about the kinds of decisions he or she can make because they lack a sense of meaning, he or she will feel less empowered. When an individual believes he or she can make an impact but does not feel he or she has the skills due to a lack of competence, he or she will feel less empowered.

Psychological empowerment is intrinsic motivation that develops along a continuous cycle, which involves perceptions influenced by external factors that surround individuals (Liden, Wayne, & Sparrowe, 2000). Intrinsic motivation involves positively valued experiences that individuals result from a task (Thomas & Velthouse, 1990). Tasks are assigned or chosen work activities directed toward a purpose. Individual assessments and interpretation regarding tasks act as a catalyst for producing intrinsic motivation. During the course of an activity, the four psychological states act as intrinsic reinforcement by energizing and sustaining individual behavior. Formal interventions and/or complementary processes in the work environment that increase intrinsic task motivation influence changes in psychological states. Thomas and Velthouse (1990) argued that empowerment not only follows from individuals' assessments of their work tasks but also depends on contextual factors, such as "inputs from superiors, staff, peers, and subordinates" (p. 671). Inputs are essentially feedback that is interpreted and aligned with an individual's recent experiences.

Thomas and Velthouse (1990) suggested that feedback from superiors, staff, peers, and subordinates could be realized through leadership, delegation, job design, and reward systems. Though the list is not exhaustive, the examples of contextual factors are

likely to influence intrinsic motivation based on both authors' theoretical assertions. Contextual factors are variables that serve as interventions that represent the likelihood that individuals will alter their interpretations and redefine empowerment perceptions. Since Thomas and Velthouse's theoretical development on intrinsic motivation, many authors have conducted research that supported that there are variables that correlated with empowerment (Aryee & Chen, 2006; Elele & Fields, 2010; Spreitzer, 1996; Wagner et al., 2010). Antecedents and consequences of empowerment continue to be widely researched (Spretizer, 2007; Seibert, Wang, & Courtright, 2011), and as a result, managerial practices that elicit high-performance outcomes, socio-political support, leadership, and work design characteristics are supported in the literature as antecedents of psychological empowerment. The degree to which a variable influences the four constructs, meaning, competence, self-determination and impact, will determine the extent of psychological empowerment perceptions.

Inasmuch as contextual variables influence empowerment perceptions, Thomas and Velthouse (1990) placed specific emphasis on individual differences as a significant influence on the subjective task assessments that make up empowerment perceptions. Spreitzer (2007) also took an explicitly interactional perspective when she defined psychological empowerment as the way individuals see themselves in relation to their task environment. According to this view, both individual characteristics and contextual variables, especially those reflecting one's self-concept, should be considered as antecedents to perceptions of empowerment (Seibert et al., 2011). Researchers have argued that personal dispositional traits influence how people interpret and respond to

their work environments (Judge, Erez, Bono, & Thoresen, 2003). Dispositional traits serve to influence the types of tasks an employee seeks out and therefore may result in positive emotions and subjective well-being. As a result, these positive feelings may serve to influence subjective task assessments that are represented in psychological empowerment perceptions (Thomas & Velthouse, 1990).

Relationship of Theoretical Framework to the Study

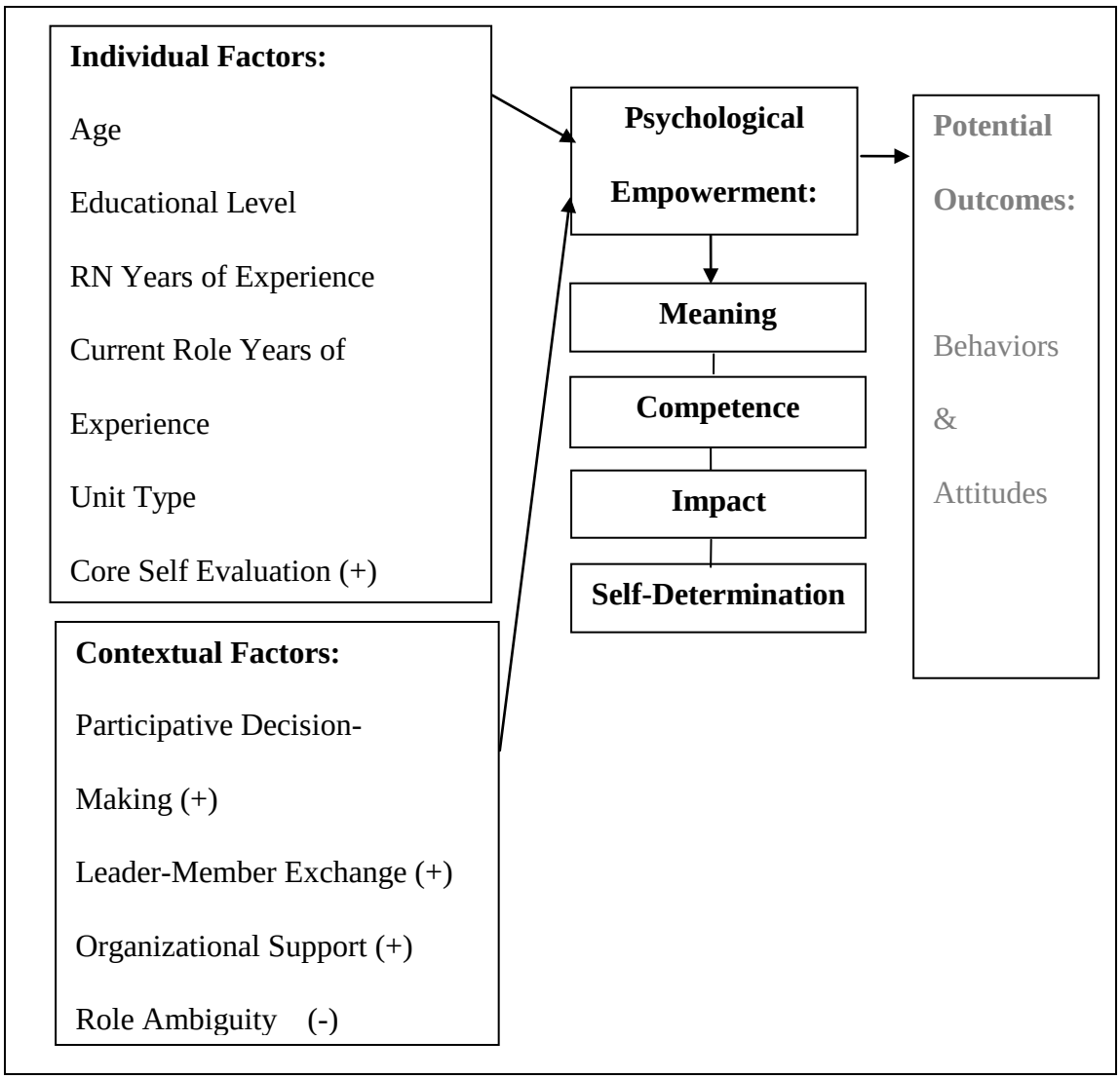

Figure 1. Thomas and Velthouse's model of intrinsic motivation adapted by Clarke (2012) to depict selected predictors of psychological empowerment among nurse managers.

A key component for this study was that the theoretical foundation provided the

understanding for how empowerment perceptions are influenced, thereby increasing intrinsic motivation. Psychological empowerment is the extent to which individuals believe in their capacity to perform work tasks with skill, execute choices that matter, influence administrative outcomes, and derive meaning from their work (Thomas & Velthouse, 1990; Spreitzer, 1995). Thomas and Velthouse (1990) suggested while an individual's personal traits can influence the four psychological states towards a task, deliberate attempts can also be introduced to increase task; therefore, both can shape psychological empowerment perceptions.

Figure 1 was a model adapted from Thomas and Velthouse's (1990) model of intrinsic motivation that depicts the proposed relationship among selected predictors in relation to nurse manger's psychological empowerment. Thomas and Velthouse's (1990) theoretical model of intrinsic motivation has been widely used as a framework in predicting the process in which individual characteristics and events known as contextual factors influence a person's psychological empowerment level. As such, this framework has been used in numerous studies relating antecedents and consequences for psychological empowerment. The selected predictors are core self-evaluations, participative decision-making, leader member relationship, organizational support, and role ambiguity. Each variable has been researched in relation to psychological empowerment and found to have influence on the phenomenon of interest. The model provides further understanding about whether the impact between the selected predictor and empowerment will be positive or negative. As nurse mangers interact within the organization, they will likely have perceptions about the selected predictors, and a

relationship may be seen on their overall psychological empowerment level. The degree to which each predictor affects the four constructs of psychological empowerment, meaning, competence, impact, and self-determination will determine the nurse mangers' overall psychological empowerment perception.

Despite not being tested in the current research study, outcome behaviors and attitudes are included in the model because research has been conducted that supports psychological empowerment acts as a mediator. Innovative behaviors, job satisfaction, organizational commitment, trust, low burnout, and work effectiveness have been researched as an outcome of psychological empowerment (Faulkner & Laschinger, 2008; Knol & van Linge, 2008; Spretizer, 1995; Wagner et al., 2010).

Definition of Key Terms

The following terms are defined as they were used in the study.

Psychological Empowerment

Theoretical Definition. Psychological empowerment is defined as a set of psychological states that are necessary for an individual to feel a sense of work control in relation to their work (Spreitzer, 1996; Spreitzer, 2007).

Operational Definition. Psychological empowerment was measured by the Psychological Empowerment Scale developed by Spreitzer (1995, 1996). The instrument consists of 12 items with answers that are measured on a 6-point Likert scale with one being *strongly disagree* and six being *strongly agree*. Once calculated, the final scores range from one to six, with higher scores illustrating that an individual has greater

psychological empowerment perceptions and lower scores indicating less psychological empowerment perceptions.

Perceived Organizational Support

Theoretical Definition. Perceived organizational support is defined as an employee's overall perception for the extent to which an organization cares about the employee's well-being and recognizes the employee's organizational contributions (Eisenberger, Huntington, Hutchinson, & Sowa, 1986).

Operational Definition. Perceived organizational support was measured by the Survey of Perceived Organizational Support (Eisenberger et al., 1986). The instrument consists of eight items with answers that are measured on a six-point Likert scale with one being *strongly disagree* and six being *strongly agree*. Once calculated the final scores range from one to six, with higher scores reflecting a positive overall belief concerning the degree to which an employee believes an organization values their contributions and cares about their well-being, while lower scores reflect a negative belief about the degree to which an employee believes an organization values their contributions and cares about their well-being.

Leader Member Exchange

Theoretical Definition. Leader member exchange is defined as the quality of relationship between an employee and his or her supervisor (Liden & Maslyn, 1998).

Operational Definition. Quality leader member relationships was measured by a Leader-Member Exchange Multidimensional instrument (Liden & Maslyn, 1998). The instrument consists of 12 items with answers that are measured on a 6-point Likert scale

with one being *strongly disagree* and six being *strongly agree*. Once calculated, the final scores range from one to six, with higher scores reflecting a positive overall belief that a subordinate experiences quality relationships with their superior and lower scores indicating a subordinate experiences lower quality relationship with their superior.

Role Ambiguity

Theoretical Definition. Role ambiguity occurs when an individual perceives that there is ambiguous communication regarding expectations, relationships, and responsibilities (Rizzo, House, & Lirtzman, 1970).

Operational Definition. Role ambiguity was measured by the Role Ambiguity Scale (Rizzo et al., 1990). The instrument consists of six items with answers that are measured on a six-point Likert scale with one being *strongly disagree* and six being *strongly agree*. Once calculated, the final scores range from one to six, with higher scores reflecting a participant perceives greater role ambiguity and lower scores indicating lower role ambiguity perceptions.

Participative Decision-Making

Theoretical Definition. Participative decision-making is defined as joint decision-making between hierarchical superiors and subordinates (Siegel & Ruh, 1973).

Operational Definition. Participative decision-making was measured by Siegel and Ruh's (1973) participation survey. The instrument consists of five items that are measured on a 6-point Likert scale with one being *strongly disagree* and six being *strongly agree*. Once calculated, the final scores range from one to six, with higher scores reflecting that an employee perceives there are more opportunities for joint decision-

making with their superior regarding circumstance that affect the job, while low scores reflecting that an employee has less opportunity for joint decision-making opportunities with a superior regarding items that affect the job (Seigel & Ruh, 1973).

Core Self Evaluation

Theoretical Definition. Core self-evaluation is defined as a broad personality concept that comprises an individual's worthiness, effectiveness, and capability (Judge et al., 2003).

Operational Definition. Core self-evaluation was measured by the Core Self E scale (Judge et al., 2003). The instrument consists of 12 items with answers that are measured on a 6-point Likert scale with 1 being *strongly disagree* and 6 being *strongly agree*. Once calculated, the final scores range from one to six, with higher scores reflecting that a participant experiences higher core-self evaluation perceptions and lower scores indicating lower core-self evaluation perceptions.

Assumptions

Assumptions of this study included that the instruments selected were valid and reliable as referenced in research studies that supported the specific instrument validity and reliability. Instruments used measured the intended construct. In addition, participants were expected to respond in a truthful manner and that the convenience sample of participants is representative of the general population of nurse managers. The intrinsic model of motivation as a framework for this research study is supported through the use of empirical studies.

Philosophical assumptions are principles that support the phenomenon of interest and provide guidelines for using the theoretical model. First, intrinsic motivation involves positively valued experiences that originate as individuals perform workplace tasks (Thomas & Velthouse, 1990). Intrinsic motivation refers directly to tasks that act as a stimulus producing enthusiasm and satisfaction. Four psychological states form subjective perceptions based on an individual's assessment of either given or chosen workplace tasks (Spreitzer, 1995; Thomas & Velthouse, 1990). Empowerment is not a lasting personality trait generalizable across every situation; rather, this concept is a set of four perceptions shaped through transactions in the work environment. These perceptions reflect the ongoing movement of individual interpretations that are specific to the work domain. As such, empowerment is a continuous variable; indivduals are either less or more empowered, rather than empowered or not empowered (Thomas & Velthouse, 1990).

Significance of the Study

Research studies have not been performed to investigate those factors that influence a manager's empowerment level, inasmuch as the motivation for achieving organizational goals and performance expectations. Considering the significant changes in healthcare, the subsequent changes in the nurse management role, and the significance of nursing leadership at this critical juncture, it was important to examine the selected predictors of psychological empowerment among nurse managers.

Nurse managers are pivotal to creating a healthy work environment that influence nursing practice, retention, quality outcomes, and organizational effectiveness. Thereby,

examining psychological empowerment may help determine what influences the nurse manager empowerment perceptions providing them ownership of their role and perhaps greater initiative towards meeting organizational initiatives and quality patient outcomes. Aspects of nursing that could potentially be impacted by the research findings were education, practice, research, and policy.

Implications for Nursing Education

Nurse educators play a significant role in the education of future nurses. It is important to begin identifying strategies that can be used to assist novice and experienced nurses in understanding the nurse manager role. In the hospital, findings can be applied to organizational development to provide educational programs for staff nurses to strengthen their understanding of leadership and the work environment. Hospital educators can assist nurse managers by providing education that will help them to better understand and implement their role. Nursing faculty can include strategies to increase nurse manager's comfort level in engaging in leadership activities and developing empowering skills. Nursing academia can integrate evidenced-based practices and strategies in leadership development and continuing education programs. The results of this study may expand the current educational platform in academia and within hospitals to prepare nurses for their role and develop ongoing programs for the nurse manager role.

Implications for Nursing Practice

Many strategies have been proposed to improve nurses' control over their practice. Institutions that do not provide an organizational climate that develops, engages, and empowers nurse managers may find a revolving door within the institution

at different staff levels (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Shirey et al., 2008). The results of this study will provide nurse executives with a greater understanding of nurse managers' perceptions regarding quality leader member relationships, participative decision-making, perceived organizational support, role ambiguity, and empowerment. Nurse executives can explore the work factors that impact professional success and organizational effectiveness and integrate strategies in initial orientation and ongoing leadership development. Strategies may be developed to increase the nurse managers' comfort level in engaging in activities and developing skills that enhance empowerment. Findings can serve as a platform for implementing strategies for creating a healthy work environment that foster nurse managers practicing with a purpose towards increasing their motivation to succeed and reach organizational performance measures. Nurse managers who are empowered may showcase innovative behaviors and develop strategies to combat the complex healthcare arena experiences.

These findings may represent a trickle-down effect in that nurse managers who review the results might have greater value for behaviors necessary to be role-modeled that will affect the performance of nursing staff and support quality patient outcomes. Exploration into the nurse manager experience might lead to a work environment in which satisfied nurse managers represent a powerful tool used to attract potential leaders within the organization. For staff nurses who perceive the nurse manager role as positive, they may consider taking on the role in the future with adequate preparation. Managers may also benefit from a work environment conducive to meeting the myriad of work

demands, which might lead to increased personal satisfaction and positive behaviors reciprocated with staff members.

Implications for Nursing Research

Nurse managers have been identified as the management professional closest to the unit level to impact patient-sensitive and organizational outcomes (Sherman & Pross, 2010; Shirey et al., 2008). Nurse managers often experience being pulled in opposing directions but attempt to juggle multiple responsibilities to transform organizational initiatives into tangible performance-driven measures (Bradley, Maddox, & Spears; 2008; Krebs, Madigan, Tullai-McGuiness, 2008). The results can provide researchers with a foundation to build on nurse manager perceptions of organizational support, the degree of quality relationships with leaders, participative decision-making, role ambiguity, and empowerment. These findings provide a baseline to examine how managers can be developed, supported, and feel empowered in their roles. Additional qualitative and quantitative research studies can be conducted to further the findings in the study and develop strategies that are applicable to the nurse manager population through use of longitudinal, experimental, or grounded theory designs. Findings can provide more support for a theoretical model that could be used as the basis for future research. Research is an integral part of nursing science and the vehicle through which questions are answered that promotes increased professionalism, gratification, and effectiveness. The results of the study can strengthen the theoretical foundation towards understanding the predictors of empowerment among nurse managers based on current work experiences.

Implications for Nursing Health/Public Policy

Professional nursing practice, retention, quality care delivery, and patient outcomes are influenced by local, state, national, and international policies. Hospital quality indicators are benchmarked, tracked, and trended, making research findings that can be positively correlated with patient outcomes and interest for communities and local and state governments. These findings provide insight and examination into how healthcare environments are shaped and regulated through public policy by reimbursement practices and regulatory guidelines. Should research findings support the value in the nurse manager role, perhaps action may be taken by nursing boards, organizations, and committees to develop policies that support the competency, development, and practice ensuring the role is supported within the profession and healthcare organizations.

Scope and Limitations

The scope of the study was centered on an intrinsic motivation theoretical model that provides an ability to investigate the variables that influence psychological empowerment among employees in the workplace. As such, this study explored the relationships among selected predictor variables and psychological empowerment perceptions among nurse managers in acute care hospitals.

The study consisted of a convenience sample of individuals who identified themselves as nurse managers and volunteered to participate. The study was conducted in Southeast Florida. As a result, participants may not represent the population of all nurse managers, limiting the generalizability of the results to all nurse managers. Another potential limitation is that since the data will be self-reported, some participants may have

been compelled to answer questions in ways they feel they should answer. Additionally, cross-sectional designs are limited because the results are retrieved in a single time period and reflect perceptions of that time period only. Furthermore, sampling bias can occur due to convenience sampling methods. General limitations for survey methodology include low response rates and whether the participants are representative of the population (Gay, Mills, & Airaisan, 2009). The response rate was evaluated at the end of the survey to determine whether the statistical analysis was compromised of a low response rate.

Threats to External and Internal Validity

Uncontrolled extraneous variables that affect performance on the dependent variable are considered threats to the validity of research results (Gay et al., 2009). Findings are valid when the results obtained are due only to the manipulated independent variable and if they are generalizable to individuals or circumstances beyond the experimental setting. External validity is the level to which study results are applicable to groups and environments outside the chosen setting. Internal validity is the degree to which observed differences on the dependent variable are a direct result of manipulation of the independent variable, rather than some other variable (Gay et al., 2009).

Threats to External Validity

The fact that the participants were from a convenience sample may create sampling bias and limit generalizability of the results. As participants were from one geographic location, the results may further limit the ability to generalize the results from which the sample will be drawn to other populations.

Threats to Internal Validity

Self-report measures can be a threat to internal validity as participants may not provide honest assessments of their behavior. Participants may feel compelled to answer in ways they think the researcher would like or in ways that are perceived politically correct and socially appropriate. Therefore, the answers may not represent the participants' true feelings. Efforts to reduce the threat to internal validity included encouraging participants to answer surveys honestly by reinforcing the fact that their responses will be anonymous. The survey content avoided vague or ambiguous language and use instruments with demonstrated validity.

Chapter Summary

The chapter outlined the challenges of the nurse manager work experience, particularly being pulled in opposing directions and juggling multiple responsibilities to manage organizational initiatives. Managers are expected to cultivate healthy work environments and develop meaning relationship with nurses providing quality patient outcomes. As a result, the study examined the nurse managers' work experience, specifically investigating the variables that influence empowerment perceptions. The Interpretive Model of Intrinsic Motivation was the theoretical framework that was used as the basis of the study.

CHAPTER TWO

LITERATURE REVIEW

The purpose of the study was to use a descriptive, predictive design to test four hypotheses that measure the propositions of Thomas & Velthouse's (1990) Model of Intrinsic Motivation to determine whether selected variables are effective predictors of psychological empowerment among the sample of nurse managers. The predictor (independent) variables that were utilized in the study include leader-member exchange, participative decision-making, role ambiguity, perceived organizational support, and core-self evaluation. The criterion (dependent) variable for the study was psychological empowerment.

Review and Critique of Literature

The study explored selected predictors of empowerment among nurse managers. In order to gain information about the nurse manager experiences and psychological empowerment, a literature review was conducted by subject and discipline. Electronic databases were searched in the fields of nursing, psychology, and sociology. The following databases were searched for relevant information: CINHAL Plus, Books@ OVID, ProQuest Nursing & Allied Health Source, Blackwell Medicine Collection, Medline in PubMed, Medline (on EBSCO), PsychINFO, and Sage Premier E Journal Collection. Literature was found in the fields of nursing, management and organizational sciences, sociology, and psychology. References were refined by the English language, full text collections. The length of time articles was retrieved over was extended from 5 years to the last 10 years due to the limited number of articles available on the topic

within the 5-year period. As such, articles were retrieved, and thus, priority was given to studies that were produced in the last 10 years, which were likely to contain current information and would be significant in their contributions to the framework for this study. Manual searches were conducted from reference lists of appropriate articles. Primary search terms included nurse manager, empowerment, psychological empowerment, nurse, stress, role, antecedents, consequences, predictors, and job characteristics.

The literature review result yielded one published study that explored psychological empowerment in the nurse manager population. The remaining articles were based on a combination of searches that resulted in less than 30 published works, which included both qualitative and quantitative studies. Research articles on the nurse managers' experience were qualitative descriptive studies. The studies on empowerment were conducted using mainly quantitative methods and generally correlational or predictive designs. Research articles on the selected variables included both qualitative and quantitative methods. The following review is a sample of the articles retrieved in the original search and is divided into five categories: nurse manager experiences, perceived organizational support, and role ambiguity, participative decision-making and psychological empowerment.

Nurse Manager Experiences

The literature suggests that nurse managers play a significant role in healthcare organizations but struggle in a complex work environment. As such, a focused review was conducted on the managers' experiences and their impact on the work environment.

McCallin and Frankson (2010) conducted a qualitative exploratory study to investigate the experiences of nurse managers (n = 12) in an acute care hospital in New Zealand. Twelve participants, 2 males and 10 females, joined the study. Ages ranged from 40 to 65 years, and the participants had held their current positions between and 10 years. One participant had a master's in nursing; one had a bachelor's in nursing; while the remaining 10 held nursing diplomas. Purposive sampling was used, and data were collected using face-to-face, semi-structured interviews. The data was systematically analyzed using thematic coding for similarities and differences and then arranged into themes. The researchers identified four themes: role ambiguity, business management, deficit, and role overload. Managers identified a lack of role ambiguity, due to a lack of role clarity. Effective management was difficult without sufficient knowledge and business skills, which made meeting work demands difficult. Role overload perceptions were due to multiple demands from various sources. Manager perceptions were that there was never enough time to manage their role expectations. As a result of the findings, the authors argued that nurse manager role is complex and demanding, suggesting training to support leadership development (McCallin & Frankson, 2010).

Shirey et al. (2010) conducted a qualitative descriptive study with a purposive sample of nurse managers (n = 21*)* at three acute care hospitals in the United States. The purpose of the study was to gain insight into the intricacies that were unique to the nurse manager role. A retrospective interview technique was used to gather information. The participants were all female, mostly white (95%), and ranged in age from 37 to 62 years. The participants had 12 to 35 years of experience in nursing and 1.5 to 18 years of

experience as nurse managers. Of the 21 nurse managers, 3 (14%) were in their role less 3 years, and 18 (86%) were in their role for greater than 3 years. Eighteen nurse managers (86%) held a baccalaureate in nursing, and 4 (19%) were master's-prepared (1 nursing, 1 education, 2 businesses). After analyzing the data, the researcher's findings generated three major themes: sources of stress, coping strategies, and health-related outcomes. The managers revealed that being inadequately trained, multiple competing performance driven priorities, an unrealistic work volume, operational inefficiencies, lack of transparency, and limited power contributed to work stress. Stress perceptions were reduced when managers received support, focused on the positive job components, and when work was completed and targets were met. Considerations to resign were the result of lacking support and an inability to have work-life balance. Irritability, anxiety, loss of confidence, high blood pressure, and sleep pattern disturbances were found to be contributors to less productivity and more procrastination. Increases in performance expectations resulted in higher stress perceptions, which made coping more difficult and was felt as potentially harming for the manager and consequently the well being of the work environment. The researchers suggested that to address stress, coping, and complexity, a variety of individual and health system strategies were necessary to enhance the nurse manager engagement and effectiveness (Shirey et al., 2010).

Laschinger, Finegan, and Wilk (2009) conducted a quantitative study to examine the relationship between leader-member quality relationships, structural empowerment, psychological empowerment, and organizational commitment among nurses (n = 3,156) on 217 hospital units in Canada. The average participant was 42 years old, with 17 years

of nursing experience and 11 years in his or her current role. A multistage stratified cluster sampling design was used that consisted of a multilevel model with two sample sizes: the number of units and the average number of nurses per unit. The authors sought to examine the contextual effects of unit leadership on individual nurse outcomes. Personal dispositional qualities were included in the study to determine whether individuals could be influential in determining work attitudes. As such, the instruments used in the study consisted of the Leader Member Exchange Multidimensional measure (LMX-MDM), Conditions for Work Effectiveness II, Psychological Empowerment Scale (PES), Core Self Evaluation Scale (CSES), and Organizational Commitment scale (Laschinger et al., 2009).

Laschinger et al. (2009) used descriptive and inferential statistics to analyze the data. The authors reported that there was a good fit of the hypothesized model to the observed relations in the data (x^2 5 = 31.734, Cumulative Fit Index (CFI = 0.976), Tucker Lewis Index (TLI) =.0922, Root Mean Square Error of Approximation (RMSEA = 0.041). As the researchers predicted, in the individual level part of the model, CSE had a significant positive effect on psychological empowerment (β = .333), which in turn had a significant positive effect on organizational commitment (β = .386). At the unit level, LMX quality had a significant direct effect on structural empowerment (β = .292), which in turn had a significant direct effect on individual-level nurses' psychological empowerment (β = .672) and job commitment (β = .392). Leader member exchange quality also had significantly direct effect (β = .412) and indirect (β = .196) effects on nurse's psychological empowerment and statistically significant direct (β = .437) and

indirect (β = .115) effects on job commitment. Core self evaluation explained 13.4% of the variance in psychological empowerment, while CSE and psychological empowerment explained 15.6% of the variance of organizational commitment. Leader member exchange quality and structural empowerment explained 44.5% of variance in job commitment and 78.3% of the variance in psychological empowerment. As such, the researchers found that the unit level predictors of leader member exchange quality and structural empowerment influenced nurses' psychological empowerment and organizational commitment perceptions (Laschinger et al., 2009).

Laschinger et al. (2009) argued that unit leadership plays a role in creating empowering work conditions that can influence individual nurses' response to the workplace, and ultimately, their commitment to the organization. Another key factor noted in the findings was the importance personal dispositional characteristics have in the nurses' interpretation of the work environment. Therefore, the results suggest that the psychological environment plays a mediating role through which personal beliefs about one's self can influence work attitudes. As such, the authors stressed that leaders who create work environments that empower employees may aid in the current nursing workforce shortage. Secondly, the importance of personal dispositional traits on nurses' interpretation of their work environments suggest that management may want to take employee beliefs about themselves into account when designing work environments (Laschinger et al., 2009).

Laschinger et al. (2007) performed a non-experimental quantitative study via a predictive design with a self-administered questionnaire on managers (n = 141) working

in acute care hospitals in Canada. The purpose of the study was to examine the effect of personal dispositional variables and test nurse managers' perceptions of the leader-member exchange (LMX) with supervisors, empowerment, and satisfaction. Personal dispositional traits were characterized as core self-evaluations and examined to determine if they would influence perceptions of LMX and job satisfaction. Standardized questionnaires were used to measure the variables: Conditions for Work Effectiveness Questionnaire-II, Psychological Empowerment Scale, LMX-MDM, the Core Self Evaluation Scale, and a work satisfaction scale (Laschinger et al., 2007).

Laschinger et al. (2007) conducted descriptive and inferential statistical analysis. Respondents were managers primarily responsible for medical surgical units, followed by critical care, maternal child, psychiatry, and outpatient services. The average age was 50 with 27 years of nursing experience, and 13 years of managerial experience, and 7 years in their current role, with most (42%) prepared at the baccalaureate level. The test of the hypothesized model supported the proposed relationships among the variables with a modification to add two additional paths. As a result, the improved model (x^2 5= 26.14, *df* = 3, CFI = 0.90, IFI = 0.90, RMSEA = 0.23) was found by the researchers to be theoretically defensible and met credible criteria for adequate fit. Leader-member exchange had a positive direct effect on structural empowerment ($\beta = .42$), which in turn had a positive direct effect on psychological empowerment ($\beta = .35$). Core self evaluation had a positive direct effect on job satisfaction ($\beta = .37$), as well as indirect effects through the other variables in the model. Core self evaluation had a significant direct effect on all model variables (range: $\beta = .18$ to .39), which in this study highlighted

the importance of dispositional variables beyond the situational variables. All paths were significant in the hypothesized directions. Laschinger et al. (2007) argued that when managers perceived a positive relationship with their immediate supervisor, they were likely to feel empowered and consequently will experience greater job satisfaction perceptions. Personal disposition variables were found to have strong effects on both the quality of leader relationships and job satisfaction, as well as on managers' perceptions of structural and psychological empowerment. As such, the researchers suggested quality leadership relationships and empowerment might be used to guide improvements to the nurse manager's work environment ensuring an adequate number of skilled leaders to fill critical roles (Laschinger et al., 2007).

Anthony et al. (2005) performed a qualitative study that described nurse manager roles and skills. Data collection was conducted in focus groups divided by educational levels for nurse managers (n=32) in seven acute care hospitals. Nurse managers represented seven acute care hospitals, participated in one of four focus groups. The focus groups were divided as follows: an associate degree or diploma group, two bachelor's degree groups, and one master's degree group. Each focus group had between six to nine mangers that were from four to five hospitals. Nurse managers were mostly female and averaged 45 years of age with nearly 21 years of nursing experience and 8 years experience as a manager. The managers on average of 1.47 units with 30.5 beds, 31.7 registered nurses, and 45.4 total full-time equivalents. Content analysis was used to identify categories, which were further divided into roles. Roles were categorized as professional and administrative with technical, professional, administrative, and fiscal

responsibilities. Key activities identified as part of the nurse manager role involved listening, empowering, conflict resolution, championing nurses, teamwork, communication, and a change agent. Major performance expectations were centered around patient care, patient satisfaction, quality care, and maintaining happiness and morale. Nurse managers recognized their role has a strong impact on retention and the overall work environment. Overall, they felt the scope of responsibilities was overwhelming and unrealistic. Researchers noted that the nurse managers' ability to get their job completed was based on adequate support and resource levels, with support identified as a key component in their effectiveness (Anthony et al., 2005).

The literature reviewed described the nuances regarding the nurse manager role and subsequent experiences. The review of literature revealed strengths, as well as weaknesses. Nurse managers were participants in four out of five studies, and purposive sampling was used in the three qualitative studies, which may have served to limit the transferability of the findings to the population. Qualitative studies represented three of the five studies in which the researchers used a descriptive design providing fruitful details about the depth and breadth of nurse managers' work experience. The research was conducted in Canada, the United States, and New Zealand. Except for one study, the participants were from several hospital and units, which lends credence to having results that may be more representative of the population. The sample sizes ranged (n = 12, n = 21, n = 32; n = 141, n = 3,156, respectively), which were adequate for the research designs. However, the relationships identified had to be viewed with caution, as the findings may not represent those perceptions of the broader nurse manager population.

One qualitative study utilized focus groups, which might have introduced bias as answers provided, were shared in a group setting, and discussions might have been different in one-on-one interviews. Another possible limitation was the range in previous experience that was reported by the nurse manager because the experience of managers with a year or less experience could be vastly different than managers who were in the role longer. However, the findings were consistent in that the nurse manager role is expanding and overwhelming and that managers lacked the support needed to be successful within a stressful work environment. Throughout the research, the authors found that nurse mangers accepted their role responsibility, but there was little evidence of empowerment. The researchers consistently discussed how positive and negative work factors contribute to retention among nurse managers and subsequently can influence nurses to consider careers in nurse management. Based on the findings in the research, the stressful environment coupled with minimal support is apt to result in a nurse manager who feels less empowered due to factors in the workplace and an inability to effectively manage the workload. For this reason, further investigation was necessary into the nurse manager population, particularly as the literature supports that the nurse manager is best positioned to impact the work environment and quality outcomes. Therefore, with the current gap in the literature, this study examined selected predictors of psychological empowerment to gain insight into what factors might prove to be beneficial to nurse managers in this critical role.

Further review of the literature revealed the influence of personal dispositional traits: self-esteem, self-efficacy, locus of control, and emotional stability on an individual's workplace attitudes (Laschinger et al., 2007; Laschinger et al., 2009). Both studies had common limitations in that they were conducted in Canada and used a cross-sectional design, which identifies perceptions that occur in one snapshot, and therefore, results have to be viewed cautiously when inferring causality among the variables to the nurse mangers in the United States. However, each instrument used was valid and reliable and lends credence to the perceptions that were reported.

Two studies examined the influence of personal dispositional traits and LMX (leader member exchange) on psychological empowerment, with one study examining nurse managers and the other with a population of nurses (Laschinger et al., 2007; Laschinger et al., 2009). However, researchers in both studies provided evidence to support the influence of personal dispositional traits and LMX on employee work attitudes and outcomes in both studies. Psychological empowerment was viewed as a mediating variable on nurse mangers' satisfaction perceptions and nurses' organizational commitment perceptions. Both quantitative studies used a structural empowerment theoretical lens, which describes that empowerment is reached through sharing resources, information, and power. However, to date, no studies had examined the contextual factors and dispositional traits that influence empowerment viewed with a psychological empowerment lens and relative to the nurse manager experience. Therefore, including a measure to test whether personal dispositional traits and LMX would influence empowerment perceptions amongst this group is appropriate, particularly since there is no

research that has been used to investigate the unique or combined effects of contextual factors and dispositional determinants on nurse manager's psychological empowerment perceptions. As a result, the findings may have provided a foundation for developing strategies that adequately support the nurse manager role. Therefore, this study aimed to examine personal dispositional traits and leader-member exchange as two variables that will be used to investigate selected predictors of empowerment among nurse managers.

Perceived Organizational Support

Bobbio, Bellan, and Manganelli (2012) conducted a cross-sectional, quantitative study among nurses (n = 273) to examine the impact of empowering leadership style, perceived organizational support, trust in the leader, and trust in the organization on nurses' job burnout in a public Italian hospital. Four valid and reliable instruments were used to measure the study variables. Questionnaires were distributed by a research assistant and returned through sealed ballot boxes placed in various locations within the hospital. The majority of participants were female (70%), with a mean age of 42.30 years and tenure greater than 10 years (72.2%). Among the participants the mean scores were low for perceived organizational support (M = 2.26, SD = 0.78), trust in the organization (M = 2.31, SD = 0.76), and job burnout factors (M = 2.69, SD = 1.04; M = 2.05, SD = 0.74; M = 2.20, SD = 0.85). However, the mean scores for trust in the leader were higher the mean score for trust in the organization, $t(272) = 14.47$, $p < 0.001$. The results suggested that though participants had faith in their leaders, both organizational trust and perceived organizational support perceptions were low. A positive correlation existed between emotional exhaustion and cynicism factors of job burnout (Bobbio et al., 2012).

Bobbio et al. (2012) found that each empowering leadership factor (leading by example, participative decision making, coaching, informing, showing concern/interacting with the team) positively correlated with perceived organizational support (average *r* = .24) and negatively correlated with job burnout emotional exhaustion (average *r* = -.30) and cynicism (average *r* = -.27). The correlation between the empowering leadership factors and trust in the leader (*r* = .75) was higher than the correlation between perceived organizational support and trust in the leader (*r* = .18). The correlation between perceived organizational support and trust in the organization (*r* = .58) was higher than the correlations between the empowering leadership factors and trust in the organization (average *r* = .32). The study revealed that trust in the leader and trust in the organization were key mediating variables that can influence perceptions of leadership style and organizational support. Furthermore, the combination of empowering leadership styles and organizational support was found to lessen nurse burnout. Leadership behaviors and organizational conditions that empower nurses may contribute to attracting and retaining a sustainable workforce. As such, hospital management can consider the link between empowerment and support to combat the daily work challenges in healthcare organizations (Bobbio et al., 2012).

Butts, Vandenberg, DeJoey, Schaffer, and Wilson (2009) quantitatively investigated a model that tested the relationships among high involvement work practices, empowerment, job satisfaction, organizational commitment, job performance, and job stress. A second analysis was performed investigating the effects of perceived organizational support on job satisfaction, organizational commitment, job performance,

and job stress. Data was collected from 21 retail centers that ranged from 40 to 145 employees that were located in the southeastern United States. Employees (n = 1,723) provided usable surveys and represented about 44% of all employees at the surveyed locations. The majority of participants (76%) worked for more than a year, and 75% held non-managerial positions. The median age was 36, 59% were married, 66% males, 79% were Caucasian, and 98% had a least a high school diploma. Valid and reliable instruments were used to obtain perceptions on high involvement work processes, psychological empowerment, perceived organizational support, job satisfaction, organizational commitment, job performance, and job stress (Butts et al., 2009).

Butts et al. (2009) conveyed that empowerment fully mediated the relationship between high involvement work practices and job satisfaction (z = 9.35, p < .01), high involvement work practices and organizational commitment (z = 8.04, p < .01), high involvement work practices and job performance (z = 2.36, p < .05), and high involvement work practice and job stress (z = -.695, p < .01). Scatter plot diagrams were used to show evidence that there were strong positive relationship between empowerment and employee outcomes (organizational commitment, job performance, job stress), when individuals perceived higher organizational support. The findings stressed that both organizations and individuals can benefit from participatory work systems when attention is given formal and informal work characteristics (Butts et al., 2009).

Patrick and Laschinger (2006) conducted a quantitative study in Canada to examine the relationships between structural empowerment, perceived organizational support, and role satisfaction among nurse (n = 84) managers. Managers were randomly

selected and mailed a survey with a reminder letter sent out two weeks after the first mailing. The average of the managers was 49 years, with the majority in the range between 46 and 54 years of age. Sixty percent worked in a community hospital setting; with a mean of 517 beds per hospital. Fifty percent of the managers were responsible for between two and four units, and 52% of the units provided medical-surgical care. Most managers (43%) held a master's degree, 41% had baccalaureate degrees, and 14% of the participants had diplomas. On average, nurse managers had 14 years of management experience, with an average of five years in their current role. The instruments used in the research study included the Conditions of Work Effectiveness Questionnaire-II, Perceived Organizational Support Survey, and the Alienation from Work Scale. Descriptive and inferential statistics were used to analyze the data. Managers reported moderate levels of structural empowerment (M = 21.06. SD = 3.16) in their work environments, which was a result of the access to information that was perceived regarding the organization's future goals. Managers reported a moderate level of organizational support (M = 4.76, SD = 1.03), which was linked to the feelings that their input was valued. On average, nurse managers were somewhat satisfied with their current role (M = 3.62, SD = 0.73). Seventy percent were satisfied with the level of authority in their position and the degree to which they were accepted as professional experts based on their education, experience, and formal position within the organization. Nurse managers were least satisfied with their progress towards achieving chosen goals related to their role in the organization (M = 3.47, SD = 0.76) (Patrick & Laschinger, 2006).

Structural empowerment was positively related to perceived organizational support ($r = 0.654$, $P = 0.0001$) and accounted for 42% of the variance in perceived organizational support (Patrick & Laschinger, 2006). Structural empowerment and perceived organizational support together explained a significant amount of variance in middle managers' role satisfaction ($r = 0.46$, $P = 0.0001$). Empowerment explained 36% of the variance in role satisfaction, and perceived organizational support added 10% to the explained variance. Both structural empowerment ($\beta = 0.32$) and perceived organizational support ($\beta = 0.42$) were significant independent predictors of role satisfaction. Perceived organizational support was strongly related to role satisfaction ($r = 0.63$, $P = 0.0001$). Formal power in the structural empowerment measurement had the strongest positive relationship with perceived organizational support ($r = 0.67$) and increased role satisfaction ($r = 0.54$). The authors suggested that job flexibility, a job central to the organizations' goals, and discretionary decision-making can serve to reflect the value the healthcare facility has for the nurse managers' organizational contribution. Though managers felt they had access to information about growth and learning opportunities, they lacked the sufficient resources to effectively perform in their role. As such, leaders may consider the importance for providing managers' access to organizational goals and knowledge that empowers nurse managers and serves to increase their feelings of control. Therefore, the findings shed light on the importance of empowering work environments and the nurse mangers' perception of organizational support in increasing role satisfaction (Patrick & Laschinger, 2006).

Laschinger, Purdy, Cho, and Almost (2006) performed a quantitative study using a descriptive, correlational survey design among nurse managers (n = 202) in Canadian acute care hospitals. The purpose of the study was to identify antecedents and consequence of nurse mangers' perceptions of organizational support. Antecedents tested were personality and organizational characteristics (job conditions, rewards, autonomy, job security, rewards, salary, and respect), while consequences included attitudes (job satisfaction, organizational commitment), performance (accomplishment, effort, quality of care), and health outcomes (physical symptoms, energy level, emotional exhaustion). A random sample of nurse mangers were selected from a registry list and mailed a survey with a reminder letter and second questionnaire package sent out three weeks later. Self-report standardized measures with reported reliability and validity were used to measure the tested variables (Laschinger et al., 2006).

Laschinger et al. (2006) conducted an analysis with descriptive and inferential statistics. The participants were a majority female (94.6%) that held diplomas (27%), bachelor's degrees (42.5%), and master's degrees (30.5%). The majority worked in a teaching hospital (51.8%) and the remaining (48.2%) in a community hospital. The majority worked on a medical surgical unit (43.4%), with 17.7% in critical care, 15.7% in outpatient clinic, 10.6% in psychiatry, 9.1% in maternal child, and 3.5% in chronic care/rehab. The average participant age was 47.54, with an average of 24.96 years of nursing experience, and 10.43 years of managerial experience. Managers reported moderate levels of perceived organizational support (M = 4.44, SD = 1.09) (Laschinger et al., 2006).

Laschinger et al. (2006) reported that the presence of a Type-A behavior in this population predicted perceived organizational support (r = -0.17 and -0.19, respectively). The organizational characteristics that most strongly correlated to POS were rewards (r = 0.64) and respect (r = 0.64), followed by job security (r = 0.48), autonomy (r = 0.32), and monetary gratification (r = 0.32). Consequences of POS included employee attitudes, performance, and health outcomes. The researchers reported the attitude consequences significantly related to POS were organizational commitment (r = 0.64), job satisfaction (r = 0.40), while performance consequences significantly related to POS were effort (r = 0.40 and nurse-assessed quality of care (r = 0.19). Finally, health outcomes such as physical symptoms (r = -0.26), energy level (r = 0.28), and emotional exhaustion (r = -0.39) were all significantly related to perceived organizational support (Laschinger et al., 2006).

Rhoades and Eisenberger (2002) conducted a review to examine the studies that consider perceived organizational support's antecedents and consequences. Several retrieval strategies were used to identify relevant published and unpublished studies. First, the researchers carried out a computer search of relevant databases beginning with the introduction of POS in 1986. Key search terms used by the authors included perceived organizational support, organizational support, or perceived support in either the title or abstract was searched in a variety of databases. Reference lists of all research projects were also used to provide a larger review of articles. The Survey of Perceived Organizational Support (SPOS) was used on the majority of studies that examined POS; therefore, the use of this instrument was one criterion for the study. Studies that used

SPOS items because they combined the items with other measures of employee attitudes such as employee commitment were excluded. Antecedents or consequences were included as long as at least three studies included the same variable. The final sample size consisted of 73 studies that were examined and found to have 177 assessments as antecedents and 166 assessments as consequences. Once the antecedent and consequence categories were established, each variable was independently coded. The researchers considered effect size, publication bias, homogeneity analyses, moderator analyses, and used path analysis in the review (Rhoades & Eisenberger, 2002).

Antecedents of POS antecedents were described as fair organizational procedures, supervisor support, favorable rewards, and job conditions (Rhoades & Eisenberger, 2002). Consequences were reported to include affective commitment to the organization, positive work attitudes, job satisfaction, increased performance, and reduced withdrawal behaviors. Organizational support provides baseline for understanding how employees determine to what extent an organization values them and cares about their welfare. The authors conveyed employees that perceive organizational often reciprocate towards the organization with increased commitment, loyalty, and performance (Rhoades & Eisenberger, 2002).

One meta-analysis and four empirical studies were reviewed that examined perceived organizational support among nurses, nurse managers, retail professionals, and managers in a variety of settings. The published articles were conducted in Canada, Italy, and the United States. Each author reported use of a cross-sectional design, which limits the generalizability of the findings. An additional limitation was that voluntary samples

can also serve to introduce selection bias. Though a cross-sectional design provides perceptions of one time period, reliable instruments were used in the research that lends support for the results. Findings in each study stressed that perceived organizational support was a consistent predictor of work attitudes and behaviors, which was also supported in the meta-analysis. Therefore, as empowerment can be equated with positive work attitudes, perceived organizational support was considered as a predictor variable in this study.

Butts et al. (2009) argued that that those striving to design and implement healthy work practices should be aware that organizational factors could serve to undermine organizational initiatives or maximize desired results. Caution should be taken to understand that formal attempts to increase empowerment may not be successful without simultaneous attention to informal organizational aspects like perceived organizational support that influence the employer-employee relationship. Another important fact conveyed by the authors was that empowerment can contribute to alleviating job stress and may act as a buffer against the stressful work environment often commonplace in work environments. Similarly, Patrick and Laschinger (2006) found that work conditions have a strong impact on an employee's ability to feel empowered and the likelihood for them to work effectively. Therefore, management may attempt to alleviate employee stress through organizational practices that emulate work practices that maximize employee psychological empowerment (Butts et al., 2009).

Laschinger et al. (2006) suggested that positive perceptions of POS are important recruitment and retention factors for nurse managers. As such, hospital administrators

can consider creating quality work settings for managers to ensure that they remain in the organization effective members of the management team. POS was consistently found to be an important predictor of positive work attitudes and behaviors (Laschinger et al., 2006; Rhoades & Eisenberger, 2002). Researchers have suggested that the link found between empowerment and perceived organizational support may serve to diminish work challenges in healthcare organizations, while serving to increase feeling of control and role satisfaction (Bobbio et al., 2012; Patrick & Laschinger; 2006).

Laschinger et al. (2006) reported that nurse managers felt moderate levels of structural empowerment, due to their perceptions related to organizational support. Most nursing studies on empowerment have been conducted in Canada by H.K.L Laschinger and based on structural empowerment, which provides a macro or organizational perspective. However, this study proposed to examine the phenomenon of interest from an individual perspective. Laschinger et al. (2006) found that when support is lacking, managers became frustrated and dissatisfied with their roles. Since perceived organizational support was found to influence nurse manager perceptions about structural empowerment, the same influence may be realized with psychological empowerment. No studies had been conducted that examine the selected predictors of empowerment among nurse managers. Based on the literature review, perceived organizational support was used as one of the selected predictors in this study, particularly as the results may provide a springboard for more research examining POS on employee outcomes.

Role Ambiguity

Mendes and Stander (2011) performed a quantitative study to examine if leader-empowering behavior positively influenced role clarity, psychological empowerment, and work engagement, with talent retention as the final outcome variable. A survey research design was included a convenience sample (n = 179) from a business unit in a chemical organization. The study population consisted of 60.3% male and 39.7% female. The participants ranged from managers (7.8%), specialists (14.5%), and non-management personnel (76.5%). The ages of the participants ranged from 24 years and younger (16.8%), to 56 years (3.9%), with the majority of participants (47.5%) in the 25-35 age range. Valid and reliable instruments to measure empowering behaviors, role clarity, role ambiguity, psychological empowerment, work engagement, and intention to leave were used to examine the variables in the study. The multiple regression analysis showed that leader empowering behavior, role clarity, and psychological empowerment predicted a large percentage of the variance in engagement. More specifically, leader-empowering behavior, role clarity, and psychological empowerment explained 43% of the variance in vigor, 61% of the variance in dedication, and 38% of the variance in absorption. As such, the authors suggested that a leader's behavior may be related to employee's experiences in the work environment, which was explained by the statistically significant relationship found between leader-empowering behavior, role clarity, psychological empowerment, work engagement, and intention to leave. The research findings are beneficial in highlighting the importance of employee development and empowerment in creating a positive organization, resulting in the likelihood of employee retention. The researchers

argued that organizations that aspired to be market leaders may want to recognize the importance of focusing on overall wellness for both the organization and employees in support of a healthy organization (Mendes & Stander, 2011).

Tarrant and Sabo (2010) performed a quantitative study using a cross-sectional design to explore the level of role conflict, role ambiguity, job satisfaction, and depression among nurse executives (n = 380) that were members of the Association of Nurse Executives. Questionnaires were completed online via Survey Monkey. Established instruments used in the study included: The Role Ambiguity Scale, Job Satisfaction Index, and the Center for Epidemiological Studies Depression Scale. Descriptive statistics were used for demographic analysis with inferential statistics to analyze correlations. The majority of participants were female (92.9%), were between 45-54 years old (38.2%), had greater than 25 years of nursing experience (73.2%), between 16-20 years of management experience, and had a master's nursing degree (71.8%). Nurse executives reported a moderate amount of role conflict (M = 3.04, sd = 0.71) and moderate role ambiguity (M = 2.91; sd = 0.79) levels. Job satisfaction scores were high (M = 4.01; sd = 0.65) and low levels of depression (M = 7.42; sd = 7.67). The nurse executives studied were well-educated, had a great deal of experience, and operated in a complex and evolving environment with moderately low stress. As a result, the argument can be made that the study provided a limited view and future studies could aim to explore more dimensions of the nurse executives (Tarrant & Sabo, 2009).

Tunc and Kutanis (2009) performed a study that explored the relationship between burnout, role conflict, and role ambiguity among health care professionals (n = 170

physicians; n = 81 nurses) in a university hospital in Turkey. Surveys were distributed to all nurses and physicians, and the completed surveys were collected the following day with a 98% response rate. Data was collected on demographic variables and the following instruments: Maslach's Burnout Inventory and Rizzo's Role Conflict/Role Ambiguity Scales. The professionals who worked 8 hours a day had less emotional exhaustion (F = 10.83, P = 0.000), but higher levels of burnout in the subscale of low personal accomplishment (F = 4.79, P = 0.009) compared to the participants who worked 9-16 hours per day (Tunc & Kutanis, 2009).

The linear progression showed that role conflict and role ambiguity (0.31-0.45, P < 0.01; 0.20-0.23, P < 0.01) were associated with the burnout variable (Tunc & Kutanis, 2009). Compared to physicians, the nurses reported higher burnout levels, role conflict, and role ambiguity. In Turkey, as nursing is a female profession, the nurses in the study were all female. As such, the researchers compared burnout among female physicians (n = 66) and the nurses. Nurses (n = 81) showed significantly higher levels of burnout in the subscales of emotional exhaustion (P < 0.001) and depersonalization (P = 0.002) compared to the female physicians, while there was no significant difference in relation to low personal accomplishment (P = 0.07). Role conflict and role ambiguity levels were significantly higher for the nurses compared to the physicians (P < 0.01). The levels of role conflict (P < 0.001) and role ambiguity (P = 0.005) were significantly higher for the nurses compared to the female physicians (Tunc & Kutanis, 2009).

Lu, While, and Barriball (2007) performed a quantitative study to explore nurses' (n = 512) views and experience regarding different components of their working lives.

Nurses selected to participate worked in the medical and surgical units in two teaching hospitals in Beijing. Demographic information and several validated questionnaires were used in the research study. Descriptive and inferential statistics were used to analyze the data. All respondents were female with a majority between 21 and 35 years old (n = 463, 90.4%). The majority had a diploma or associate degree (n = 230, 44.9%, n = 232, 45.3%, respectively), while < 10% had a bachelor's degree (n = 50, 9.8%). Almost two-thirds of respondents had worked in their healthcare facility for 5 or more years (n = 324, 63.6%), while more than two-thirds had expressed their intention to leave their current posts (n = 368, 71.9%) (Lu et al., 2007).

Lu et al. (2007) reported that job satisfaction had the strongest correlation with organizational commitment (r^2= 0.561, $p < 0.01$), followed by occupational stress, role conflict, professional commitment, and role ambiguity (r^2 = -0.349, r^2 = 0.330, r^2 = -0.358, r^2 = -0.231; $p < 0.01$, respectively). Statistically significant relationships were found between the independent variables ($p < 0.01$). Organizational commitment was related to professional commitment, (r^2 = 0.457), role ambiguity (r^2 = -0.278), role conflict (r^2 = -0.276), and occupational stress (r^2 = -0.211). Occupational stress was associated with role conflict (r^2 = 0.352) and professional commitment (r^2 = -.0.169). Professional commitment was negatively related to role ambiguity (r^2 = -.0439) and role conflict r^2 (r^2 = -0.279, while role conflict was positively related to role ambiguity (r^2 = 0.256). About 40% of the job satisfaction variance could be explained by the set of independent variables: organizational commitment, occupational stress, professional commitment, role conflict, role ambiguity, educational level, age, and number of working

years in current hospital (r^2 = 0.396). The researcher findings provided support for a job satisfaction model among nurses (Lu et al., 2007).

Joiner and Bartram (2004) conducted a quantitative study to examine the role of social support and empowerment in reducing work stress among Australian nurses (n = 157). The sample consisted of 97% women (mean age 41 years; mean tenure 8 years). Clinical nurses represented 70% of the total responses with the remainder of participants as nurse managers (26%) and nurse educators (4%). Valid and reliable instruments were used to measure supervisor support, coworker support, psychological empowerment, and role stress (job stress, work control, conflict/ambiguity, resource inadequacy, and work overload). Reported findings were that supervisor support (r^2 = -0.05, p < 0.01), co-worker support (r^2 = -0.99, p < 0.01), the empowerment dimensions of impact (r^2 = -0.40, p < 0.01) and competence (r^2 = -0.84, p < 0.01) were negatively associated with aggregated job stress (R^2 = 0.40, F = 17.78, p < 0.01). A negative relationship was reported between three independent variables (supervisor support- (r^2 = -0.30, p < 0.01), co-worker support (r^2 = -0.37, p < 0.01), and impact (r^2 = -0.39, p < 0.01) and stress (R^2 = .44, F = 21.13, p < 0.01) derived from a lack of control over work issues. In addition, supervisor support (r^2 = -0.12, p < 0.01), co-worker support (r^2 = -0.27, p < 0.01), and self-determination (r^2 = -0.19, p < 0.05) were all negatively associated with job stress (R^2 = 0.26, F = 9.69, p < 0.01) as evidenced by role conflict/ambiguity. Supervisor support (r^2 = -0.06, p < 0.05), co-worker support (r^2 = -0.16, p < 0.05), competence (r^2 = -0.41, p < 0.01), and self-determination (r^2 = 0.18, p < 0.05) were all negatively associated with job stress (R^2 = 0.22, F = 7.99, p < 0.01) as evidenced by resource inadequacy. A

negative relationship was also noted between supervisor support (r^2 = -0.12, $p < 0.05$), co-worker support (r^2 = -.026, < 0.05), and distress from work overload (r^2 = 0.06, F = 2.58, $p < 0.05$), but a relationship between the dimensions of empowerment and work-overload was not supported. The results demonstrated that the presence of social support structures, particularly from supervisors and colleagues, is negatively associated with all the main work stressors (Joiner & Bartram, 2004).

In a review of the literature on role ambiguity, five quantitative studies were examined among a variety of populations that included managers, specialists, non-management personnel, nurse executives, physicians, and nurses in a variety of settings. Cross-sectional sampling was used, which can limit the determination of cause-and-effect relationships, participants' opinions, beliefs, and attitudes that are representative of one point in time. Larger sample sizes may have been more desirable, but the samples did provide descriptive statistics that seemed a reasonable representative of the population. Valid and reliable instruments were used that provided support for the relationships that were presented in the researched literature.

Tarrant and Sabo (2010) revealed nurse executives perceived moderate levels of role ambiguity in their jobs. However, healthcare organizations are likely to evolve and increase in complexity, thus putting pressure on nurses in many roles. Though role ambiguity levels were not high amongst this group, there was some level of role stress in this nurse executive population, which may be related to mastering the ability to problem solve and autonomy to change activities as stress levels rise. As the nurse manager role has been referred to as complex and ambiguous, the baseline perceptions among the nurse

executive population warrants further examination of role ambiguity among the nurse manager population. Among nurses and physicians, Tunc and Kutanis (2009) revealed that there was a strong correlation between role ambiguity and low personal accomplishment among healthcare professionals, which might diminish one's work experience and jeopardize the quality of care. In their study, nurses perceived lower levels of role ambiguity, role conflict, and burnout than physicians. While Lu et al. (2007) found support that among nurses, job satisfaction was influenced by perceptions of organizational commitment, occupational stress, professional commitment, role conflict, role ambiguity, role perception, and role content. Both studies illustrated that given the degree of role ambiguity employees experienced, the result can generate positive or negative work attitudes. Therefore, empowerment as a work attitude would likely be influenced similarly by role ambiguity perceptions.

Nurse managers, due to the complexity of their role, limited role preparation, and unmatched skills, are likely to experience role ambiguity. Spreitzer (1996) identified that role ambiguity influenced empowerment perceptions amongst managers in a Fortune 500 company, providing further evidence for examining role ambiguity and empowerment among nurse managers. There were no studies that examined role ambiguity in the nurse manager population, though role ambiguity influenced burnout perceptions. As such, Tunc and Kutanis (2009) suggested that more studies are needed to redesign the organizational work environment with clear role expectations in healthcare institutions to prevent burnout among nursing professionals, which lends support for studying a variable

that rather than supporting a negative work attitude (burnout) will examine a positive work attitude (empowerment).

Joiner and Bartram (2004) found that empowerment was negatively associated with main work stressors. Consequently, higher empowerment perceptions were associated with lower perceptions of the stressors of lack of control, reduced role conflict/ambiguity and resource inadequacy. Nurses who were confident and competent reported experiencing lower stress levels. As such, hospital management may choose to implement strategies aimed at promoting the health and well-being of nursing staff (Joiner & Bartram, 2004; Lu et al., 2007; Mendes & Stander, 2011). Basically, empowerment has been associated with positive work attitudes and behaviors and a tool to combat stressful work environments, which can result in negative work perceptions and increased turnover. As such, the research findings may be beneficial in highlighting the importance of empowerment in creating a positive organization and for employees. Leaders may consider ensuring that employees have clear career paths, detailed job models, and a structured process to consult when there is a need to clarify expectations (Joiner & Bartram, 2004; Mendes & Stander, 2011; Tarrant & Sabo, 2010; Tunc & Kutanis, 2009). Support was provided on how the level of role ambiguity can influence positive or negative work attitudes. As such, in an attempt to understand the nurse managers' work experience and understand what factors influence empowerment among this group, role ambiguity was one of the selected predictors in examining psychological empowerment amongst this population.

Participated Decision Making

Agarwal and Sharma (2011) performed a quantitative study to investigate paramedic employees' (n = 200) perceptions on hospital work factors, job satisfaction, and psychological well-being in a teaching hospital and non-teaching hospital. Equal numbers of employees were selected from both hospitals. Participant ages ranged from 22 to 50 years, and each had a minimum service of three years and maximum of 25 years. Statistical analysis of the data showed that there were significant differences in the perceived workplace factors; the reported levels of psychological well-being and job satisfaction of the participants were nearly the similar in the two hospitals (Agarwal & Sharma, 2011).

The authors reported that staff in the non-teaching hospitals reported significantly higher levels of coordination (t = 4.65, p < .01) and work autonomy (t = 3.07, p < .01) (Agarwal & Sharma, 2011). Similarly, the staff reported higher levels of participation (t = 2.45, p < .01) and intra-professional relationships (t = 2.67, p < .01). Several stepwise regressions were completed and analyzed for the participant sample. Work autonomy predicted 7.6% of the variance in job satisfaction in the teaching hospital, while co-ordination predicted 19.5% of the variance in job satisfaction among those in the non-teaching hospital. Intra-professional relationships and participation predicted 30.3% and 8%, respectively, of the variance in job satisfaction in the teaching hospital. In the non-teaching hospital, participation predicted 27.2 % of the variance in job satisfaction. Work autonomy and coordination predicted 21.7% and 5%, respectively, of the variance in the psychological well-being of paramedic employees in the teaching hospital. However,

work autonomy and coordination predicted 26.4% and 6.9% of the variance in psychological well-being in the non-teaching facility. Intra-professional relationships and participation predicted 33.3% and 14.2%, respectively, of the variance in psychological well-being among paramedic employees in the teaching hospital, while intra-professional relationships, participation, and perceived organizational support predicted 27.1%, 5%, and 6% of the variance in psychological well-being of the paramedic staff in non-teaching hospitals (Agarwal & Sharma, 2011).

Nooritajer and Mahfozpour (2008) studied decision-making participation level perceptions of head-nurses (n = 94) through the use of a correlational research study that utilized a self-report questionnaire. All of the participants worked in education hospitals in a Tehran, Iran. The hospital specialties were (3) general, (1) orthopedic and rehabilitation, (1) pediatric, (1) gynecology and obstetrics, (1) psychiatric, (1) burn, (1) nephrology, and (1) plastic surgery. Descriptive and inferential statistics were used after valid and reliable instruments were administered to the participants. Each participant had over six months in his or her current department. Head-nurses reported a moderate level of participative decision making (40.4%) and were moderately satisfied (55.4%) with the level of opportunity they had to engage in participative decision-making activities. There was a strong and statistically significant correlation (r = 0.661, p = 0.000) reported among participative decision-making and the degree of opportunity provided to engage in participative decision-making activities (Nooritajer & Mahfozpour, 2008).

Campbell, Fowles, and Weber (2004) performed a descriptive, quantitative study to describe the relationship of organizational structure and job satisfaction in public

health nursing. Twenty county public health departments located in central Illinois participated in the study. Nurses (n = 192) participated in completing the survey, which included general demographic information, a 14-item instrument assessing organizational structure, a 31-item job satisfaction survey, and three qualitative items regarding intent to stay and suggestions for improvement. Descriptive and inferential statistics were used to analyze the data provided by the instruments. The majority of respondents were females (96.9%), aged 41- 50 (40.5%), married (76.6%), and worked full-time (85.9%). Most participants were in nursing 20 or more years (48.4%), employed in the department less than 5 years (40.4%), registered nurses (94.8%). Position classifications ranged from staff nurses (66.1%), supervisors (17.9%), nursing directors (5.2%), and nurse administrators (3.5%). The greater amount of vertical and horizontal participation was associated with higher job satisfaction among participants. The analysis of variance revealed a significant difference in scores by site of employment on the Alexander Vertical Participation subscale (F = 2.06, p < 0.01). The largest difference occurred between two counties, and one experiencing labor and union issues (t = 0.04). Scores (n = 176) on the participation instrument ranged from 22 to 62, with a mean score of 44.85 (SD = 7.28). Overall organizational structure scores among participants described the health departments as exhibiting a slightly higher degree of participation in an informal, flexible, and decentralized environment (Campbell et al., 2004).

Significant relationships were found between job satisfaction and vertical and horizontal participative decision-making (Campbell et al., 2004). Significant differences were reported among different classifications: administrator, nurse director,

supervisor/manager, and staff nurse for total the Alexander score ($F = 8.541$, $p = 0.000$), Alexander Vertical Participation subscale ($F = 6.99$, $p = 0.000$), and Alexander Horizontal Participation subscale ($F = 7.32$, $p = 0.00$). Post hoc tests revealed significant differences for the total Alexander Structure Score between administrators and staff nurses ($p = 0.037$), nurse directors, and staff nurses ($p = 0.004$), and between supervisors and staff nurses ($p = 0.004$). In addition, significant differences were noted for the Alexander Vertical Participation subscale scores between nurse administrators and staff nurses ($p = 0.021$), nursing directors and staff nurses ($p = 0.011$), and supervisors and staff nurses ($p = 0.044$). Significant differences were also reported for the Alexander Horizontal Participation subscale scores between administrators and staff nurses ($p = 0.037$) and director of nurses and staff nurses ($p = 0.001$) (Campbell et al., 2004).

Parsons and Stonestreet (2003) conducted a qualitative research study with nurse managers ($n = 28$) to describe factors that contribute to managerial retention. The study used open-ended data generating questions. The interviewees were nurse managers who had been in their roles two years, employed in one of the health system's five hospitals in a large southwest metropolitan city. Descriptive statistics were employed to describe the sample and narrative analysis used to identify a list of major themes. The majority (43%) were employed in the largest tertiary hospital in the system, while 25% were employed in outlying facilities with an integrated administration, 14% employed in a transplant specialty, 11% in the children's hospital, and 7% in the ambulatory surgery hospital. The mean age was 46 years with average total years of nursing, of which 13 years were in nursing management, with a mean of 7.8 years in their current role. Most were Caucasian

(93%) followed by Hispanic (7%). Educationally, 18% were prepared at the master's level, 39% baccalaureate, 32%, associate degree, and 11% diploma in nursing. Communication was the dominant theme including sub-themes of superior accessibility for listening and guidance, effective communication, clear expectations, and feedback. The second theme related approaches to leadership that were participative planning and decision-making as well as empowering management in terms of daily management. Effective administrative systems were the third major theme including systems for managing staffing, professional development, and manager compensation. The remaining themes included work/life balance, providing quality of care, and retention. The researchers reported that strategies implemented to support nurse manager retention might include development of positive work environments to retain and recruit nurses (Parsons & Stonestreet, 2003).

Ray, Turkel, and Marino (2002) conducted a qualitative study using a grounded-theory design with nurses (n = 32) and administrators (n = 14) from military and civilian healthcare systems. A comparative analysis was performed by the researchers to identify relevant themes. The goal was to discover the basic social processes for balancing cost while maintaining organizational caring with the economically driven health care environment. Participants' descriptions of their experiences provided researchers with rich data for simultaneous data analysis. The researchers concluded that the healthcare organization was being driven by financial decisions that resulted in decreased employee trust. Consequences of losing trust in the organization included nurses becoming disillusioned with nursing practice and experiencing decreased loyalty to the

organization. Five themes were identified that could be used as strategies for repairing the low trust that was being experienced throughout the organization. The authors acknowledged the themes as strategies that could improve the work environment: respect, communication, maintaining visibility, and participative decision-making (Ray et al., 2002).

Knoop (1991) initiated a quantitative study to examine the relationships between values that are realized in the workplace and participative decision-making among nurses (n = 171) from five government-funded hospitals in a large metropolitan area. Work values were identified as the degree of worth, importance, and desirability regarding work situations. Participative decision-making was equated with the act of sharing with others in deciding what happens to be done to achieve organizational objectives. The sample had an average age of 43 years; 72% married, 63% had children, 85% were women, 63% had diplomas, and median years of nursing experience was six years. Two instruments were used in the study: one to measure work values and the other one measured participative decision-making. The findings that were reported identified that nurses considered having responsibility (M = 4.2), as the highest work value they experienced on the job, followed by use of abilities (M = 4.1) and doing meaningful work (M = 4.0). Conversely, nurses did not experience much influence in the organization (M = 2.1), recognition (M = 3.1), or favorable working conditions (M = 3.3) (Knoop, 1991).

Knoop (1991) reported that the highest correlations between participative decision-making and values were found for influence over work (r = .69), influence in the organization (r = .64), and independence in work (r = .63). Multiple regression analyses

showed that five of the work values contributed significantly to participative decision-making. The best predictor was perceived influence over work ($r = .48$, $p < .001$), followed by independence in work ($r = .07$, $p < .001$), influence in the organization ($r = .04$, $p > .001$), convenient hours of work ($r = .02$, $p < .001$), and having responsibility ($r = .02$, $p < .01$). These five values predicted 63% of the variance in participative decision-making for this sample of nurses, and as such, several achieved work values were related to participative decision-making. Knoop (1991) argued that the relationships between participative decision-making and work values can be linked to motivational theories because participation seemed to ignite feelings of security and satisfy needs for responsibility, while fostering work independence. As such, participation was associated with feelings of influence that employees had at work and in organization. In particular, influence over work was the single greatest predictor of participation in decision-making. Moderate correlations between work value and participation and the substantial variance in participation contributed to consideration for future research that might be directed towards work values, beliefs, and attitudes (Knoop, 1991).

The participative decision making review of literature provided insight into the variable of interest. Six studies were examined with two qualitative designs and four quantitative designs with participants that included nurses, nurse directors, administrators, nurse managers, and paramedics. The qualitative studies provided evidence that identified participative decision making as a factor that contributes to nurse manager retention, while the other study qualitative study outlined how participative decision making increases organizational trust. Participative decision-making was

identified as a vehicle that influences positive employee work attitudes (Argawal & Sharma, 2011; Campbell et al., 2004; Knoop, 1991). Meanwhile, Nooritajer and Mahfozpour (2008) found that nurse managers welcomed the opportunity to engage in participative decision-making within the workplace and concluded that such opportunities have an important role in job satisfaction. Campbell et al.'s (2004) research brought to light that participative decision-making perceptions are different among those in staff, middle management, and executive roles, which supports the fact that this study will be conducted with a specific focus on the nurse manager. Knoop's (1991) study provided evidence to support that participative decision-making was likely when one felt influence, responsibility, and independence in work activities. As such, positive work environments were characterized with having participative decision-making opportunities.

The review of literature is critical as results support the relationships among participative decision-making and work values, which are thought to be connected to motivational theories (Knoop, 1991). The link to motivation was made as participative decision making was correlated with bringing about feelings of security, satisfying the need for responsibility, self-efficacy, and self-worth (Argawal & Sharma, 2011; Knoop, 1991). As participative decision-making is a vehicle to include staff involvement and serves to bring about positive feelings related to workplace contribution, this study examined selected predictors of empowerment among nurse managers. Participative decision-making was one of the variables included as a predictor variable based on the literature.

Psychological Empowerment

The literature suggests that in chaotic and stressful work environments, particularly in places where there is constant change, empowerment in an important concept. Empowerment is associated with positive experiences that are known to influence employee practices in the workplace. As such, a focused review was conducted on the empowerment. Seibert et al. (2011) performed a meta-analysis to support an integrated model specifying the antecedents and consequences of psychological empowerment. The authors sought to integrate a broad range of theoretical perspectives that have emerged over 30 years on empowerment including socio-structural characteristics, psychological or an individual viewpoint, and from a team perspective. In addition, the authors examined the validity and reliability of psychological empowerment as a unitary construct. More than 1,000 abstracts were reviewed for content and consideration for inclusion in the meta-analysis with exclusions resulting in a final set of 142 articles. Coding accuracy and reliability were reached through each author independently coding the articles (Seibert et al., 2011).

Results indicated that contextual antecedent constructs represent high-performance managerial practices, socio-political support, leadership, and work characteristics were strongly related to psychological empowerment (Seibert et al., 2011). Positive self-evaluation traits were a strong indicator of psychological empowerment and equally correlated to empowerment, as were contextual factors. Psychological empowerment was positively associated with a broad range of employee outcomes, including job satisfaction, organizational commitment, performance, and negatively

associated with employee strain and turnover intentions. Determination of psychological empowerment as a unitary secondary-order construct was also validated, and there was strong support for Spreitzer's conceptualization of psychological empowerment as a single second-order construct made up of the four cognitions of meaning, competence, self-determination, and impact (Seibert et al., 2011).

Wagner et al. (2010) conducted a meta-analysis to examine the literature that was conducted focusing on the relationship among structural empowerment and psychological empowerment for registered nurses. The initial search included online bibliographic data review. The search included publications from inception of the research on structural and psychological empowerment until March 2009. English peer-reviewed articles were searched using the following search terms: structural empowerment, workplace empowerment, psychological empowerment, structural and psychological empowerment, workplace and psychological empowerment, professional autonomy, power, organizational climate and organizational culture. Autonomy, organizational climate, and organizational culture were included as search terms to assist in the identification of articles that met criteria, but empowerment was not used as a key word. Gretchen Spreitzer and Heather Laschinger empowerment websites were searched for additional articles because of the extensive empirical research each author conducted in psychological and structural empowerment, respectively (Wagner et al., 2010).

Wagner et al. (2010) identified the inclusion criteria that guided the selection of papers were: (1) a practicing registered nurse (RN) population, (2) qualitative or quantitative peer-reviewed papers reporting primary research, (3) studies investigating the

relationship between structural empowerment and psychological empowerment, with structural empowerment as the predictor variable, and psychological empowerment the outcome variables. To establish inter-rater reliability, a second reviewer evaluated a random sample of 100 articles using the same exclusion criteria. The search yielded 20,628 titles and abstracts, which resulted in 744 studies after application of the exclusion criteria. Through a second screening based on the inclusion criteria, 10 articles were considered an acceptable level of quality for further review. Findings revealed the positive relationships between social structure and overall empowerment, as well as proven outcomes, which highlighted the importance of workplace interventions that provide empowerment to nursing professionals. Strengths of the studies were identified as predictive designs, use of multiple sampling sites, reliable instruments for both empowerment measures along with correlational analysis for multiple effects. Weaknesses revealed that in one or more studies there was failure to discuss the protection of anonymity or confidentiality of respondents, thee was no description of sample size, response rates were less than 60%, and there was no description of the measurement instrument reliability. Yet, research that explored empowerment suggested a direct positive relationship between structural empowerment and psychological empowerment for nurses and managers. Increased empowerment perceptions were associated with increased innovation, satisfaction, and reduced burnout. As such, workplace empowerment research has been linked to positive work behaviors and attitudes. Research demonstrated the essential relationship between structural empowerment and psychological empowerment was aimed at providing direction for

future interventions aimed at the development of a strong and effective healthcare sector (Wagner et al., 2010).

El-Salam, Ibrahim, Mohsen, and Hassanein (2008) performed a quantitative study to determine organizational climate and empowerment perceptions among nurses (*N* = 164) at two Egypt hospitals. The researchers used a descriptive, comparative design and two instruments to measure the variables of interest: organizational climate and psychological empowerment. Before data collection, a pilot study was conducted to test the reliability, clarity, applicability, and comprehensiveness of the questionnaire. Descriptive statistics were used to describe the sample, which showed the largest number of nurses was less than 25 (40.9% from a teaching hospital; 59.2% from a non-teaching hospital). There were no nurses in the age groups 35 to 45 and older than 45 at the non-teaching hospital. The mean ages were 27.76 (*SD* 8.27) years at the teaching hospital and 23.82 (*SD* 3.66) years at the non-teaching hospital. The majority of nurses had less than 10 years experience; 69.1% at the teaching hospital and 80.7% at the non-teaching facility. Mean years of experience were 9.40 (*SD* 7.89) at the teaching hospital and 5.76 (*SD* 3.57) as the non-teaching hospital (El-Salam et al., 2008).

El-Salam et al. (2008) reported that the highest percentage of nurses at both hospitals reported a moderate level of organizational climate (84.5%; 92.2%) at the teaching and non-teaching hospital, respectively. The mean scores for organizational climate were 77.69 (*SD* 16.53) and 74.76 (*SD* 12.82), respectively. The authors reported a statistical difference between the two hospitals regarding nurse's empowerment level (*P* = 0.007). The majority of nurses reported moderate empowerment in both hospitals

(64.6% and 86.0%, respectively), which accounted for 35.4% of nurses in the teaching hospitals compared to 14.0% at the teaching hospital that reported good empowerment levels. The teaching hospital had a higher mean empowerment score 64.96 (*SD* 8.69) versus 61.04 (*SD* 8.26). The correlation between organizational climate and empowerment was significantly positive at the intensive care unit at the teaching hospital ($r = .944$, $p < 0.0001$) and in the burn ($r = .580$, $p < 0.0001$) and operating room ($r = 0.458$, $p < 0.001$) in the non-teaching hospital. Statistically significant correlations were also noted between organizational climate and nurses' empowerment for the following dimensions' meaning ($r = 0.191$, $p < .015$), competence ($r = 0.333$, $p < 0.0001$), self-determination ($r = 0.730$, $p < 0.0001$), impact ($r = 0.287$, $p < 0.001$), as well as the overall psychological empowerment ($r = 0.397$, $p < 0.0001$). Based on the findings to improve organizational climate and nurses' empowerment, recommendations were made, focusing on interventions that could be initiated in the workplace (El-Salam et al., 2008).

Wallach and Mueller (2006) conducted a quantitative, non-experimental study to explore whether and to what extent job characteristics, role ambiguity, role overload, participation, supervisor-supervisee relationships, and peer support would predict empowerment among paraprofessionals ($n = 165$) in public and private human service organizations. Fifteen administrators within nine human service staff organizations were approached about recruiting staff to participate in the study. Once potential sites were identified, administrators were contacted through a telephone call to further explain the purpose of the study, review research methodology, and respond to questions. Thomas and Velthouse's intrinsic motivation model was used as a theoretical framework for this

study to explain how workers are impacted by workplace characteristics. Questionnaires were directly administered and returned in unidentified confidential envelopes or sent out via the mail. Measurement scales that were used included the Psychological Empowerment Scale, Role Ambiguity Scale, Role Overload Scale, a participative decision-making scale, the Supervisory Working Alliance Inventory, a peer support scale measured the extent of support obtained from co-workers, and the Unit Decisions Scale (Wallach & Mueller, 2006).

Correlations and regression analyses were calculated to examine hypothesized relationships (Wallach & Mueller, 2006). The research findings indicated that work stressors, participation, supervisory relationships, and peer support were associated with empowerment perceptions among paraprofessionals. The researchers found a negative association between role ambiguity and empowerment. The findings provided support for development of an empowerment-oriented supervisory model that might be used to guide training and mentoring activities within organizations. The researchers suggested that organizations cultivating mission driven efforts and developing a confident workforce might consider increasing workers' opportunities for promoting cooperative behaviors and job clarity coupled with participatory decision-making (Wallach & Mueller, 2006).

Yukl and Becker (2006) in a commentary argued that psychological empowerment in organizations is the perception by members that they have the opportunity to help determine work roles, accomplish meaningful work, and influence important decisions. Over the past several decades, an interest in empowerment has been

seen in many subject areas within psychology and management, including motivation, leadership, group processes, decision-making, and organizational design. Empowerment is considered important because of the potential benefits that can result from it, including increased commitment, better decisions, improved quality, more innovation, and increased job satisfaction. As such, psychological empowerment theory attempts to determine the essential components that contribute to the efforts that make empowerment successful, facilitate conditions that will be successful, and provide aid with the circumstances that people will experience empowerment in the workplace. Influences on empowerment have involved a diverse range of options, such as job design, participative leadership, organizational structure, organizational culture employee skills and traits, and leader selection and assessment. The author stressed there had been some evidence that employee characteristics are related to empowerment due to the responsiveness of employees for more responsibility and participation. In addition, employees with higher education levels, tenure, and job level have reported more feelings of empowerment. Organizations have implemented strategies to increase empowerment that have included employee stock ownership plan, sharing information, sharing power through parallel structures, self-managed teams, and democratic decision processes. Ironically, reasons for failure have been found to be related to managers feeling threatened and not wanting to relinquish control to employees (Yukl & Becker, 2006). Both authors stressed that managers need organizational support and training in empowering leadership behaviors for empowerment efforts succeed. Effort should be taken to provide support for

employees to be included in the decision-making process, which involves encouraging people to speak up to express concerns and ideas (Yukl & Becker, 2006).

Mok and Au-Yeung (2002) explored the relationship between organizational climate and empowerment among nurse staff (n = 331) in Hong Kong in a quantitative study. Most respondents (78.5%) were aged 26 to 45 years. Registered nurses were the largest group of respondents, being 59.5% of the total respondents. Participants included 21 (6.3%) top-level nurse managers, 55 (16.6%) middle nurse managers, and 255 (77%) frontline nurses. The majority (52%) of participants had worked in the hospital for six to 15 years and 25.7% for 16 to 25 years. Just more than half (51.1%) of the respondents had a bachelor's degree, 26.9% had a diploma or certificate, 0.9% held a postgraduate diploma and 3% held a master's degree. Six factors were found to represent 42% of the variance of organizational climate: leadership (9.4%), work harmony (8.9%), challenge (6.3%), recognition (6.3%), teamwork (5.6%), and decision-making (5.5%). Top nurse managers were more positive towards organizational climate, with higher ratings on leadership, recognition, and teamwork. All the factors in the organizational climate scale were moderately and positively related to empowerment, with correlations ranging from 0.51 to 0.34. The highest positive correlations for empowerment were with teamwork and leadership. Regression analysis findings revealed that the six climate factors accounted for 44% of the variance and were significant at the 0.001 level (Mok & Au-Yeung, 2002).

Spreitzer (1996) performed a quantitative study to examine the work characteristics of an empowering system. Participants were middle managers (n = 393)

representing diverse units of a Fortune 500 organization. Data were collected at the beginning of a managerial development program and took a total of three years to collect, ensuring stratification across functions, locations, and divisions. The author chose to examine six work characteristics in relation to empowerment: role ambiguity, span-of-control, sociopolitical support, access to information, access to resources, and a participative work climate. Descriptive and inferential statistics were used to analyze the data. The results supported the notion that contextual factors influence empowerment perceptions by middle managers. Role ambiguity was negatively associated with empowerment, yet found to have the strongest relationship compared to other variables. The results indicated that when a manager's boss has a wider span of control, he or she was less likely to micro-manage the manager's actions, which increased the manager's perceptions regarding empowerment. Spreitzer found that socio-political support, participative support, and access to information significantly and positively influenced empowerment. Contrary to the researchers' expectations, access to resources was not significantly related to empowerment. In sum, the researcher argued that ambiguity, span of control, sociopolitical support, access to information, and work unit climate provided a clearer understanding about the social structural factors associated with managerial empowerment perceptions (Spreitzer, 1996).

A total of seven articles were reviewed: two meta-analyses, one commentary, and four quantitative studies that used correlational designs. Each research study examined antecedents or consequences of empowerment among various populations (El-Salem et al., 2008; Mok & Au-Yeung, 2002; Spreitzer, 1996; Wallach & Mueller, 2006). Cross-

sectional methods were limitations and reduced the ability to generalize the findings about data that were extracted in a single time period to examine relationships among variables. Evidence was provided that identified variables that significantly influenced psychological empowerment, based on the theoretical framework of intrinsic motivation (Seibert et al., 2011; Spreizter, 1996; Wallach, 2009). A noted strength in the studies was the same framework was used as the basis for understanding how the findings support how the overarching areas of leadership, organizational policies, and work design characteristics are strongly related to empowerment. Intrinsic motivation is an interpretive process and as such positive self-evaluation traits displayed a strong positive relationship with psychological empowerment. The Psychological Empowerment Scale was identified as the predominant instrument used in throughout the research literature to measure psychological empowerment and to test relationships among other variables.

Spreitzer (1996) and Seibert et al. (2011) suggested further studies were necessary to examine the joint effects of personal dispositional characteristics and work design on empowerment to expand individual and organizational links in the organization. Though, the review of literature included paraprofessionals and sales managers in the population, the researchers suggested that additional studies should be employed across different contexts. Wagner (2010) pointed out that, to date, research was limited to those that examined the relationships between structural empowerment as the predictor variable and psychological empowerment as the variable receiving the effects. For these reasons, this study focused on the nurse manager population; particularly due to the crucial role managers' play within the healthcare environment. Psychological empowerment

perceptions can be shaped by contextual antecedents and individual characteristics, which can have far-reaching benefits within organizations and for employees. Another noted strength was the strong evidence that was provided to support that leadership and work design characteristics, leader-member relationships, participative decision-making, role ambiguity, and organizational support can impact an employee's empowerment perceptions.

Organizations that concentrate on higher performance managerial practices (extensive training, open information sharing, decentralization, participative decision-making, and contingent compensation) and work designs conducive to positive experiences promote an empowered workforce (El-Salem et al., 2008; Mok & Au-Yeung, 2002; Seibert et al., 2011; Wallach & Mueller, 2009). Though psychological empowerment is shaped by the workplace experiences, an individual comes with personal traits. Findings suggested employers may consider selecting employees who have positive self-evaluation traits to establish a workforce that shows initiative and takes an active role in improving their own performance (Seibert et al., 2011). No studies had been conducted that examine predictors of psychological empowerment among the nurse manager population. Therefore, this study examined the selected predictors of psychological empowerment to gain insight into the nurse manager experience.

Chapter Summary

Review of the literature revealed that studies conducted on empowerment among nurse managers are limited. Several studies have been conducted on the empowerment among the nurse population. Strong evidence was provided that supports the Model of

Intrinsic Motivation as the theoretical model and valid and reliable instruments to test selected predictor variables. Researchers have identified that empowerment will likely be influenced by overarching areas of leadership, organizational policies, and work design characteristics. A gap in the literature revealed that no studies had been conducted to examine the selected predictors of empowerment among nurse manager.

CHAPTER THREE

Methods

The purpose of the study was to use a descriptive, predictive design to test four hypotheses that measure the propositions of Thomas & Velthouse's (1990) model of intrinsic motivation to determine whether selected variables are effective predictors of psychological empowerment among the sample of nurse managers. The predictor (independent) variables to be utilized in the study included leader-member exchange, participative decision-making, role ambiguity, perceived organizational support, and core-self evaluation. The criterion (dependent) variable for the study was psychological empowerment.

In this chapter, the following are presented: (a) study design, (b) sample and setting, (c) inclusion and exclusion criteria, (d) ethical considerations, (e) recruitment procedures, (f) proposed procedures for data collection, (g) instrumentation, (h) data analysis, and (i) chapter summary.

Study Design

A non-experimental, descriptive, predictive design was used to investigate the relationship of predictor (independent) variables including: individual characteristic (core self evaluation) and select contextual factors (leader-member exchange, organizational support, role ambiguity, and participative decision) and the criterion (dependent) variable, psychological empowerment among nurse managers. The study was cross-sectional, which is a method chosen to describe variable distributions that occur in a single point in time (Gay et al., 2009). A predictive design was selected for the ability to go beyond the

ability to explore relationships between variables, without the ability to identify cause and effect. Yet, in predictive designs variables are examined to determine the likelihood independent and dependent variables are present together.

The four hypotheses that were tested to examine the relationships among the study variables are:

H1. There will be a significant positive relationship between contextual factors (perceived organizational support, leader-member exchange, participative decision-making) on psychological empowerment among nurse managers.

H2. There will be a significant positive relationship between the individual characteristic (core self-evaluation) and psychological empowerment among nurse managers.

H3. There will be a significant negative relationship between contextual factor (role ambiguity) and psychological empowerment among nurse managers.

H4. The four contextual factors (perceived organizational support, role ambiguity, leader-member exchange, participative decision-making) and one individual characteristic (core self-evaluation) uniquely and in combination will have a significant positive effect on psychological empowerment among nurse managers.

Sample and Setting

Convenience sampling was used to recruit participants. Convenience sampling is the process of including those that are readily available at the time or volunteer to be part of the sample for a particular research study (Gay et. al., 2009). Participants were recruited from hospitals with a minimum 100-bed capacity from three Southeast Florida

healthcare systems. The purpose of using the three healthcare settings was to achieve a sample size that was representative of the population and increase the likelihood of generalization of the results.

Projected Sample Size

Gay et al. (2009) suggested that a minimum of 30 participants can be used as a guideline in correlational research studies, while other researchers (Cone & Foster, 2006) have suggested that 100 participants is an adequate sample size. An a priori power analysis provides another option for computing the required sample size given the level of significance (alpha error probability), power (1-beta error probability) and effect size will be calculated by means of G*Power (Faul, Erdfelder, Lang & Bucher, 2007). The computer software program is widely used for common statistical tests in behavioral research. In order to control for making a Type 1 error, alpha will be set at 0.05 and to control for Type II error beta will be set at 0.20 and a medium effect size.

An a priori analysis was conducted using G*Power 3.1 to compute power values for sample size related to the specific statistical test, anticipated effect size, alpha level, and power analyses (Faul et al., 2007). The alpha level (α) for estimating the appropriate sample size for this study was set at the accepted level of .05 and the beta (β) at .20. The preferred power was calculated as 1- β=.80 with a chosen medium effect size.

Hypotheses 1 and 4 considered a predictive correlational relationship between three and five predictor variables, respectively. The data analysis required computing a linear multiple regression, fixed model, *R2* deviation from 0, medium effect, alpha .05, power .80. A sample size of 77 was necessary with three predictor variables and 92 with five

predictor variables. Hypotheses 2 and 3 considered a correlational relationship between an independent and the dependent variable that required a bivariate normal model correlation that would use a two-tailed test, medium effect, alpha .05 and power .80, and a sample size of 84 would be necessary for each hypothesis. Therefore, though both correlation and regression analysis were performed, the minimum sample size is increased to accommodate for the multiple regression. As some questionnaires may be returned incomplete and therefore unusable, 150 questionnaires were distributed to obtain the required sample size for computing statistical tests for the stated hypotheses.

Inclusion Criteria

The inclusion criteria for participant selection includes the following: (a) registered nurses with 24-hour, seven days a week responsibility for at least one clinical nursing unit, (b) a direct reporting relationship to a nurse leader, and (c) ability to speak and read English.

Exclusion Criteria

The exclusion criteria include the following: (a) a registered nurse that does not have 24-hour, seven days a week responsibility for at least once clinical unit, (c) does not have a direct reporting relationship to a nurse leader, and (c) is unable to speak and read English.

Ethical Considerations

Researchers are responsible for conducting studies in an ethical manner, maintaining the rights and privacy of their participants (Berg, 2007; Creswell, 2007; Gay et al., 2009). Participants should be ensured that their trust will not be comprised

throughout the study, from inception and to the reported findings (Gay et al., 2009). Every effort was taken to protect participants and ensure that the study will be conducted in a respectful manner to adhere to ethical and legal guidelines. As such, prior to data collection, approval was obtained from the Barry University Institutional Review Board (IRB) (Appendix A) and each participating healthcare facility for the protection of human subjects. The study met the Barry IRB category 2 exempt status and required the use of survey procedures in administering six cognitive tests that measure: perceived organizational support, participative decision-making, role ambiguity, leader-member exchange, core self-evaluation, and psychological empowerment among nurse mangers.

Complete anonymity was assured as participants placed surveys in sealed envelopes and then in the researcher's portable lockbox. The portable lockbox remained with the researcher during hospital data collection. Demographic information did not include any identifiers and participant responses did not put anyone at risk for criminal or civil liability. Damage to the participant's standing, employability, or reputation was not possible based on the topic and the study is designed to maintain anonymity. No stigmas, embarrassment, or items of a sensitive nature were brought up due to the nature of the study.

Once participants volunteered, they were be provided with a copy of the cover letter (Appendix B) to read, which indicated that by completing the questionnaire, they were giving their consent to participate in the study. The cover letter included the purpose of the study, information related to the researcher's name, organization affiliation, benefits and potential risks, data collection procedures and data management

strategies, data reporting and dissemination of the findings of the study. In addition, the cover letter included that the responses provided were to be anonymous and therefore no one, including the researcher, would be able to link the questionnaires to the participants.

Participants were informed that their participation in the study was voluntary and that they may withdraw from the study and refrain from answering questions at any time throughout the study. Participants that decided to stop and not complete the study were free to so without consequence. However, for the participants that submitted their surveys in the lockbox, there was no way to identify their survey for withdrawal from the other questionnaires. All participants were provided with contact information for the researcher, faculty advisor, the contact persons for Barry University's IRB, and the local hospital IRB should any questions arise. Further assurance was given that only the researcher and advisor would have access to the completed questionnaires, which did not include identifiers. After reading the cover letter and agreeing to participate in the study, the participants were provided with a 63-item questionnaire in an envelope. The length of time to complete the questionnaire was estimated to be about 15 minutes.

Participants were also informed that there were no known risks associated with the study. There were no direct benefits to the participants. However, examining selected predictors of empowerment among nurse managers would shed light on those variables that are effective predictors of empowerment among nurse managers. The results could serve to guide nurse executives in designing strategies that empower nurse managers within the healthcare organization. Completed questionnaires were placed in the envelope provided, sealed, and placed by the participant in the researcher's portable

lockbox. Participants were also informed that completed questionnaires will be stored in a locked cabinet in the researcher's home office for five years following the completion of the study and will then be destroyed. The disclosure that the collective findings from the study may be disseminated through poster and podium presentations, as well as through newspaper and journal articles was be shared with the participants.

Recruitment Procedure

Participants who met the inclusion criteria were recruited from those hospitals within the healthcare system that have a minimum 100-bed capacity during a 21-week period. After nurse executive approval to proceed, all policies and protection of human subjects mandated by local hospital institutional review boards were followed.

The researcher made contact by phone or email with the committee chair for nurse manager meetings or their designee to obtain approval to attend those meetings that nurse managers would be in attendance. Once the dates and times of meetings were confirmed, and approval was granted, the researcher attended the meeting. The researcher distributed and read the flyer, which was used as a script to recruit nurse managers. The estimated time to complete the 63-item questionnaire was about 15 minutes. If the meeting was chaired by a nurse executive, he or she was asked to leave the room while participants were taking the survey, in case participants may be uncomfortable having a supervisor in attendance. The researcher left the room to reduce any uneasiness the participants may have felt while taking the survey. However, the researcher remained in close proximity to collect the completed surveys.

Data Collection Procedure

The researcher sought permission (Appendix C) from nurse executives, and upon receipt of written (Appendix D) nurse executive approval, the researcher followed all policies and protection of human subjects mandated by the local hospital. After all approvals were obtained, the following procedures were followed: 1) the researcher contacted the committee chair or designee of nurse manager meetings for approval to attend meetings that nurse managers will be in attendance; 2) once the dates were confirmed, the researcher attended the meeting to distribute and read the flyer (Appendix E), which was used as a script to recruit participants for the research study; 3) for those that volunteered to participate, the researcher distributed a packet that included a cover letter, the 63-item survey that should take about 15 minutes to complete, and a sealable envelope; 4) participants were instructed to read the cover letter and survey instructions, record their answers, and place the completed surveys with no identifiers into the envelope provided and seal it; 5) once the nurse managers were finished, they were instructed to deposit the sealed envelope in the researcher's portable lockbox; 6) and the nurse manager kept the cover letter to refer to as necessary.

The cover letter explained the purpose of the study, emphasized that participation was voluntary and anonymous, and clarified that completion and return of the survey indicated implied consent to participate. The researcher remained in close proximity and waited for all distributed surveys by returning to the room once the nurse managers completed the survey. The completed surveys were to remain secured in a locked cabinet in the researcher's home office for five years following the completion of the study and will then be destroyed. The researcher reviewed the completed surveys after each

distribution session for usable data, which aided in determining when the minimum sample size was reached. Files were stored in a locked cabinet only accessible to the researcher.

Instrumentation

The questionnaire used to collect data was comprised of a researcher-developed demographic instrument (Appendix F) with items to describe the sample and confirm whether the participant will meet the inclusion criteria. In addition to the demographic instrument, the research study included six standardized instruments to measure the study variables. The Core Self-Evaluation Scale (CSES) (Appendix G) was used to measure the variable perception of core self evaluation (Judge et al., 2003); the Survey of Perceived Organization Support (SPOS) (Appendix H) was used to measure the perceived organizational support beliefs (Eisenberger et al., 1986); the Multidimensional Leader Member-Exchange Scale (LMX-MDM) (Appendix I) was used to measure leader-member exchange perceptions (Liden & Maslyn, 1998); the Participative Decision Making Scale(PPDMS) (Appendix J) was utilized to measure participative decision making beliefs (Siegel & Ruh,1973); the Role Ambiguity Scale (RAS) (Appendix K) was used to measure role ambiguity perceptions (Rizzo et al., 1970); and the Psychological Empowerment Scale (PES) (Appendix L) was utilized to measure psychological empowerment perceptions (Spreitzer, 1995; Spreizer, 1996). The instruments were easy to read and have been used in diverse populations to measure these variables. The questionnaire was comprised of a total of 63 items and was estimated to take the participant about 15 minutes to complete. The researcher received permission to use the

RAS (Appendix M) and the PDMS (Appendix N). The PES, SPOS, and CSES standardized instruments did not require written permission for use as they were retrieved from the public domain. The MDM-LMX (retrieved from PsychTESTS) did not require written permission once the instrument was used for non-commercial research and educational purposes.

The Demographic Questionnaire

An eight-item, researcher-developed demographic questionnaire was used to describe the participants and to assess whether participants meet the inclusion criteria. Items 1 through 4 seek to determine age, gender, years as a registered nurse, and years in the current role. Items 5 through 7 are interval items used to determine to whom the participant reports to in the healthcare facility, describe the participant's education level employment status, and the describes the type of clinical nursing unit that participant has 24 x 7 responsibility over. The number of units that the nurse manager is responsible for was answered in Item 8.

Core-Self Evaluation Scale

A number of studies have found a significant association between personal dispositional traits measured by the Core Self Evaluation Scale (CSES) and an individual's interpretation of work attitudes (Lashinger, Finegan, & Wilk, 2011; Laschinger et al., 2009; Laschinger & Finegan, 2008; Laschinger et al., 2007). Laschinger et al. (2011) and Laschinger and Finegan (2008) found that CSE mediated the relationship between burnout and job satisfaction among nurses (n = 3,156) and that CSE predicted burnout among nurse managers (n = 134) over a 1-year period. Laschinger et

al. (2009) and Laschinger et al. (2007) determined that psychological empowerment mediated the relationship between CSE and organizational commitment among nurses (*n* = 3,156; *n* = 101). In both studies, CSE was also found to be an important determinant of satisfying work environments. More generally, these results support Judge's et al. (2003) opinion that CSE influences the way individuals interpret and react to their organizational environment.

The Core-Self Evaluation Scale (CSES) is an instrument developed by Judge et al. (2003) designed to measure personal dispositional traits an appraisal of one's worthiness, effectiveness, and capability as a person. As such, the CSES has been tested among the nurse population and will serve to measure the independent variable of core self-evaluation. Judge et al. (2003) aimed to use their research findings to develop and provide support for use of a direct measure of core-self evaluations, rather than the indirect measurement practices that had been used in the past. The instrument consists of 12 items with four subscales designed to measure four personality characteristics: self-esteem, general self-efficacy, locus of control, and emotional stability. The even numbered items on the scale were reverse coded. The original 5-point Likert scale was modified to a 6-point scale to allow for logical comparisons among all instruments. Scores on the 6-point Likert scale ranged from one *strongly disagree* to six *strongly agree*. Once calculated, the final scores ranged from one to six, with higher scores reflecting that a participant experiences higher core-self evaluation perceptions and lower scores indicating lower core-self evaluation perceptions.

Reliability. An instrument is considered reliable when the same thing is measured and the outcomes are consistent, trustworthy, and dependable (Gay et al., 2009). Judge et al. (2003) began their study with a pool of 65 items based on the relevant literature on individual core traits and self-concept. Data were collected from four for a total of six convenience samples for a total of six data sets. Samples included food service employees (n = 280), pharmaceutical company (n = 175), southeastern undergraduates in two different periods (n = 265; n = 205), and Midwestern undergraduates (n = 126). The Midwestern graduates provided names of a close family friend or family member that could evaluate them using the CSE. Judge et al. (2003) reported internal consistency reliability for sample 1 (α = .85), sample 2 (α = .83), sample 3 – time 1 (α = .85), sample 3 – time 2 (α = .87), sample 4 – self (α = .83), sample 4 – other (α = .81). Test-retest reliability was examined with sample 3 at time periods that spanned 1 month (α = .81).As such, Judge et al. (2003) found acceptable scale reliability and a unitary factor structure that correlated significantly with job satisfaction, job performance, and life satisfaction.

In addition to Judge's et al. (2003) research study, four published works that involved the nurse population provided evidence of reliability in the CSES (Laschinger et al., 2007; Laschinger & Finegan, 2008; Laschinger et al., 2009; Laschinger et al., 2011). Laschinger et al. (2007) used the instrument to explore the influence among quality relationships with supervisors, empowerment, satisfaction, and core self-evaluation among nurse managers (n = 223). The results indicated a significant association between CSE and all the model variables (range: β = .18 to .39), with the association between CSE and psychological empowerment depicting the highest correlation (β= .39). Laschinger et

al (2007) reported an internal consistent reliability among the CSES subscales that ranged from 0.56 to 0.77, which indicated a moderate internal consistency.

Laschinger and Finegan (2008) examined the influence of effort reward balance and core self-evaluation on nurse manager's (n = 134) burnout levels over a 1-year period. Effort reward balance and CSE influenced nurse manager burnout over a 1-year time frame. Although burnout levels at Time 1 accounted for significant variance in emotional exhaustion levels 1 year later (β = 0.355), nurse's effort-reward imbalance (β = 0.371) and core self-evaluations (β = 0.166) explained significant additional amounts of variance in burnout one year later. The researchers reported an internal consistent reliability score that measured 0.81 for the CSES (Laschinger & Finegan, 2008). Laschinger et al. (2009) investigated the relationship among nurses (n = 3,156) LMX, structural empowerment, psychological empowerment, and organizational commitment among nurses. Core self-evaluation had a significant positive effect on psychological empowerment (β = .333) and had 13.4% of the variance in psychological empowerment. Internal consistent reliability was recorded at .69 for the CSES (Laschinger et al., 2009). Laschinger et al. (2011) tested the relationship among CSE, LMX, structural empowerment, job satisfaction, burnout, and job satisfaction among nurses (n = 3156). Higher CSE was associated with lower levels of burnout. CSE had a significant negative effect on the burnout constructs of emotional exhaustion (β = -.419, p < .05) and cynicism (β = -.164, p < .05). Internal consistency reliability was recorded at .78 for the CSE scale (Laschinger et al., 2011). Overall, strong reliability for the CSES has been

demonstrated based on the findings reported in the published research articles within the nursing population.

Validity. An instrument is considered to be valid when it measures the intended purpose and reflects the intentional function (Gay et al., 2009). Judge et al. (2003) reported validation of the CSES from six independent samples. Judge et al. (2003) supported construct validity with following observations: strong sample internal consistency reliability estimates, alpha coefficients greater than .80; test-retest reliability of .81, good stability demonstration; and a single factor model that was supported across all samples, suggesting that the CSE is uni-dimensional. In addition, Gardner and Pierce (2010) noted that the CSE had been proven to have good convergent and discriminant validity, which supported the theoretical expectations for strong correlations with global self-esteem, generalized self-efficacy, locus of control, and neuroticism. Strong construct validity was demonstrated by the relationship with three criteria, job satisfaction, life satisfaction, and task performance, and was useful in predicting the distinct criteria over and above the four base traits (Gardner & Price, 2010; Judge et al., 2003). Predictive validity for the CSES correlated with job satisfaction (r = .49 - .59), job performance (r = .26 - .27), and life satisfaction (r = .53 - .66) and more importantly, predicted outcomes better than scales measuring the four individual traits. Core self-evaluation instrument validity is further supported as researchers have used the instrument in published research studies to measure the personal dispositional trait (Judge et al., 2003; Laschinger et al., 2007; Laschinger & Finegan, 2008; Laschinger et al., 2009; Laschinger et al., 2011).

Survey of Perceived Organizational Support

Findings in research studies have determined a significant association between POS and attitudes about the workplace with using the SPOS (Bobbio et al., 2012; Butts et al., 2009; Lashinger et al., 2006; Patrick & Laschinger, 2006). In Bobbio et al.'s (2012) research study, nurses (n = 273) reported that empowering leadership behaviors positively correlated with organizational support and negatively correlated with job burnout, emotional exhaustion, and cynicism. Laschinger et al. (2006) found that among nurse managers (n = 202), attitudes, performance levels, and health outcomes were better in employees with higher perceived organizational support. Patrick and Laschinger (2006) determined that the combination of empowerment and perceptions of organizational support were significant predictors of among nurse managers' (n = 84) role satisfaction.

Eisenberger et al. (1986) developed the Survey of Perceived Organizational Support as an eight-item, self-report Likert scale that measures employee beliefs that organizations have a positive or negative orientation toward them based on the degree the organization values them and is concerned with their welfare. To control for agreement bias, half of the statements on the instruments were formulated positively and half were worded, negatively. Scale items 2, 3, 5, and 7 were reverse coded. Scores on the 6-point Likert scale ranged from one *strongly disagree* to six *strongly agree*. Once calculated the final scores range from one to six, with higher scores reflecting a positive overall belief concerning the degree to which an employee believes an organization values their contributions and cares about their well-being, while lower scores reflect a negative belief about the degree to which an employee believes an organization values their contributions

and cares about their well-being.

During the initial development, this instrument was initially tested as a 36-item instrument on employees (*n* = 361), ranging from employees in various specialty organizations: manufacturing firms with white-collar workers and secretaries (*n* = 66); credit bureau clerical workers (*n* = 12); telephone company workers (*n* = 12); bookstore bookkeepers and clerks (*n* = 17); law firm secretaries (*n* = 19), high school teachers (*n* = 50), financial trust company employees (*n* = 120); and postal clerks (*n* = 65). A shorter version of the instrument was developed and tested through administration to private high school teachers (*n* = 97). The correlation among POS and an instrument measuring an employee's belief that work effort should depend on treatment by the organization (exchange – ideology) was tested. In the Rhoades and Eisenberger (2002) meta-analysis, most studies used the 17 highest loading items in the SPOS; however, for practical reasons, many studies used the eight-item scale. The researchers stressed that since the original scale was uni-demensional and has high internal reliability, the use of the shorter version is acceptable, though when used the Eisenberger et al. (1986) study is to be referenced indicating that the scale is selected from the highest loading items. As such, the shorter eight-item scale will be used in this research study. The original seven-point Likert scale will be modified to a six-point scale to allow for logical comparisons among all instruments.

Reliability. The reliability and item analysis was performed on the 36-item instrument and resulted in a reliability coefficient (Cronbach's alpha) of .97, with item-total correlations ranging from .42 to .83 (Eisenberger et al., 1986). The mean and

median item-total correlations were .67 and .66, respectively. In the same study, with testing teachers (n = 97) POS and exchange ideology, a test of a 17 item-instrument was found to have a reliability coefficient (Cronbach's alpha) of .93. Laschinger et al. (2006) expected to find that personal and organizational characteristics would influence perceptions of organizational support. Among the nurse managers (n = 202), POS was found to have a reliability coefficient (Cronbach's alpha) of 0.91 with reports of moderate levels of perceived organizational support (M = 4.44; SD = 1.09). Patrick and Lashinger (2006) found that empowerment was positively correlated to perceived organizational support. Empowerment explained 36% of the variance in role satisfaction and perceived organizational support added another 10% explained variance. Both empowerment (β = 0.32) and perceived organizational support (β = 0.42) were significant independent predictors of role satisfaction. The authors reported an internal consistent reliability score of 0.90 in this study for perceived organizational support. Bobbio et al. (2012) and Laschinger et al. (2006) have provided further evidence of the strong reliability for the SPOS instrument as evidenced by reported internal consistency of .76 and .91, respectively.

Validity. In the Eisenberger et al. (1986) study, teacher absenteeism from those with the top third, middle third, and bottom third of POS scores were compared with the three strengths of exchange ideology. For teachers with a high or moderate exchange ideology, perceived high support produced half the number of absence periods and days than perceived low support, t (62) = 2.58, $p < .01$, and t(62) = 2.00, $p < 0.25$, respectively. As such, the authors reported that construct validity for was established for this

instrument in the original study. Laschinger et al.'s (2006) results were consistent with those of Rhoades and Eisenberger's (2002) meta-analysis of antecedents and consequences of POS in the general management literature and strengthened the support for the validity of the theory in the nursing population. Similar to the meta-analysis findings, nurse manager perceptions of organizational support were more strongly associated with organizational characteristics than personal factors. Patrick and Laschinger's (2006) findings reinforced the positive influence managers' perception of perceived organizational support can have on managers' role satisfaction. Bobbio et al. (2012) tested convergent and standard factor loadings showed that each factor was defined only by its own indicators, thus supporting convergent validity. The instrument validity of the Survey of Perceived Organizational Support is further supported as researchers have used the instrument in published research studies to measure organizational support (Bobbio et al., 2012; Butts et al., 2009; Eisenberger et al., 1986; Lashinger et al., 2006; Patrick & Laschinger, 2006).

Leader-Member Exchange Multidimensional Measure

Research studies have been conducted using the Leader-Member Exchange Multidimensional Measure (LMX-MDM) among samples of nurses and nurse managers (Chen, Wang, Chang, & Hu, 2008; Laschinger et al., 2009; Laschinger et al., 2007). Chen et al. (2008) found that a higher level of LMX can enhance nurses' commitment and promote organizational citizenship behaviors, which result in greater organizational effectiveness. The sample consisted of 200 supervisor-subordinate responses that were further broken down into 14 head nurses and 200 nurses. Laschinger et al. (2009) found

that when managers (n = 141) perceived a positive relationship with immediate supervisors, they will likely feel that the work environment empowers them to meaningfully accomplish their work. Laschinger et al. (2007) determined that LMX and structural empowerment significantly influenced nurses' (n = 3156) psychological empowerment and organizational commitment.

Liden and Maslyn (1998) developed the Leader Member-Exchange Multidimensional Measure (LMX-MDM), which is a 12-item instrument that measures subordinates' perceptions regarding the quality relationship that exists between the subordinates and their superiors. The instrument measures four dimensions: loyalty, respect, contribution, and affect. Answers are measured on a six-point Likert scale with one being *strongly disagree* and six being *strongly agree*. Once calculated, the final scores ranged from one to six, with higher scores reflecting a positive overall belief that a subordinate experiences quality relationships with their superior and lower scores indicating a subordinate experiences lower quality relationship with their superior. The original seven-point Likert scale were be modified to a six-point scale to allow for logical comparisons among all instruments.

Reliability. Liden and Maslyn (1998) used test-retest correlation to test the instrument reliability over time and reported correlation values for each subscale. Internal consistency reliabilities were acceptable for the affect, loyalty, and professional respect scales, but low for the contribution scale. Coefficient alphas were reported as .90, .78, .60, and .92, respectively, for affect, loyalty, contribution, and professional respect in the student samples, and .90, .74, .57, and .89, respectively, for affect, loyalty,

contribution, and professional respect for the organizational employee samples. Test-retest correlations for the subsample of students were .83, .66, .55, and .79 respectively for affect, loyalty, contribution, and professional respect. A question was then added and one modified, in an effort to improve measurement for the contribution dimension. The contribution dimension including the three items produced a coefficient alpha internal consistency reliability of .74 with working undergraduate students (n = 34) and .77 with production workers (n = 227). In recent studies, Laschinger et al. (2009) reported the Cronbach's alpha for the total LMX-MDM at .94; while in Laschinger et al. (2007), the internal consistency reliability estimates for LMX-MDM ranged from 0.72 to 0.97. In Chen et al. (2008), the authors reported LMX-MDM at .91. Overall, strong reliability for the LMX-MDM instrument has been demonstrated based on the findings reported in the published research articles within the nursing population.

Validity. Content validation was performed with experts on two occasions from two universities. The first group consisted of eight university organizational behavior faculty and doctoral students. The second group consisted of six organizational behavior and human resources management faculty and doctoral students. The resultant 100 items served as a basis for item categorization on the four remaining dimensions of LMX, which were then reduced to 31 items until the final 12 were selected. Liden and Maslyn (1998) argued that the validity of the LMX-MDM was derived from the support for the four-factor model using exploratory factor analysis. However, these authors went further by using multiple approaches to support claims of instrument validity that included response bias susceptibility, convergent validity, discriminant validity, and criterion

related validity. The instrument validity of the LMX-MDM is further supported as researchers have used the instrument in published research studies to measure the quality of relationship between a superior and subordinate (Chen et al., 2008; Laschinger et al., 2009; Laschinger et al., 2007; Liden & Maslyn, 1998).

Role Ambiguity Scale

Role ambiguity has been tested using Rizzo et al.'s (1970) Role Ambiguity Scale within nursing (Joiner & Bartram, 2004; Lu et al., 2007; Tarrant & Sabo, 2009; Tunc & Kuntanis, 2009). Tarrant and Sabo (2009) examined role ambiguity among nurse executives and reported moderate levels of role ambiguity among this senior leadership group. Among nurses, researchers continue to identify that higher role ambiguity perceptions were positively correlated with occupational stress and burnout, yet negatively correlated with organizational commitment and satisfaction (Joiner & Bartram, 2004; Lu et al., 2007; Tunc & Kutanis, 2009).

The Role Ambiguity Scale (RAS) is described as one tool but uses separate scales that are factorially identifiable and independent (Rizzo et al., 1970). The scale measures individual perceptions regarding the level of ambiguous communication about role expectations, relationships, and responsibilities. The instrument consists of six items with answers that are measured on a six-point Likert scale with one being *strongly disagree* and six being *strongly agree*. Answers to each question were reverse coded. Once calculated the final scores range from one to six, with higher scores reflecting a participant perceives greater role ambiguity and lower scores indicating lower role

ambiguity perceptions. The original seven-point Likert scale will be modified to a six-point scale to allow for logical comparisons among all instruments.

Reliability. In the development of the initial instrument, Rizzo et al. (1970) created a questionnaire that consisted of 30 items, 15 for role ambiguity and 15 for role conflict. Participants were requested to respond to each item indicating the degree to which the condition existed for them, on a seven-point Likert scale. For the purpose of relating the role measures to other measures, the role measures were correlated with 45 variables in specific categories: satisfaction, leadership, organization, and anxiety. The first sample (n = 199) represented salaried central office and plant personnel, while the second sample (n = 91) represented research and engineering personnel. Internal consistency reliabilities were reported at .78 for the first sample and .808 for the second sample. Further support for instrument reliability was provided by researchers: Tarrant and Sabo (2009) reported an $\alpha = .771$ for the role ambiguity portion of the RCAS; Tunc and Kutanis (2009) revealed an $\alpha = .79$; and Lu et al. (2007) recorded an $\alpha = .80$. Overall, strong reliability for the ambiguity section of the RAS has been demonstrated based on the findings reported in the published research articles within the nursing population.

Validity. Rizzo et al. (1970) showed that the role conflict and role ambiguity measures correlated with the two samples in expected directions for measures of organizational and managerial practices, leader behavior, satisfaction, anxiety, and propensity to leave the organization. Factor analysis was used to provide evidence of validity. The factor and item analysis results supported that fact that the two concepts of role conflict and role ambiguity emerged as different dimensions. Furthermore, the scales

that were derived on the basis of both samples were independent for both samples. When the scales developed to measure the concepts were correlated with other variables, there was negative correlation with need fulfillment and stronger correlations with leader behaviors indicative of direct interactions with subordinates. Tarrant and Sabo found that when exploring role ambiguity and depression, r was found to be 0.464, $P < .01$, revealing a moderate relationship indicating that as role ambiguity increased, depression increased among nurse executives and among this population role ambiguity was moderate ($M = 2.91$; $SD = 0.79$). Tunc and Kutanis' (2009) multiple linear regressions showed that role conflict and role ambiguity accounted for 29.2% of the variance (adjusted $R^2 = 28.6\%$, $F = 51.14$, and $P < 0.001$) in emotional exhaustion, 22.6% of the variance (adjusted $R^2 = 22.6\%$, $F = 36.13$, and $P < 0.001$) in depersonalization, and 12.8% of the variance (adjusted $R^2 = 12.1\%$, $F = 18.22$, and $P < 0.001$) in low personal accomplishment. As hypothesized, correlations were found between role conflict, role ambiguity, and burnout subscales. The instrument validity of the RAS is further supported as researchers have used the instrument in published research studies to measure role ambiguity (Joiner & Bartram, 2004; Lu et al., 2007; Rizzo et al., 1970; Tarrant & Sabo, 2009; Tunc & Kuntanis, 2009).

Participative Decision Making Scale

Research studies have been conducted using Siegel and Ruh's (1973) participative decision-making scale among nurses and bank employees. Knoop (1991) performed a study to investigate the relationship among workplace values and participative decision-making among nurses ($n = 171$). Lam, Chen, and Schaubroek (2002) investigated the

relationship among participative decision-making and employee performance in the United States (*n* = 288) and in Hong Kong (*n* = 265). Researchers in both studies found strong correlations with the variables of interest with two very different populations.

Siegel and Ruh (1973) developed the participative decision making scale as a five-item self-report Likert scale that reflects the degree of influence one has in decisions that affect participative decision making perceptions. Participative decision-making was measured by Siegel and Ruh's (1973) participation survey. The instrument consists of five items that are measured on a six-point Likert scale with one being *strongly disagree* and six being *strongly agree*. Questions are focused on determining the degree of participation one has in decisions that affect his or her job. Once calculated, the final scores range from one to six, with higher scores reflecting that an employee perceives there are more opportunities for joint decision-making with their superior regarding circumstance that affect the job, while low scores reflecting that an employee has less opportunity for joint decision-making opportunities with a superior regarding items that affect the job (Seigel & Ruh, 1973). The original five-point Likert scale will be modified to a six-point scale to allow for logical comparisons among all instruments.

Reliability. Siegel and Ruh's published work (1973) examined the relationship of job involvement with participative decision-making, education, community size, and job performance among employees (n = 2868) from a total of 22 separate units in a manufacturing firm. The median level of education for this sample was the 12th grade, and the mean age was approximately 35 years. Fifty-one percent of the subjects were males, and 49% were females. The Cronbach's alpha was reported at .81, and two other

researchers provided further support for reliability. Lam et al. (2002) reported an α of .92 for participative decision-making questions; Knoop revealed an α of .86 in their study for participative decision-making. Overall, strong reliability for the PDMS has been demonstrated based on the findings reported in the published research articles.

Validity. Questionnaire development for the PDMS was constructed with items that were first grouped in clusters by face validity and the results of subsequent data analysis (Siegel & Ruh, 1973). Items were then eliminated and regrouped on the basis of inter-item correlations, item-cluster correlations and alpha estimates. Siegel and Ruh (1973) reported significant correlations among job involvement and participative decision-making ($r = .51$, $p < 0.01$). The correlations between job involvement and participative decision-making were significant ($p < 0.01$) and positive for each of the education and community size subgroups. Lam et al. (2002) found that when exploring participative decision-making and employee performance, r was found to be 0.634, $P < .01$, revealing a moderate relationship. Knoop (1991) reported that the highest correlations between participative decision-making and values were found for influence over work ($r = .69$), influence in the organization ($r = .64$), and independence in work ($r = .63$). Multiple regression analyses showed that five of the work values contributed significantly to participative decision-making. The best predictor was perceived influence over work ($r = .48$, $p < .001$), followed by independence in work ($r = .07$, $p < .001$), influence in the organization ($r = .04$, $p > .001$), convenient hours of work ($r = .02$, $p < .001$), and having responsibility ($r = .02$, $p < .01$). These five values predicted 63% of the variance in participative decision-making for this sample of nurses, and as such,

several achieved work values were related to participative decision-making. As hypothesized, correlations were found between participative decision making and positive workplace factors. The instrument validity of the PDM scale is further supported as researchers have used the instrument in published research studies to measure participative decision-making (Knoop, 1991; Lam et al., 2002; Siegel & Ruh, 1973).

Psychological Empowerment Scale

The psychological empowerment concept has been analyzed in meta-analyses and in research among diverse populations (Seibert et al., 2011; Wagner et al., 2010; Wallach & Mueller, 2006; Spreitzer, 1996). Canadian author Laschinger has studied psychological empowerment extensively in research with structural empowerment among nurses. In both meta-analyses, the Psychological Empowerment Scale was used in the majority of research studies that measured psychological empowerment perceptions (Seibert et al., 2011; Wagner et al., 2010). Wallach and Mueller (2006) tested whether role ambiguity, role overload, participation, supervisor-supervisee relationships, and peer support would predict empowerment among paraprofessionals. As such, evidence was provided that an empowerment-oriented supervisory model may be used to guide training and mentoring activities within organizations. The Psychological Empowerment Scale is a 12-item self-report Likert-style scale on a 7-point disagree-agree scale (Spreitzer, 1996). Psychological empowerment was measured by the Psychological Empowerment Scale developed by Spreitzer (1995, 1996). The instrument consisted of 12 items with answers that were measured on a 6-point Likert scale with 1 being *strongly disagree* and 6 being *strongly agree*. Once calculated, the final scores ranged from one to six, with higher

scores illustrating that an individual has greater psychological empowerment perceptions and lower scores indicating less psychological empowerment perceptions. The original seven-point Likert scale will be modified to a six-point scale to allow for logical comparisons among all instruments.

Reliability. Spreitzer (1995) found that role ambiguity was negatively related to empowerment ($\beta = -.20$, $p < .001$), and a wide span of control ($\beta = .09$, $p < .05$), sociopolitical support ($\beta = .15$, $p < .01$), access to information ($\beta = .19$, $p < .01$), and unit climate ($\beta = .12$, $p < .01$) were found to be positively related to empowerment. Spreitzer's (1995) tested the PES in two industries and found an internal consistency of .72 for the industrial sample and .62 for the insurance sample. In 1996, in a Fortune 500 company, the PES resulted in Cronbach's alpha in the four subscales (meaning, competence, self-determination, and impact) ranged between, .87, .81, .81, and .88; respectively. While Laschinger et al. (2009) reported a Cronbach's alpha on the subscales that ranged from .70 to .90, Wallach and Mueller (2006) documented a Cronbach's alpha of .90 among paraprofessionals.

Validity. Spreitzer (1995, 1996) used various techniques to validate the instrument, which has been used successfully in numerous studies in contexts ranging from nurses to service workers. A second order confirmatory factor analysis was used to assess the convergent and discriminatory validity of the empowerment measures in the industrial and insurance samples (Spreitzer, 1995). In the industrial sample, an excellent fit was obtained (AGFI = .93, RMSR = .04, NCNFI = .97). A modest fit was obtained for the insurance sample (AGFI = .87, RMSR = .07, NCNFI = .98). Each item was loaded on

the appropriate factor, and the four factors were significantly correlated with each other in both samples. Spreitzer (1995) documented that the strong correlations suggested the need for continued work on discriminant validity. Seibert et al. (2011) tested discriminant and predictive validity and confirmed Spreitzer's (1995) results that psychological empowerment psychological empowerment is a uni-dimensional construct (Spreitzer, 1995). The instrument validity of the PES is further supported as researchers have used the instrument in published research studies to measure psychological empowerment (Spreitzer, 1995; Spreitzer, 1996; Seibert et al., 2011; Wagner et al., 2010; Wallach & Mueller, 2006).

Data Analysis

Following the retrieval of the questionnaires from the lockbox at the researcher's home office, the researcher examined each questionnaire for incomplete data to determine when the minimum sample size was reached. Creswell (2007) suggested that when there an instrument is returned with more than 30% missing data that the information is excluded from the data entry and analysis process (Creswell, 2007). However, with the exception of the demographic instrument; any instruments with missing data were not used in the data analysis. Predictive Analytic Software (PASW), formerly known as Statistical Package for the Social Sciences (SPSS) version 20.0, was used to analyze data from the study. Instruments were scored by the statistical software and by hand for verification.

Detection of flaws and outliers was monitored closely. Outliers are scores that are +/- 3 SD from the mean. Once outliers were detected with the use of box-plots, the

researcher retained them with consideration for transformation if the data for the dependent variable was not normally distributed. Assurance that the data met the statistical test assumptions was made by determining if the scores for the dependent variable use are normally distributed. A histogram and the Kolmogorov-Smornov (*K-S*) statistics was used to determine values that were significant for indicating whether data is not normally distributed and violates assumptions of normal distribution.

Data was stored on two backup files: one on a password-protected flash drive and one on a hard drive residing on a password protected computer. The flash drive was kept secured in a file cabinet in the researcher's home office, when not being used for the purposes of data management for the study. The hard drive that was used to store the data was locked in the researcher's home office. Files were stored in a locked cabinet only accessible to the researcher, and after five years, all hard copies will be destroyed as per Barry University's protocol.

Data were analyzed using descriptive and inferential statistical techniques inclusive of correlation and multiple regression analysis. Descriptive statistical analyses of demographic characteristics, inclusive of frequency distributions (i.e., percentages, histograms), measures of central tendencies (i.e., means, medians), measures of variability (i.e., standard deviations, ranges of scales), and items on all instruments were conducted. Psychometric reliability estimates (Cronbach's alpha) for each instrument were computed for this sample and compared with previous studies. Regression analysis (*R*) was used to test hypotheses 1 and 4. Pearson product correlation (*r*) was used to test hypotheses 2 and 3.

Chapter Summary

This chapter described the methodology utilized in measuring and testing the relationships between select variables (core self evaluation, role ambiguity, leader-member exchange, perceived organizational support, and participative decision-making) among psychological empowerment among nurse managers. Data collection took place at three Southeast Florida healthcare systems with a convenience sample of nurse managers. The optimal sample size had been determined and the rights of the participants will be protected. Participants completed a 63-item questionnaire compiled of demographic items along with items from six previously constructed research instruments that have been tested for psychometric properties. Information was reported using both descriptive and inferential statistics. Hypotheses testing was carried out by means of correlation and regression techniques.

CHAPTER FOUR

FINDINGS OF THE STUDY

The purpose of the study was to test the propositions of Thomas and Velthouse's (1990) model of intrinsic motivation to determine whether selected variables were effective predictors of psychological empowerment among the sample of nurse managers. The selected study variables included core self-evaluation, perceived organizational support, leader-member exchange, role ambiguity, participative decision making, and psychological empowerment. As a result, nurse executives may better understand what factors influence empowerment among nurse managers and can focus on the design and implementation of adequate workplace strategies to improve the nurse manager work experience. Similarly, nurse managers may have a better understanding of what factors in the workplace are likely to influence empowerment amongst those in the role.

A descriptive, predictive design was used to examine the relationship of the predictor (independent) variables—core self-evaluation, perceived organizational support, leader-member exchange, role ambiguity, and participative decision-making—and the criterion (dependent) variable—psychological empowerment. Data were collected over a 21-week period from full-time nurse managers that reported to a nurse leader and had 24 x 7 responsibilities for at least one clinical unit. Convenience sampling was used to recruit participants from hospitals with a minimum 100-bed capacity from three Southeast Florida healthcare systems. The study utilized a researcher-developed demographic instrument, the Core Self Evaluation Scale (CSES) (Judge et al., 2003), the Survey of Perceived Organization Support (SPOS) (Eisenberger et al., 1986), the

Multidimensional Leader Member-Exchange Scale (LMX-MDM) (Liden & Maslyn, 1998), the Participative Decision Making Scale (PPDMS) (Siegel & Ruh,1973), the Role Ambiguity Scale (RAS) (Rizzo et al., 1970), and the Psychological Empowerment Scale (PES) (Spreitzer, 1995) to collect data. Descriptive statistics were computed and used to describe the demographic characteristics of the sample, as well as the descriptive characteristics of the various scales. Reliability estimates were computed for all scales. The four hypotheses were tested using descriptive, correlation, and multiple regression statistics. Data was analyzed using PASW Statistics 20.0 (SPSS, 2012).

Sample Description

Through the use of convenience sampling, a total of 150 surveys were distributed and returned, representing a 100% return rate. However, only 115 questionnaires were usable; 35 participants reported responses on the demographic instrument that did not meet the inclusion criteria. The number of usable questionnaires exceeded the recommended sample size through power analysis. Thus, the response rate for this study was acceptable (Gay et al., 2009). Only completed scales were included; scales with missing information were not included in the analysis.

The sample consisted of males (n = 15, 13.0%) and females (n =100, 87.0%), ranging in age from 30 to 66 years (n = 113, M = 48.04, SD = 8.83), who had been a RN for between 4 to 45 years (n = 115, M = 22.95, SD = 10.0), and in their current position between less than 1 to 32 years (n = 115, M = 7.65, SD = 7.08). They reported directly to either a nurse director (n = 88, 76.5%), a chief nursing officer (n = 14, 12.2%), or an associate vice president (n = 13, 11.3%). They were in charge of inpatient units (n = 67,

58.3%), outpatient units (*n* = 26, 25.2%), or both types of units (*n* = 19, 16.5%). The participants provided information related to their educational background and the number of units for which they had 24 hours a day, seven days a week responsibilities. This information is presented in Table 1.

Table 1

Selected Demographic Characteristics of Participants

Characteristic	*n*	%
Highest nursing education level completed (*n* = 115)		
Diploma	1	.9
Associate degree	8	7.0
Bachelor's degree	45	39.1
Master's degree	61	53.0
Number of units 24X7 responsibilities (*n* = 113)		
1 unit	64	55.7
2 units	37	32.2
3 units	8	7.0
4 units	2	1.7
5 units	1	.9
8 units	1	.9

Results of Psychometric Estimations

Frequency distribution and a histogram with a superimposed normal curve was run for the outcome criterion variable to determine outliers, skewness, and kurtosis. In addition, reliability estimates (Cronbach's alpha) were calculated for all scales in the sample study and then compared with those from previous studies. The scores on the scale measuring psychological empowerment, the outcome criterion were evaluated for shape of distribution. The histogram, with the normal curve super imposed, is presented in Figure 2. The value for skew (-.93) and kurtosis (1.34) were not close to zero and indicated that the scores tend to pile up to the right of the distribution. The significant Kolmogorov-Smirnov (*K-S*) statistic, .09, $p = .02$, provided further evidence that the scores were not normally distributed. Stem and leaf detected two extreme scores of < 3.5; the specific cases were identified by means of boxplots. As transformation of these two outlying scores did not substantively influence the distribution, they were retained.

It is recognized that normal distribution is considered a necessary assumption for parametric statistical testing such as multiple regression, an *F*-test. An alternative to the use of parametric applications is the use of a nonparametric test, which does not assume anything about the underlying distribution. However, there is no nonparametric replacement for multiple regression analysis, and Donaldson (1966) contends that neither Type I nor Type II error of the *F*-test is much affected by non-normality and that the test is robust for even moderate sample sizes. The data analyses progressed as planned; however, in light of these concerns, conclusions cannot be guaranteed.

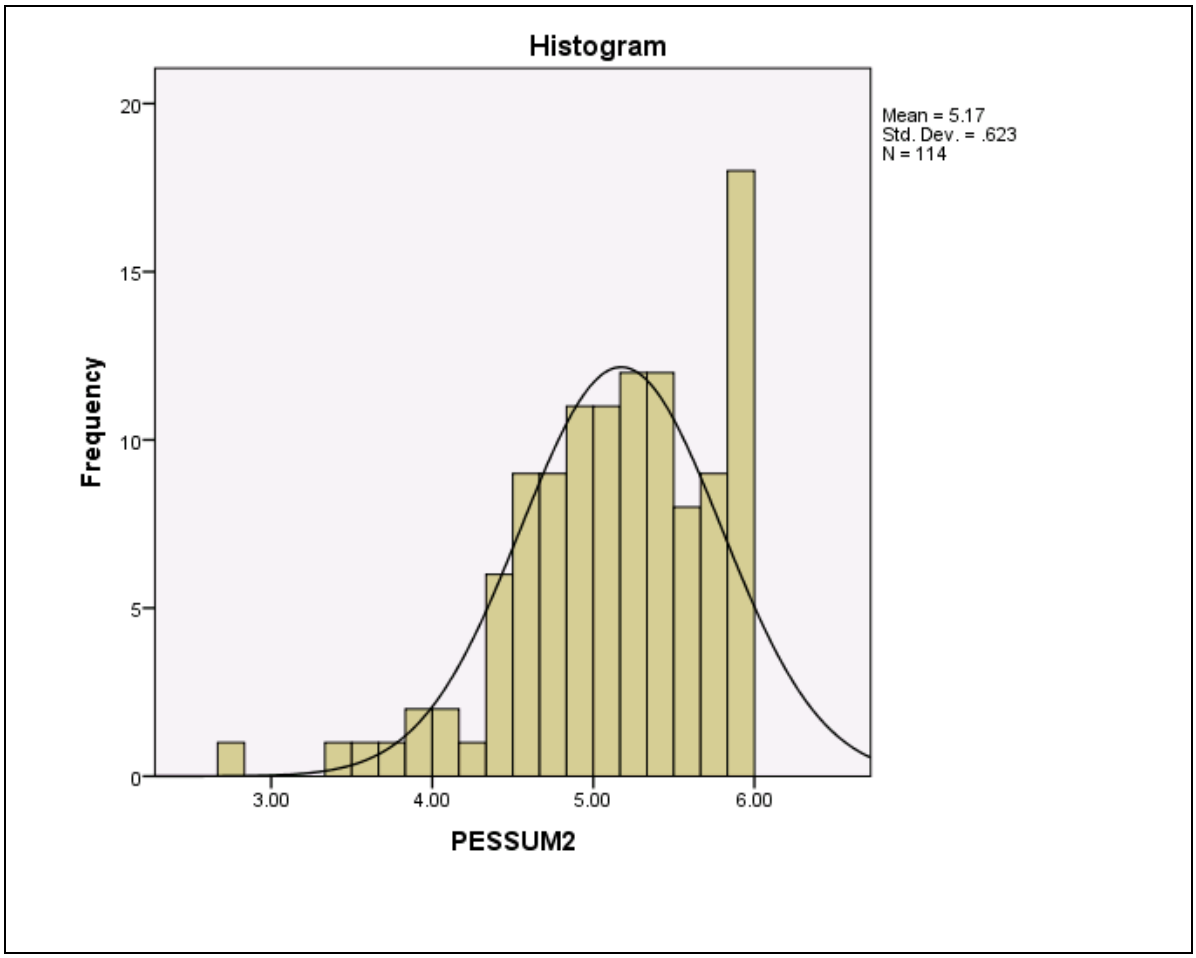

Figure 2. Histogram depicting the distribution of the scores for psychological empowerment scale.

Six instruments were used to measure the variables. Initially, the items on each scale were summed for a composite raw score. Next, the raw scores were divided by the number of items on the scale in an attempt to obtain a relative score that clearly equated to the one to six increments. The Likert scales used on each instrument allowed for logical comparisons between the scales. Cronbach's alpha was calculated for each scale. Each scale exceeded the acceptable benchmark of .70 value, which was accepted as an

indication that the items on each scale measured the same attribute. The summary statistics of the relative scores for each scale are provided in Table 2.

Table 2

Summary of the Relative Scores of the Measurement Scales

Scale	range	*M*	*SD*	*n*
Core self-evaluation	3.17 to 6.00	4.77	.61	113
Perceived organizational support	1.00 to 6.00	4.46	1.06	114
Leader-member exchange	1.75 to 6.00	4.78	.98	113
Role ambiguity	1.00 to 4.50	2.13	.80	115
Participative decision making	1.00 to 6.00	4.00	1.08	115
Psychological empowerment	2.75 to 6.00	5.17	.62	114

The Core-Self Evaluation Scale (CSES) (Judge et al., 2003) was used to measure personal dispositional traits, which is an appraisal of individual worthiness, effectiveness, and capability. The instrument consists of 12 items with answers measured on a 6-point Likert scale with 1 being *strongly disagree* and 6 being *strongly agree*. Final scores ranged from one to six, with higher scores reflecting participants experience higher core self-evaluation perceptions and lower scores indicating lower core-self evaluation perceptions. The CSE scores ranged from 3.17 to 6.00 ($M = 4.77$, $SD = .61$). The results suggest that this sample of nurse managers have moderate personal dispositional trait

perceptions. A high reliability estimate, Cronbach's alpha (α) was calculated (n = 113, α = .75) from the use of the scale with this sample of nurse managers. The Cronbach's alpha results were consistent with studies reported by Laschinger et al. (2007) that ranged from 0.56 to 0.77, Laschinger and Finegan (2008) of 0.81, Laschinger et al. (2009) of 0.69, and Laschinger et al. (2011) of 0.78.

The Survey of Perceived Organizational Support (SPOS) scale (Eisenberger et al., 1986) was used in this study to measure an employee's perception about the extent to which an organization cares about the employee's well-being and recognizes his or her organizational contribution. The instrument consists of eight items measured on a six-point Likert scale with one being *strongly disagree* to and six being *strongly agree.* The POS scores ranged from 1.00 to 6.00 (M = 4.46, SD = 1.06). The results suggest that this sample of nurse managers had a moderate overall positive belief regarding the organization valuing their contributions and caring about their well-being. A high reliability estimate, Cronbach's alpha (α) was calculated (n = 114, α = .93) from the use of the scale with this sample of nurse managers. The Cronbach's alpha results were consistent with those reported by Laschinger et al. (2006) of .91, Patrick and Laschinger (2006) of .91, and Bobbio et al. (201) of .76.

The Multidimensional Leader-Member Exchange (LMX-MDM) scale (Liden & Maslyn, 1998) was used to measure the quality of relationship between an employee and his or her supervisor. The instrument consists of 12 items measured on a 6-point Likert scale with 1 being *strongly disagree* to and 6 being *strongly agree.* The LMX scores ranged from 1.75 to 6.00 (M = 4.78, SD = .98). The results suggest that this sample of

nurse managers perceive a moderate quality relationship exists with their superior. A high reliability estimate, Cronbach's alpha (α) was calculated (n = 113, α = .94) from the use of the scale with this sample of nurse managers. These Cronbach's alpha results were consistent with those reported by Laschinger et al. (2009) of .94, Laschinger et al. (2007) of .72 to .97, and Chen et al. (2008) of .91.

The Role Ambiguity Scale (RAS) (Rizzo et al., 1970) was used in this study to measure individual perceptions of role ambiguity. The instrument consists of six items measured on a six-point Likert scale with one being *strongly disagree* to and six being *strongly agree.* The RAS scores ranged from 1.00 to 4.50 (M = 2.13, SD = .80). The results suggest that nurse managers have moderate role ambiguity perceptions regarding their work expectations, relationships, and responsibilities. A high reliability estimate, Cronbach's alpha (α) was calculated (n = 115, α = .84) from the use of the scale with this sample of nurse managers. These Cronbach's alpha results were consistent with those reported by Tarrant and Sabo (2009) of .771, Tunc and Kutanis (2009) of .79, and Lu et al. (2007) of .80.

The Participative Decision-Making Scale (PDMS) (Siegel and Ruh, 1973) was used in this study to measure participative decision-making. The instrument consists of five items measured on a six-point Likert scale with one being *strongly disagree* and six being *strongly agree*. The PDMS scores ranged from 1.00 to 6.00 (M = 4.00, SD = 1.08). The results suggest that nurse managers have moderate perceptions regarding the joint decision-making opportunities with a superior regarding items that affect their job. A high reliability estimate, Cronbach's alpha (α) was calculated (n = 115, α = .93) from the

use of the scale with this sample of nurse managers. These Cronbach's alpha results were consistent with those reported by Lam et al. (2002) of .92 and Knoop (1991) of .86.

The Psychological Empowerment Scale (PES) (Spreitzer, 1995; Spreitzer 1996) was used in this study to measure psychological empowerment. The instrument consists of 12 items measured on a 6-point Likert scale with 1 being *strongly disagree* to 6 being *strongly agree.* The PES scores ranged from 2.75 to 6.00 (M = 5.17, SD = .62). The results suggest that this sample of nurse managers have moderate empowerment perceptions. A high reliability estimate, Cronbach's alpha (α) was calculated (n = 114, α = .88) was obtained from the use of the scale with this sample of nurse managers. These Cronbach's alpha results were consistent with those reported by Laschinger et al. (2009) from .70 to .90, and Wallach and Mueller (2006) of .90.

Hypotheses Testing

Four hypotheses were posed. Statistical analyses included multiple linear regression and bivariate correlation. Prior to interpreting the regression results, collinearity statistics were calculated to assure that the proportion of the variability in one independent variable was not explained by another independent variable. All tolerance values were > .10 and all variance inflation factor (*VIF*) were <10, indicating that collinearity is not a concern.

Hypothesis 1

Hypothesis 1 sought to determine if the measure of three contextual factors: perceived organizational support, leader-member exchange, and participative decision-making, uniquely and in combination, had a significant positive relationship with

psychological empowerment among nurse managers. The research hypothesis was accepted. Regression analysis found that 54.5% (R^2 = .545, adj R^2 = .533) of the variance in the dependent variable was explained by the model and that the relationship was significant, F (3, 107) = 42.79, p = .00. Examination of the beta weights revealed that each of the predictor variables uniquely contributed to the model. Tables 3 and 4 provide a summary of the analyses. Table 4 provides the data used to determine the prediction equation score on empowerment based on the model tested in hypothesis one. The predicted total score on empowerment = 2.98 + .17(perceived organizational support) + .16(leader-member exchange) + .17(participative decision-making).

Table 3

Means, Standard Deviations, and Intercorrelations for Psychological Empowerment and Selected Predictor Variables (N = 111)

Variable	*M*	*SD*	1	2	3
Psychological empowerment	5.16	.63	.67**	.62**	.67**
Predictor variable					
1. Perceived organizational support	4.48	1.07	--	.64	.73
2. Leader-member exchange	4.77	1.00		--	.63
3. Participative decision-making	4.00	1.09			--

** p < .01.

Table 4

Regression Analysis Summary for Participant Variables Predicting Psychological Empowerment

Variable	*B*	*SE B*	β	*t*	*p*
(Constant)	2.98	.21		14.15	.00**
Perceived organizational support	.17	.06	.29	2.88	.00**
Leader-member exchange	.16	.06	.24	2.76	.00**
Participative decision-making	.17	.06	.30	3.01	.00**

** $p < .01$.

Hypothesis 2

Hypothesis 2 considered the correlational relationship between the variables of core self-evaluation and psychological empowerment among nurse managers. The research hypothesis was stated: There will be a significant positive relationship between the individual characteristic (core self-evaluation) and psychological empowerment among nurse managers. The research hypothesis was accepted. Bivariate correlation analysis found that core self-evaluation was significantly correlated with psychological empowerment; the relationship was positive, $r = .53$, p (two-tailed) $< .01$, indicating that as the scores for core self-evaluation increased so did the scores for psychological empowerment. The effect was medium.

Hypothesis 3

Hypothesis 3 considered the correlational relationship between the variables of role ambiguity and psychological empowerment among nurse managers. The research hypothesis was stated: There will be a significant negative correlation between the contextual factor (role ambiguity) and psychological empowerment among nurse managers. The research hypothesis was accepted. Bivariate correlation analysis found that role ambiguity was significantly correlated with psychological empowerment, r = -.77, p (two-tailed) < .01; the relationship was negative, indicating that as scores for role ambiguity increased, scores for psychological empowerment decreased. The effect was large.

Hypothesis 4

Hypothesis 4 sought to determine if the measure of four contextual factors—perceived organizational support, role ambiguity, leader-member exchange, and participative decision-making—and one individual characteristic, core self-evaluation, uniquely and in combination, had a significant relationship with psychological empowerment among nurse managers. Table 5 illustrates that individually the independent variables—perceived organizational support, leader-member exchange, participative decision-making, and core self-evaluation—had a significant positive relationship; while role ambiguity had a significant negative relationship. The research hypothesis was accepted. Regression analysis found that 68.3% (R^2 = .683, adj R^2 = .668) of the variance in the dependent variable was explained by the model and that the relationship was significant, F (5, 104) = 44.87, p = .00. Tables 5 and 6 provide a

summary of the analyses. Table 6 provides the data used to determine the prediction equation for empowerment based on the model tested in hypothesis four. The predicted total score on empowerment = 4.04 + .00(perceived organizational support) + .10(leader-member exchange) + .11(participative decision-making) + -3.5(role ambiguity) + .19 (core self-evaluation). Perceived organizational support with regard to this equation did not have a significant effect.

Table 5

Means, Standard Deviations, and Intercorrelations for Psychological Empowerment and Selected Predictor Variables (N = 110)

Variable	*M*	*SD*	1	2	3	4	5
Psychological empowerment	5.16	.63	.66**	.62**	.67**	-.77**	.53**
Predictor variable							
Perceived organizational support	4.48	1.07	--	.66	.73	-.68	.58
Leader-member exchange	4.77	1.00		--	.63	-.60	.32
Participative decision-making	4.00	1.09			--	.65	.38
Role ambiguity	2.14	.80					-.49
Core self-evaluation	4.77	.62					--

** $p < .01$.

Table 6

Regression Analysis Summary for Participant Variables Predicting Psychological Empowerment

Variable	*B*	*SE B*	β	*t*	*p*
(Constant)	4.04	.47		8.57	.00**
Perceived organizational support	.00	.06	.01	.09	.93
Leader-member exchange	.10	.05	.16	2.08	.04*
Participative decision-making	.11	.05	.19	2.23	.03*
Role ambiguity	-.35	.06	-.45	-5.41	.00**
Core self-evaluation	.19	.07	.19	2.73	.00**

*$p < .05$, **$p < .01$.

Chapter Summary

This research included 115 nurse managers. Data used to measure the variables were collected through previously developed research instruments that were found to be reliable among other populations. Data obtained from this sample was subjected to tests for reliability as internal consistency and were found to be internally consistent for this sample. Scores obtained to measure the dependent variable, psychological empowerment, were tested to determine frequency distribution. The scores were found to be non-normal; however, as there is no non-parametric test equivalent for multiple

regression and the *F*-test is considered to be robust even when applied to severely non-normal distributions, parametric testing was pursued. Four research hypotheses, reflective of propositions in Thomas and Velthouse's (1990) model of intrinsic motivation, were tested and accepted. All variables contributed to the final model, hypothesis 4, except for perceived organizational support.

CHAPTER FIVE

SUMMARY AND DISCUSSION

This chapter summarizes the study and discusses the findings from several standpoints. Four research hypotheses, reflective of propositions in Thomas and Velthouse's (1990) model of intrinsic motivation were tested and accepted based on statistical analysis. The chapter will be presented in the following order: (a) significance of the study, including implications for education, practice, research, and health/public policy, (b) strengths and limitations of the study, (c) recommendations for future study, and (d) conclusions.

The healthcare industry is intricate and unpredictable, and this sector is further challenged with financial obligations, reimbursements, staffing complexities, and high patient acuity levels, which makes working in the healthcare arena a complex task (Anthony et al., 2005). Nurse executives no longer provide oversight strictly to nursing units; rather, their scope has evolved to include patient care services throughout the continuum of care. As such nurses, who represent the largest numbers of employees in healthcare institutions, have recognized changes to the professional practice role. Consequently, there have been changes in the depth and breadth of the nurse manager role with less support from busy nurse executives (Shirey et al., 2010; Tulgan, 2007). Researchers have validated that the nurse manager role is considered complicated, ambiguous, and demanding (McCallin & Frankson, 2010; Shirey et al., 2008). To

compound the issue, research findings have been reported indicating that work factors in stressful work environments are less conducive to motivate individuals and reduce their perceptions of effectiveness (Laschinger et al., 2007; Wallach & Mueller, 2006). Decreased motivation perceptions among nurse managers threaten the critical link managers play in sustaining organizational efficiencies and work environments that foster professional nursing practice and quality outcomes.

Researchers have found that empowerment has been effective in neutralizing stressful work conditions (Kanter, 1993; Spreitzer & Doneson, 2007). Similarly, nurse managers have identified that stress is related to workplace complexities and perceptions that the work environment lacked empowering structures (Shirey et al., 2008). Empowerment research within the nursing discipline has focused on staff nurses who provide direct patient care. A review of the pertinent literature revealed that research studies had not been performed to investigate those factors that contribute to managers' empowerment level, inasmuch as the motivation for achieving organizational goals and performance expectations.

The purpose of this study was to determine whether selected variables were effective predictors of empowerment among nurse managers. The study variables were leader-member exchange, participative decision-making, role ambiguity, perceived organizational support, core-self evaluation, and psychological empowerment. The theoretical framework for this study was comprised of Thomas and Velthouse's (1990) model of intrinsic motivation to test four hypotheses. The following hypotheses were tested:

Hypothesis 1. There will be a significant positive relationship between contextual factors (perceived organizational support, leader-member exchange, participative decision-making) on psychological empowerment among nurse managers.

Hypothesis 2. There will be a significant positive relationship between the individual characteristic (core self-evaluation) and psychological empowerment among nurse managers.

Hypothesis 3. There will be a significant negative relationship between contextual factor (role ambiguity) and psychological empowerment among nurse managers.

Hypothesis 4. There will be a unique or combined significant effect on four contextual factors (perceived organizational support, leader member exchange, participative decision-making, role ambiguity) and one individual characteristic (core self-evaluation) on psychological empowerment among nurse managers.

A descriptive, predictive design was used to examine the relationship of the predictor (independent) variables: leader-member exchange, participative decision-making, role ambiguity, perceived organizational support, core-self evaluation, and the criterion (dependent) variable: psychological empowerment. Data were collected using 7 instruments with a total of 63 items including a researcher-developed demographic instrument with items to describe the participants, as well as the six standardized instruments that were used to measure the major study variables. The Core Self Evaluation Scale (CSES) (Judge et al., 2003), the Survey of Perceived Organization Support (SPOS) (Eisenberger et al., 1986), the Multidimensional Leader Member-

Exchange (LMX-MDM) Scale (Liden & Maslyn, 1998), the Participative Decision Making Scale (PPDMS) (Siegel & Ruh,1973), the Role Ambiguity Scale (RAS) (Rizzo et al., 1970), and the Psychological Empowerment Scale (PES) (Spreitzer, 1995) were the instruments used to collect data.

Descriptive and inferential statistics were computed to describe the demographic characteristics of the sample, as well as descriptive characteristics and reliability estimates for all scales. The four hypotheses were tested using descriptive, correlation, and multiple regression statistics. Data were analyzed using PASW Statistics 20.0 (SPSS, 2012). Data were collected over a 21-week period from full-time nurse managers (n = 115) that reported to a nurse leader and had 24 x 7 responsibilities for at least one clinical unit. Participants were recruited from hospitals with a minimum 100-bed capacity from three Southeast Florida healthcare systems.

The sample consisted of males (n = 15, 13.0%) and females (n =100, 87.0%), ranging in age from 30 to 66 years (n = 113, M = 48.04, SD = 8.83), who had been RNs between to 45 years (n = 115, M = 22.95, SD = 10.0) and in their current position between less than 1 to 32 years (n = 115, M = 7.65, SD = 7.08). They reported directly to either a nurse director (n = 88, 76.5%), a chief nursing officer (n = 14, 12.2%), or an associate vice president (n = 13, 11.3%). They were in charge of inpatient units (n = 67, 58.3%), outpatient units (n = 26, 25.2%), or both types of units (n = 19, 16.5%). The participants provided information related to their educational background and the number of units for which they had 24 hours a day, seven days a week responsibilities.

Significance of the Study

In recent decades, healthcare organizations continue to increase in complexity, and nurse leaders have aligned their roles to ensure organizational success and quality professional nursing practices. Organizational and professional changes have had an impact on nurses throughout the healthcare system, particularly the nurse manager (Hyrkas, Koivula, Lehti, & Paunonen-Ilmonen, 2003). Nurse managers are expected to manage the critical aspects of daily patient care, as well as the professional and administrative unit components (DeCampli et al., 2010; McLarty & McCartney, 2009; Shirey et al., 2010).

In this study, nurse managers had moderate empowerment perceptions (M = 5.17, SD = .62) within the range of (4.24 to 5.69) found in other studies using Spreitzer's scale with managerial, professional and technical staff from diverse organizational settings (El-Salam et al., 2008, Farr-Wharton, Brunetto, & Shacklock, 2012; Mok & Au-Yeung, 2002; Sparks, 2012; Spreitzer, 1995; Spreitzer, 1996; Spreitzer et al., 1997; Wallach & Mueller, 2006;). Findings from this study indicated that role ambiguity, participative decision-making, perceived organizational support, a quality relationship between the nurse manager and his/her superior, and core self-evaluation were all associated with nurse managers' perceptions of empowerment. Relevant literature review conducted among management and professionals in organizational settings has noted similar findings (Butts et al., 2009; Joiner & Bartram, 2004; Laschinger et al., 2007; Laschinger et al., 2009; Mendes & Stander, 2011; Mok & Au-Yeung, 2002; Patrick & Laschinger, 2006; Seibert et al., 2011; Spreitzer, 1996; Wallach & Mueller, 2006). As hypothesized, a negative significant relationship was found between empowerment and role ambiguity

(r = -.77, $p < .01$), and positive significant relationships were found between empowerment and participative decision-making ($r = .67$, $p < .01$), empowerment and perceived organizational support ($r = .66$, $p < .01$), empowerment and leader member exchange ($r = .62$, $p < .01$), and empowerment and core self evaluation ($r = .53$, $p < .01$). Together these variables accounted for 68% of the variance in nurse management empowerment. When controlling for the influence of the selected predictors on empowerment, the results were as follows: role ambiguity ($\beta = -.45$, $p < .01$), core self-evaluation ($\beta = .19$, $p < .01$), participative decision-making ($\beta = .19$, $p < .05$), and leader member exchange ($\beta = .16$, $p < .05$). Perceived organizational support was the only variable that was not significant in the model.

To date, this is the first study conducted to explore the factors that influence nurse managers' psychological empowerment level. Trus et al. (2012) conducted a literature review and found nine empirical articles published between 1990 and 2009 that examined some aspect of empowerment among nurse managers. Of the nine studies, one was qualitative, and the remaining eight were quantitative: five descriptive studies, one secondary analysis, one correlational study, and one predictive design conducted in Canada using a structural empowerment theoretical framework. In consideration of the significant changes in healthcare, the subsequent changes in the nurse management role, and the significance of nursing leadership at this critical juncture within healthcare, there was a need to examine those factors that influence psychological empowerment among nurse managers. Findings from this study provide a foundation towards filling that void and will add significantly to the body of scientific nursing knowledge. As such, the

findings of this study have implications that impact the nursing discipline in education, practice, research, and policy.

Implications for Nursing Education

Nurse educators play a significant role in the education of future nurses and the continued knowledge and advancement of nurses actively practicing that seek to further their education. Researchers have found that innovative behaviors, job satisfaction, organizational commitment, trust, low burnout, and work effectiveness are an outcome of psychological empowerment (Faulkner & Laschinger, 2008; Knol & van Linge, 2008; Spreitzer, 1995; Wagner et al., 2010). Nurse managers are key to sustaining a work unit that displays a healthy working environment and is credited with quality professional practice and patient outcomes (Sherman & Pross, 2010; Shirey, 2009; Shirey et al., 2010). As such, academic curriculums can integrate a focus on helping novice and experienced nurses understand the nurse manager role, meanwhile developing awareness regarding the personal dispositional traits and workplace factors that are likely to influence motivating behaviors. In the hospital setting, organizational development programs can integrate ongoing learning opportunities for nurse leaders and those nurses interested in the management track to aid in seamless succession planning. Simulation strategies focused on increasing the nurse managers' comfort level in engaging in leadership activities that develop empowering skills may prove to be beneficial. The results of this study can expand the current educational platform in academia and within hospitals to prepare nurses for their role and develop ongoing programs for effective nurse managers.

Implications for Nursing Practice

This study provides support for an organizational model that can be utilized to guide, influence, and sustain nurse manager empowerment. Nurse executives can explore the personal dispositional traits and work factors that impact professional success and organizational effectiveness to provide enhanced empowerment opportunities. To the extent that nurse executives and managers understand the factors that influence psychological empowerment, work environments can be cultivated that better enable nurse managers to feel knowledgeable, gain meaning from their work, impact decisions, and influence professional practice and patient outcomes. Empowered nurse managers can promote positive communication and offer constructive performance feedback (Wallach & Mueller, 2006). In an effort to develop quality relationships between nurse managers and their superiors, specific opportunities can be considered to adequately communicate work initiatives, job responsibilities, and receive timely feedback on goal accomplishment. Opportunities to diminish ambiguous communication or role expectations may limit the degree of role ambiguity perceptions among nurse managers. The development of training and mentoring activities combined with building a work environment that cultivates, engages, and empowers nurse managers is likely to experience less turnover and be more successful with internal succession planning efforts (Aiken et al., 2008; Shirey et al., 2008).

Implications for Nursing Research

Nurse managers are the management professionals closest to those nurses that provide direct patient care and have the largest impact on patient care, professional

practice, and organizational outcomes (Sherman & Pross, 2010; Shirey et al., 2008). The ability to balance both administrative and clinical responsibilities generally adds to the challenges found among the nurse managers (Bradley et al., 2008; Krebs et al., 2008). The results provide researchers with a foundation to build future studies on empowerment among nurse managers. All study variables (core self-evaluation, role ambiguity, participative decision making, perceived organizational support) individually had a significant relationship on psychological empowerment. Collectively, each of these variables with the exception of perceived organizational influenced psychological empowerment among nurse managers in this study. Additional qualitative and quantitative research studies should be conducted to further scientific nursing knowledge of nurse manager empowerment. This study can be replicated in another geographic region or with additional variables. Research conducted using longitudinal, experimental, phenomenological, or grounded theory designs could provide advantageous results. Findings may provide more support for a theoretical model that could be used as the basis for future research.

Implications for Nursing Health/Public Policy

The results of the study showcase that there are tangible mechanisms that can be deployed to influence empowerment among nurse managers. Professional nursing practice, quality care delivery, and patient outcomes are influenced by local, state, national, and international policies. Hospital quality indicators are benchmarked and trended, making strategies that can be positively correlated with patient outcomes of interest for communities and local, state, and federal agencies and government. The

findings can be the catalyst for academia, nursing organizations, and hospital organizations to conduct additional research, implement strategies, and showcase results regarding empowerment, empowering behaviors, and positive outcomes. Results could open the door to funding sources that support initiatives related implementing empowerment models in academia and healthcare organizations. Initiatives can include policy development that supports integrating work factors that influence empowerment in the training, competency, and practice ensuring the nurse manager role gains the support within the profession and healthcare organizations.

Strengths and Limitations of the Study

Findings from this study provided valuable information and insight into the factors that influence psychological empowerment among nurse mangers. The information gained may be utilized to increase the understanding of empowerment among the nurse manager population. As a result, there may be development and implementation of strategies within nursing education, nursing practice, nurse research, and nursing health/public policy. However, there were strengths and limitations to this study. The strengths were as follows:

1. The study was guided by a theoretical framework.
2. Valid and reliable instruments were used for the study with Cronbach's alpha calculated for each instrument that was above the established benchmark.

3. Each survey packet was returned indicating 100% return rate and the number of usable questionnaires exceeded the recommended sample size through power analysis.
4. The results from each hypothesis were found to be statistically significant.
5. Individually, each selected variable influenced empowerment, and collectively, four of the five variables influenced empowerment as reported in the results.
6. Though participants were from one geographic location, the healthcare systems resulted in responses from 14 hospitals. The collective organizational cultures from the three healthcare systems were distinctive and representative of the population.

The limitations were as follows:

1. The Southeast Florida geographic location may not represent the population of all nurse managers.
2. A cross-sectional design was used to collect data for the study. Thus, generalizations cannot be made with regard to trends or developments over time.
3. A convenience sampling strategy was used to collect data for this study. Therefore, sampling bias may have occurred, thus limiting generalizability of the study findings.

4. As responses on the questionnaire were self-reported, participants may have answered based on social desirability rather than on the actual belief or practice and response bias and inaccuracies could have occurred.

Recommendations for Future Study

The magnitude of research addressing empowerment in the nursing discipline is growing at a moderate pace but has been conducted less within the nurse manager population. While empowerment has been investigated using different designs throughout the nursing literature, within the nurse manager population, the most common study design was a descriptive survey design. Further studies are necessary to expand the current knowledge base on nurse manager empowerment. A focus on other predictors in the workplace, personal dispositional traits, outcomes, generational, and cultural differences may prove beneficial to further understand nurse manager empowerment. Replication of the current study should continue in other geographic locations to determine whether the findings would be consistent. This study was cross-sectional, and longitudinal studies could be conducted with this same population to identify other influential factors over a period of months or years.

Qualitative studies such as phenomenology and grounded theory would provide a vehicle to understand the meaning and experience of empowerment from nurse managers in everyday practice and how it could be enhanced within their practical settings. Mixed methods would shed light on how nurse managers perceive empowerment, maintain empowerment, and identifying barriers.

The Intrinsic Model of Motivation (Thomas & Velthouse, 1990) was used as a theoretical framework for this study and has been used in varied populations to examine psychological empowerment. Of the six instruments utilized in this study, three were never used in this population before. Future studies should be designed with consideration of using the same instruments to provide an opportunity to compare psychometrics with this study as well as previous studies.

Conclusions

The purpose of the study was to test the propositions of Thomas and Velthouse's (1990) model of intrinsic motivation to determine whether selected variables were effective predictors of psychological empowerment among the sample of nurse managers. The selected study variables included core self-evaluation, perceived organizational support, leader-member exchange, role ambiguity, participative decision making, and psychological empowerment. A descriptive, predictive design was used to examine the relationship of the predictor (independent) variables; core self-evaluation, perceived organizational support, leader-member exchange, role ambiguity, and participative decision-making, and the criterion (dependent) variable; psychological empowerment.

One hundred and fifteen nurse managers from three healthcare systems in Southeast Florida provided data for this study. Hospitals had a minimum of 100 beds. The sample consisted of males (n = 15, 13.0%) and females (n =100, 87.0%), ranging in age from 30 to 66 years (n = 113, M = 48.04, SD = 8.83). Data was using a 63-item anonymous questionnaire, which was comprised of a researcher-developed demographic instrument to ensure participants met the study criteria and adequately describe the

sample. Six standardized instruments that were used were found to be reliable, appropriate for the target population and were used to measure additional study variables. The Core Self Evaluation Scale (CSES) was used to measure the variable personal dispositional traits comprised of individual worthiness, effectiveness, and capability (Judge et al., 2003) and the Survey of Perceived Organization Support (SPOS) was used to measure the variable of perceived organizational support (Eisenberger et al., 1986). The Multidimensional Leader Member-Exchange Scale (LMX-MDM) was used to measure the variable regarding quality of the relationship between a subordinate and their superior (Liden & Maslyn, 1998) and the Participative Decision Making Scale (PPDMS) was used to measure the variable of participative decision-making (Siegel & Ruh, 1973). The Role Ambiguity Scale (RAS) was used to measure the variable of role ambiguity (Rizzo et al., 1970) and the Psychological Empowerment Scale (PES) was used to measure the variable of psychological empowerment (Spreitzer, 1995).

Hypotheses were tested using correlational and multiple regression techniques. Four hypotheses were supported. Perceived organizational support, leader-member exchange, participative decision-making, and core self-evaluation had a significant positive relationship, while role ambiguity had a significant negative relationship. Also, the predictor variables made significant combined contributions to psychological empowerment among nurse managers, with the exception of perceived organizational support.

Hopefully, the findings from this study will influence other quantitative studies to explore other variables that may influence nurse manager empowerment. Furthermore,

increasing the knowledge base in the nursing literature will be the catalyst to developing and implementing strategies in nurse education, practice, research, and health/public policy. As a result, nurse managers may be better equipped to face complex healthcare challenges and positively impact professional nursing practice and patient outcomes.

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APPENDIX A

APPROVAL FROM BARRY UNIVERSITY AND HOSPITAL

INSTITUTIONAL REVIEW BOARD

[redacted]

[redacted]

OFFICE OF THE PROVOST
INSTITUTIONAL REVIEW BOARD

Research with Human Subjects
Protocol Review

Date:	June 29, 2012
Protocol Number:	120603
Title:	Selected Predictors of Empowerment among Nurse Managers
Approval Date:	6/29/12
Name:	Ms. Deborah S. Clarke
Address:	[redacted]
Sponsor:	Dr. Jessie Colin [redacted] School of Nursing

Dear Ms. Clarke:

On behalf of the [redacted] Institutional Review Board (IRB), I have verified that the specific changes requested by the IRB have been made. Therefore, I have granted final approval for this study as exempt from further review.

As principal investigator of this protocol, it is your responsibility to make sure that this study is conducted as approved by the IRB. Any modifications to the protocol or consent form, initiated by you or by the sponsor, will require prior approval, which you may request by completing a protocol modification form.

It is a condition of this approval that you report promptly to the IRB any serious, unanticipated adverse events experienced by participants in the course of this research, whether or not they are directly related to the study protocol. These adverse events include, but may not be limited to, any experience that is fatal or immediately life-threatening, is permanently disabling, requires (or prolongs) inpatient hospitalization, or is a congenital anomaly cancer or overdose.

The approval granted expires on June 29, 2013. Should you wish to maintain this protocol in an active status beyond that date, you will need to provide the IRB with and

IRB Application for Continuing Review (Progress Report) summarizing study results to date.

If you have questions about these procedures, or need any additional assistance from the IRB, please call the IRB point of contact [redacted]. Finally, please review your professional liability insurance to make sure your coverage includes the activities in this study.

Sincerely,

[redacted]

Note: The investigator will be solely responsible and strictly accountable for any deviation from or failure to follow the research protocol as approved and will

[redacted]

Subject: [redacted] # 120603

[redacted]

Ms. Clarke:

The [redacted] Review Committee (CRRC) reviewed the study referenced below on June 13, 2012. This study is now approved and may commence at [redacted]

[redacted] **IRB STUDY #:** **120603**

Principal Investigator: **Deborah S. Clarke, MSN, MBA, RN**

Study Title: **Selected Predictors of Empowerment Among Nurse Managers**

Funding: **PI-Initiated**

Type of Study: **Survey**

ClinicalTrials.gov Identifier: **N/A**

Thank you for working with the Clinical Trials Office.

[redacted]

1

[redacted]

July 17, 2012

[redacted]

RE: **IRB EXEMPT REVIEW: MH# 212.028 SELECTED PREDICTORS OF EMPOWERMENT AMONG NURSE MANAGERS**

Dear Ms. Clarke:

We are in receipt of the IRB exempt application form, cover letter, flyer, and the 63-item survey (Appendix D through J), for the above mentioned study. This study meets the criteria for an exemption from IRB review as outlined in 45 CFR 46.101(b). This study meets the exemption category #2: Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, **unless**: a. information obtained is recorded in such a manner that subjects can be identified, directly or through identifiers linked to the subjects **and** b. any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability or reputation.

It is noted that no identifiers will be recorded for this study on the questionnaires or demographic form, and no protected health identifiers will be collected. There will be no link to subjects who complete the questionnaire, and the subjects' return of the questionnaire will indicate their acceptance to participate in the study.

This study will be conducted within [redacted]. Any changes to this study may further review and approval. You may begin this study without the requirement for IRB approval.

As the principal investigator, you are responsible for complying with the following policies:

{1} Conduct the study according to what has been presented in your application.
{2} Submit for review and approval by the IRB any changes to the study plan prior to the implementation of the change that could affect a change in this exemption declaration.
{3} Provide adequate training to staff involved in the conduct of your research.
{4} Record the minimally required information to conduct this study.

Prior to using any facility's name associated with [redacted] in any publication related to this research, administrative approval is required. The posting of the flyer in the hospital areas is conditioned upon the area director's needs. It may be removed at anytime without your permission. The flyer should be kept out of sight from general display to patients and families.

Sincerely,

[redacted]

[redacted]

[redacted]

September 28, 2012

[redacted]

RE: IRB 12-079: Selected Predictors of Empowerment among Nurse Managers (PI initiated)

[redacted]

Your application for the study listed above was reviewed and approved by the [redacted] Institutional Review Board. This study qualifies for expedited review in accordance with 45 CFR 46.110(7) research on individual or group behavior. The approval date for this study is 9/27/2012 and the expiration date for this study is 9/26/2013.

The study is next subject to continuing review on or before 9/26/2013 unless closed before that date. You will receive a notice to submit a progress report approximately 60 days before the study expiration date.

You have been granted approval to conduct your research at [redacted]. The IRB has approved this study for the enrollment of 100 participants.

You must provide participants with a copy of the IRB stamped approved consent letter.

Please note that any changes to the IRB approved study or consent letter must first be approved by the IRB before the changes can be implemented.

[redacted] if you have any questions or require further information.

Sincerely,

[redacted]

[redacted]

APPENDIX B

BARRY UNIVERSITY COVER LETTERS

Barry University
Cover Letter

Dear Research Participant:

Your participation in a research project is requested. The title of the study is: Selected Predictors of Empowerment among Nurse Managers.

The research is being conducted by Deborah S. Clarke, MSN, MBA, RN; a doctoral student in the Nursing Division at Barry University who is seeking information that will be useful in the field of nursing. The aim of the study is to collect information from nurse managers on those factors that influence empowerment.

In accordance with these aims, the following procedures will be used to obtain data for this study: complete questionnaires that use a Likert scale on personal traits and workplace factors that are related to empowerment. The questionnaire is estimated to take about 15 minutes to complete. I anticipate there will be 150 participants involved in the study. Your consent to be a research participant is strictly voluntary and should you decline to participate or choose to drop out at anytime during the study, there will be no adverse effects to you.

There are no known risks to you for your involvement in this study. Though there are no direct benefits to you for participating in this study, your participation will contribute to research in the area of understanding the perceptions and responses of nurse manager that may assist in determining the effective predictors of empowerment.

As a research participant, the information you provide will be anonymous. As such, no names or other identifiers will be collected on the questionnaires that you submit and there will be no way to identify your responses. Once the survey data has been entered into the statistical program for analysis the surveys will be destroyed. The data will be kept for five years and then destroyed. By completing and returning this survey you have shown your agreement to participate in this study.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Deborah Clarke at [redacted], or by email [redacted] or Research Chair Dr. Jessie M. Colin at [redacted]. You may also contact the Institutional Review Board point of contact [redacted] by phone at [redacted] or by email at [redacted].

Thank you for your participation.

Sincerely,

Deborah Clarke, MSN/MBA, RN

Barry University/[redacted]
Cover Letter

Dear Research Participant:

Your participation in a research project is requested. The title of the study is: Selected Predictors of Empowerment among Nurse Managers.

The research is being conducted by Deborah S. Clarke, MSN, MBA, RN; a doctoral student in the Nursing Division at Barry University who is seeking information that will be useful in the field of nursing. The aim of the study is to collect information from nurse managers on those factors that influence empowerment.

In accordance with these aims, the following procedures will be used to obtain data for this study: complete questionnaires that use a Likert scale on personal traits and workplace factors that are related to empowerment. The questionnaire is estimated to take about 15 minutes to complete. I anticipate there will be 150 participants involved in the study. Your consent to be a research participant is strictly voluntary and should you decline to participate or choose to drop out at anytime during the study, there will be no adverse effects to you.

There are no known risks to you for your involvement in this study. Though there are no direct benefits to you for participating in this study, your participation will contribute to research in the area of understanding the perceptions and responses of nurse manager that may assist in determining the effective predictors of empowerment.

As a research participant, the information you provide will be anonymous. As such, no names or other identifiers will be collected on the questionnaires that you submit and there will be no way to identify your responses. Once the survey data has been entered into the statistical program for analysis the surveys will be destroyed. The data will be kept for five years and then destroyed. By completing and returning this survey you have shown your agreement to participate in this study.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Deborah Clarke [redacted] deborah.clarke@mymail.barry.edu or Research Chair Dr. Jessie M. Colin [redacted] You may also contact the [redacted] Institutional Review Board point of contact, [redacted] bcook@mail.barry.edu [redacted]

Thank you for your participation.

Sincerely,

Deborah Clarke, MSN/MBA, RN

Barry University/[redacted]
Cover Letter

Dear Research Participant:

Your participation in a research project is requested. The title of the study is: Selected Predictors of Empowerment among Nurse Managers.

The research is being conducted by Deborah S. Clarke, MSN, MBA, RN; a doctoral student in the Nursing Division at Barry University who is seeking information that will be useful in the field of nursing. The aim of the study is to collect information from nurse managers on those factors that influence empowerment.

In accordance with these aims, the following procedures will be used to obtain data for this study: completion of questionnaires that use a Likert scale on personal traits and workplace factors that are related to empowerment and a demographic data form. The questionnaire is estimated to take about 15 minutes to complete. I anticipate there will be 150 participants involved in the study. Your consent to be a research participant is strictly voluntary and should you decline to participate or choose to drop out at anytime during the study, there will be no adverse effects to you.

You may experience minimal feelings of anxiety in relation to answering questions regarding your supervisor and the organization. However, the information you provide will be kept anonymous and unable to be traced back to you or your organization. No names or other identifiers will be collected on any of the questionnaires that you submit and there will be no way to identify your responses. Once the survey has been entered into the statistical program for analysis the surveys will be destroyed. Access to the data in aggregate format will be limited to the research personnel. The aggregate data will be kept for a total of five years and then destroyed. By completing and returning this survey you have shown your agreement to participate in this study.

Though there are no direct benefits to you for participating in this study, your participation will contribute to the knowledge in the area of understanding the perceptions and responses of nurse managers that may assist in determining the effective predictors of empowerment.

If you have any questions or concerns regarding the study or your participation in the study, you can contact me, Deborah Clarke [redacted] deborah.clarke@mymail.barry.edu or [redacted] eveb@baptisthealth.net [redacted] Research Chair Dr. Jessie M. Colin [redacted] For questions about your rights as a research participant you may also contact the Institutional Review Board point of contact, [redacted] bcook@mail.barry.edu [redacted]

Thank you for your participation.

Sincerely,

Deborah Clarke, MSN/MBA, RN

APPENDIX C

ACCESS LETTER TO NURSE EXECUTIVES

Date
Hospital Name
Chief Nursing Officer
Address
City, State, Zip Code

Dear Chief Nursing Officer,

I will be conducting a study for my dissertation titled: SELECTED PREDICTORS OF EMPOWERMENT AMONG NURSE MANAGERS. As such, I am requesting your permission to invite nurse managers from your facility to participate in completing anonymous surveys. The purpose of the study is to ascertain the individual characteristics and work related factors that influence empowerment among nurse managers.

Prior to any recruitment efforts, I will submit the appropriate documents to your hospital institutional review board for approval. Once approved, I would like to recruit managers for my study through assistance from your directors, or the person(s) you deem appropriate. I will maintain responsibility for the distribution and collection of all surveys. Thanks in advance for your time and consideration. I look forward to your response to whether you will grant permission for me to access managers from your facility for the purposes of data collection.

Deborah Clarke, MSN, MBA, RN
Doctoral Student
Barry University
College of Health Sciences
Division of Nursing
305 XXX-XXXX
[redacted]

APPENDIX D

APPROVAL LETTERS FROM NURSE EXECUTIVES

[redacted]

Maggie Hansen
Chief Nursing Officer
[redacted]

June 11, 2012

Dear Ms. Clarke:

I approve your request for access to [redacted] to conduct your study for your dissertation titled: SELECTED PREDICTORS OF EMPOWERMENT AMONG NURSE MANAGERS once you receive [redacted] IRB approval.

Sincerely,

Maggie Hansen

Maggie Hansen
Chief Nursing Officer

[redacted]

April 30, 2012

Deborah Clarke, MSN, MBA, RN
Doctoral Student
Barry University
College of Health Sciences
Division of Nursing

Dear Ms. Clarke:

Once you receive [redacted] IRB approval, I approve your request for access to [redacted] Hospital to conduct your study for your dissertation entitled: "SELECTED PREDICTORS OF EMPOWERMENT AMONG NURSE MANAGERS."

Sincerely,

[redacted] MSN, RNC, CNO

Bella Cabrera
Chief Nursing Officer

[redacted]

[redacted]

Rebecca Caschette
Chief Nursing Officer
[redacted]

March 20, 2012

Dear Ms. Clarke:

I approve your request for access to [redacted] to conduct your study for your dissertation titled: SELECTED PREDICTORS OF EMPOWERMENT AMONG NURSE MANAGERS once you receive [redacted] IRB approval.

Sincerely,

Rebecca Caschette

Rebecca Caschette
Chief Nursing Officer

[redacted]

March 9, 2012

Ms. Deborah Clarke
[redacted]

Dear Ms. Clarke:

I hereby approve your request for access to [redacted] to conduct your study for your dissertation titled: SELECTED PREDICTORS OF EMPOWERMENT AMONG NURSE MANAGERS, once you receive [redacted] IRB approval.

If I can be of any further assistance, please feel free to contact me at [redacted]

Sincerely,

Sue E. Bradford

Sue E. Bradford, RN, DNP
Chief Nursing Officer

SEB:rj

[redacted]

[redacted]

March 14, 2012

Deborah Clarke, MSN, MBA, RN
Doctoral Student
Barry University
College of Health Sciences - Division of Nursing
[redacted]

Dear Ms. Clarke:

I approve your request for access to [redacted] to conduct your study for your dissertation titled: SELECTED PREDICTORS OF EMPOWERMENT AMONG NURSE MANAGERS.

Additionally, the use of [redacted] name in any publication will require special permission from the [redacted]

Sincerely,

Grisel Fernandez-Bravo
Chief Nursing Officer

GFB:id

[redacted]

[redacted]

Denise Reynolds
Chief Nursing Officer
[redacted]

DATE

Dear Ms. Clarke:

I approve your request for access to [redacted] to conduct your study for your dissertation titled: SELECTED PREDICTORS OF EMPOWERMENT AMONG NURSE MANAGERS once you receive [redacted] IRB approval.

Sincerely,

Denise Reynolds
Chief Nursing Officer

[redacted]

[redacted]

May 30, 2012

Ms. Deborah Clarke
Doctoral Student
Barry University
College of Health Sciences
Division of Nursing

Dear Ms. Clarke:

On April 5, 2012 the Chief Nursing Officers approved your request to conduct your dissertation study on "Selected Predictors of Empowerment among Nurse Managers" at [redacted] pending [redacted] IRB approval.

Sincerely,

Deborah Mulvihill
Corporate Vice President and Chief Nursing Officer

[redacted]

[redacted]

5/17/2012

Dear Ms. Deborah Clarke,

This letter is to inform you that your research proposal titled **"Selected Predictors of Empowerment among Nurse Managers"** has been reviewed and approved by the Nursing Research & Evidence-Based Practice Council at [redacted]

The next step in the approval process will be to contact the [redacted] Clinical Research Review Committee for approval, followed by the designated Institutional Review Board.

Should you have any questions please feel free to contact me.

Sincerely,

Bridgette M. Johnson, PhD, ARNP, CDE

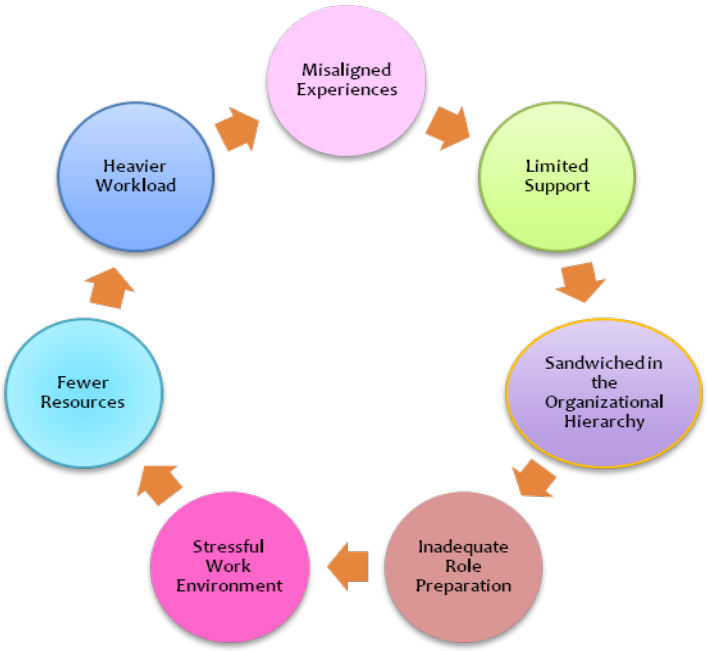
[redacted]

APPENDIX E

FLYERS

SEEKING NURSE MANAGERS FOR A STUDY TITLED:

"Selected Predictors of Empowerment among Nurse Managers"

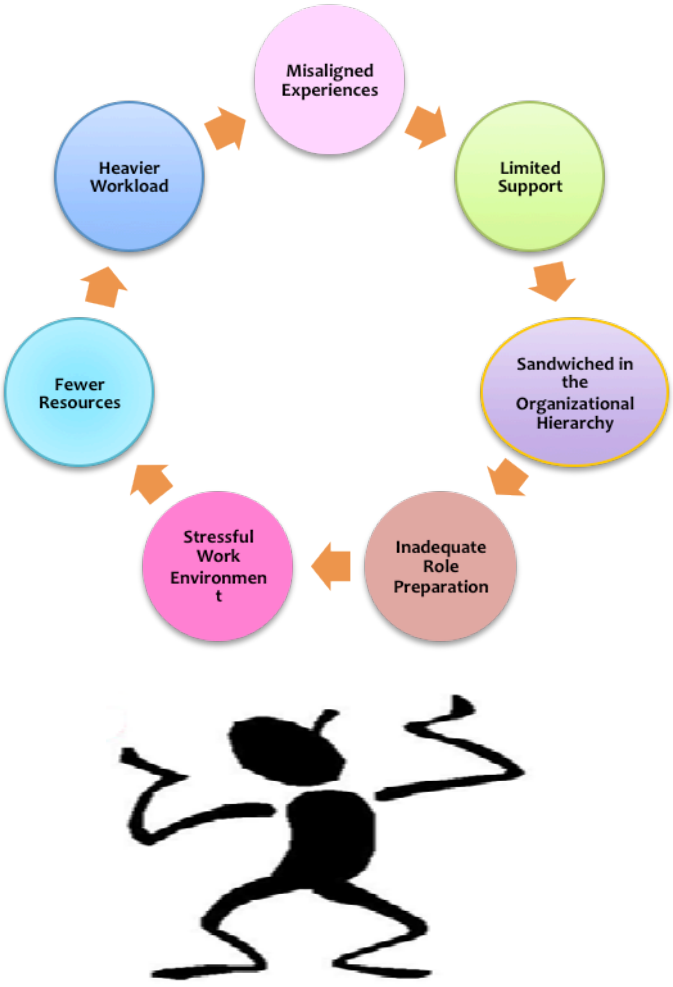


If you are a nurse manager with 24 x 7 responsibility for at least one clinical unit and report directly to a nurse leader, then you are invited to participate in this voluntary study that will take about 15 minutes. There study is anonymous and no identifying information will be collected. After the surveys are distributed, read the cover letter and instructions, record your responses and place the

completed survey in envelope and seal it. Once finished with the surveys, place the sealed envelope in the lockbox on the desk and keep the cover letter to use as necessary.
For any questions regarding the study or participation in this study, please contact the researcher Deborah Clarke at [redacted], or by email [redacted] or Research Chair Dr. Jessie M. Colin at [redacted]. You may also contact the Institutional Review Board point of contact, [redacted]

SEEKING NURSE MANAGERS FOR A STUDY TITLED:

"Selected Predictors of Empowerment among Nurse Managers"



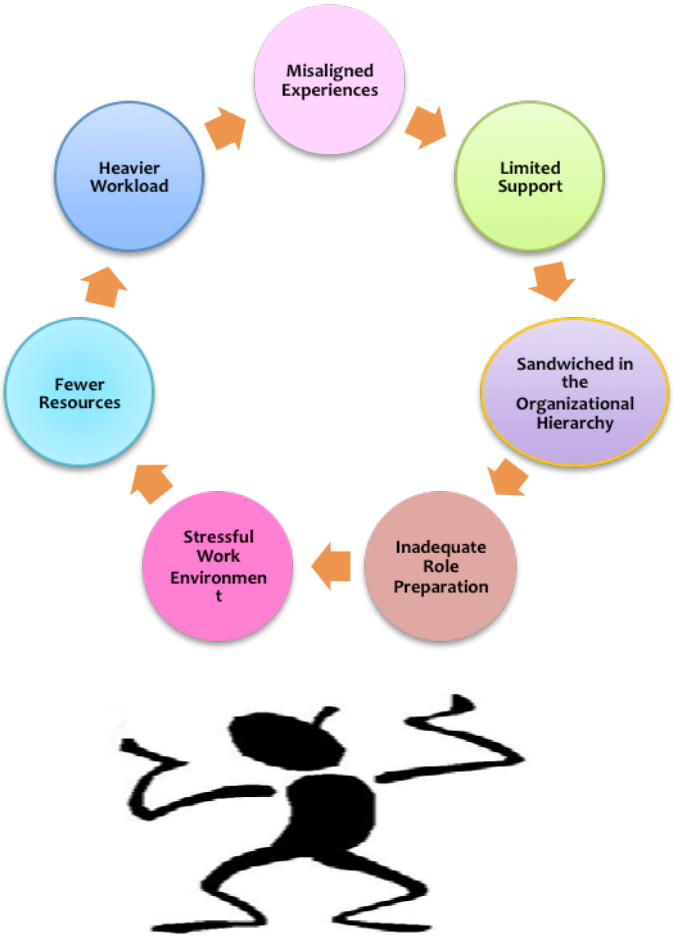
If you are a full-time nurse manager with 24 x 7 responsibility for at least one clinical unit and report directly to a nurse leader, then you are invited to participate in this voluntary study that will take about 15 minutes. The study is anonymous and no identifying information will be collected. After the

surveys are distributed, read the cover letter and instructions, record your responses and place the completed survey in the envelope and seal it. Once finished with the surveys, place the sealed envelope in the collection box on the desk and keep the cover letter to use as necessary.

For any questions or concerns regarding the study or your participation, you may contact me, Deborah Clarke [redacted] deborah.clarke@mymail.barry.edu or Research Chair Dr. Jessie M. Colin [redacted]. You may also contact the Institutional Review Board point of contact, [redacted] bcook@mail.barry.edu [redacted]

SEEKING NURSE MANAGERS FOR A STUDY TITLED:

"Selected Predictors of Empowerment among Nurse Managers"



If you are a full-time nurse manager with 24 x 7 responsibility for at least one clinical unit and report directly to a nurse leader, then you are invited to participate in this voluntary study that will take about 15 minutes. There study is anonymous and no identifying information will be collected. After the surveys are distributed, read the cover letter and instructions, record your responses and place the completed survey in envelope and seal it. Once finished with the surveys, place the sealed envelope in the collection box on the desk and keep the cover letter to use as necessary.

For any questions regarding the study or participation in the study, please contact the researcher Deborah Clarke [redacted] deborah.clarke@mymail.barry.edu or Research Chair Dr. Jessie M. Colin [redacted] You may also contact the [redacted] Institutional Review Board point of contact, [redacted] bcook@mail.barry.edu . If you have any

questions about your rights as a research participant you may contact [redacted]

APPENDIX F

DEMOGRAPHIC QUESTIONNAIRE

Please answer the following questions by circling the answer that reflects a description of yourself. **Please do not write your name on this page.**

1. What is your gender?

    1. _____Male

    2. _____Female

2. What is your current age? _____

3. How many years have you been a registered nurse? _____

4. Throughout your nursing career, how many years have you held a position in your current role? _____

5. Circle the answer that best describes to whom you directly report.

    1. Nurse Director
    2. Chief Nursing Officer
    3. Other, please specify_____

6. Circle the answer that describes the highest nursing degree that you have completed?

    1. Diploma
    2. Associate's Degree
    3. Bachelor's Degree
    4. Master's Degree
    5. Doctoral Degree

7. Circle the type of clinical nursing unit for which you currently have responsibility.

    1. Inpatient
    2. Outpatient
    3. Other, please specify _____

8. How many units do you have 24 x 7 responsibilities for? _____

APPENDIX G

CORE SELF-EVALUATION SCALE (CSES)

Core Self-Evaluation Scale (CSES)

Read each statement below and indicate by ***circling the one number*** *(1, 2, 3, 4, 5, 6)* that indicates your level of agreement or disagreement with the statement.

Key: 1 = Strongly Disagree
2 = Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Agree
6 = Strongly Agree

Please respond to every question and complete your responses for the each question, enclose the completed survey in the envelope provided, seal it, and return to researcher.

1. I am confident I get the success I deserve in life.

Strongly disagree Strongly agree

1 2 3 4 5 6

2. Sometimes I feel depressed.

Strongly disagree Strongly agree

1 2 3 4 5 6

3. When I try, I generally succeed.

Strongly disagree Strongly agree

1 2 3 4 5 6

4. Sometimes when I fail I feel worthless.

Strongly disagree Strongly agree

1 2 3 4 5 6

5. I complete tasks successfully.

Strongly disagree Strongly agree

1 2 3 4 5 6

6. Sometimes, I do not feel in control of my work.

Strongly disagree Strongly agree

1 2 3 4 5 6

7. Overall, I am satisfied with myself.

Strongly disagree Strongly agree

1 2 3 4 5 6

8. I am filled with doubts about my competence.

Strongly disagree Strongly agree

1 2 3 4 5 6

9. I determine what will happen in my life.

Strongly disagree Strongly agree

1 2 3 4 5 6

10. I do not feel in control of my success in my career.

Strongly disagree Strongly agree

1 2 3 4 5 6

11. I am capable of coping with most of my problems.

Strongly disagree Strongly agree

1 2 3 4 5 6

12. There are times when things look pretty bleak and hopeless to me.

Strongly disagree Strongly agree

1 2 3 4 5 6

APPENDIX H

SURVEY OF PERCEIVED ORGANIZATIONAL SUPPORT (SPOS)

Survey of Perceived Organizational Support (SPOS)

Below are statements that represent possible opinions that YOU may have about working at your current organization. Read each statement below and indicate by ***circling the one number*** *(1, 2, 3, 4, 5, 6)* that best describes your agreement or disagreement regarding your current organization.

Key: 1 = Strongly Disagree
2 = Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Agree
6 = Strongly Agree

Please respond to every question and complete your responses for the each question, enclose the completed survey in the envelope provided, seal it, and return to researcher.

1. The organization values my contribution to its well-being.

Strongly disagree Strongly agree

1 2 3 4 5 6

2. The organization fails to appreciate any extra effort from me.

Strongly disagree Strongly agree

1 2 3 4 5 6

3. The organization would ignore any complaint from me.

Strongly disagree Strongly agree

1 2 3 4 5 6

4. The organization really cares about my well-being.

Strongly disagree Strongly agree

1 2 3 4 5 6

5. Even if I did the best job possible, the organization would fail to notice

Strongly disagree Strongly agree

1 2 3 4 5 6

6. The organization cares about my general satisfaction at work.

Strongly disagree Strongly agree

1 2 3 4 5 6

7. The organization shows very little concern for me.

Strongly disagree Strongly agree

1 2 3 4 5 6

8. The organization takes pride in my accomplishments at work.

Strongly disagree Strongly agree

1 2 3 4 5 6

APPENDIX I

MULTIDIMENSIONAL LEADER-MEMBER EXCHANGE SCALE (LMX-MDM)

Multidimensional Leader-Member Exchange Scale (LMX-MDM)

Read each statement below and think of your immediate supervisor who rates your performance. Please indicate by ***circling the one number*** **(***1, 2, 3, 4, 5, 6)* that best describes your agreement or disagreement with each statement.

Key: 1 = Strongly Disagree
2 = Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Agree
6 = Strongly Agree

Please respond to every question and complete your responses for the each question, enclose the completed survey in the envelope provided, seal it, and return to researcher.

1. **I respect my supervisor's knowledge of and competence on the job.**

   Strongly disagree Strongly agree

   1 2 3 4 5 6

2. **My supervisor would defend me to others in the organization if I made an honest mistake.**

   Strongly disagree Strongly agree

   1 2 3 4 5 6

3. **My supervisor is the kind of person one would like to have as a friend.**

   Strongly disagree Strongly agree

   1 2 3 4 5 6

4. **I do not mind working my hardest for my supervisor.**

   Strongly disagree Strongly agree

   1 2 3 4 5 6

5. **My supervisor would come to my defense if I were "attacked" by others.**

   Strongly disagree Strongly agree

   1 2 3 4 5 6

6. I like my supervisor very much as a person.

Strongly disagree Strongly agree

1 2 3 4 5 6

7. I do work for my supervisor that goes beyond what is specified in my job description.

Strongly disagree Strongly agree

1 2 3 4 5 6

8. I admire my supervisor's professional skills.

Strongly disagree Strongly agree

1 2 3 4 5 6

9. My supervisor defends (would defend) my work actions to a superior, even without complete knowledge of the issue in question.

Strongly disagree Strongly agree

1 2 3 4 5 6

10. My supervisor is a lot of fun to work with.

Strongly disagree Strongly agree

1 2 3 4 5 6

11. I am willing to apply extra efforts, beyond those normally required, to meet my supervisor's work goals.

Strongly disagree Strongly agree

1 2 3 4 5 6

12. I am impressed with my supervisor's knowledge of his/her job.

Strongly disagree Strongly agree

1 2 3 4 5 6

APPENDIX J

PARTICIPATIVE DECISION MAKING SCALE

Participative Decision Making Scale

Read each statement below and indicate by ***circling the one number (****1, 2, 3, 4, 5, 6*) that best describes your agreement or disagreement regarding your organization.

Key: 1 = Strongly Disagree
2 = Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Agree
6 = Strongly Agree

Please respond to every question and complete your responses for the each question, enclose the completed survey in the envelope provided, seal it, and return to researcher.

1. **In this organization, I have a high degree of influence in company decision.**

   Strongly disagree Strongly agree

   1 2 3 4 5 6

2. **In this organization, I often participate in decisions regarding my job.**

   Strongly disagree Strongly agree

   1 2 3 4 5 6

3. **In this organization, I have a high degree of influence in the decisions affecting me.**

   Strongly disagree Strongly agree

   1 2 3 4 5 6

4. **In this organization, I can participate in setting new company policies.**

   Strongly disagree Strongly agree

   1 2 3 4 5 6

5. **In this organization, my views have a real influence in company decisions.**

   Strongly disagree Strongly agree

   1 2 3 4 5 6

APPENDIX K

ROLE AMBIGUITY SCALE (RAS)

Role Ambiguity Scale (RAS)

Read each statement below and indicate by **circling the one number** (*1, 2, 3, 4, 5, 6)* that best describes your agreement or disagreement.

Key: 1 = Strongly Disagree
2 = Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Agree
6 = Strongly Agree

Please respond to every question and complete your responses for the each question, enclose the completed survey in the envelope provided, seal it, and return to researcher.

1. **I feel certain about how much authority I have.**

   Strongly disagree Strongly agree

   1 2 3 4 5 6

2. **I have clear planned goals and objectives in my job.**

   Strongly disagree Strongly agree

   1 2 3 4 5 6

3. **I know that I have divided my time properly.**

   Strongly disagree Strongly agree

   1 2 3 4 5 6

4. **I know what my responsibilities are.**

   Strongly disagree Strongly agree

   1 2 3 4 5 6

5. **I know exactly what is expected of me.**

   Strongly disagree Strongly agree

   1 2 3 4 5 6

6. Explanation is clear of what has to be done.

Strongly disagree					Strongly agree
1	2	3	4	5	6

APPENDIX L

PSYCHOLOGICAL EMPOWERMENT SCALE (PES)

Psychological Empowerment Scale (PES)

Listed below are a number of perceptions that people generally have regarding their work role. Read each statement below and indicate by ***circling the one number*** *(1, 2, 3, 4, 5, 6)* that represents the best response.

Key: 1 = Strongly Disagree
2 = Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Agree
6 = Strongly Agree

Please respond to every question and complete your responses for the each question, enclose the completed survey in the envelope provided, seal it, and return to researcher.

1. I am confident about my ability to do my job.

Strongly disagree Strongly agree

1 2 3 4 5 6

2. The work that I do is important to me.

Strongly disagree Strongly agree

1 2 3 4 5 6

3. I have significant autonomy in determining how I do my job.

Strongly disagree Strongly agree

1 2 3 4 5 6

4. My impact on what happens in my department is large.

Strongly disagree Strongly agree

1 2 3 4 5 6

5. My job activities are personally meaningful to me.

Strongly disagree Strongly agree

1 2 3 4 5 6

6. I have a great deal of control over what happens in my department.

Strongly disagree Strongly agree

1 2 3 4 5 6

7. I can decide on my own how to go about doing my own work.

Strongly disagree Strongly agree

1 2 3 4 5 6

8. I have considerable opportunity for independence and freedom in how I do my job.

Strongly disagree Strongly agree

1 2 3 4 5 6

9. I have mastered the skills necessary for my job.

Strongly disagree Strongly agree

1 2 3 4 5 6

10. The work I do is meaningful to me.

Strongly disagree Strongly agree

1 2 3 4 5 6

11. I have significant influence over what happens in my department.

Strongly disagree Strongly agree

1 2 3 4 5 6

12. I am self-assured about my capabilities to perform my work activities.

Strongly disagree Strongly agree

1 2 3 4 5 6

APPENDIX M

PERSMISSION TO USE ROLE AMBIGUITY SCALE

RE: Participative Decision Making

Robert Ruh [redacted]
Sent: Monday, February 06, 2012 2:34 PM
To: Clarke, Deborah (Barry Student)

Hi Deborah,

You certainly have my permission to use the questionnaire but I am unable to provide the instrument or any psychometrics.

All the best,
Bob

From: Clarke, Deborah (Barry Student) [mailto:[redacted]
Sent: Wednesday, February 01, 2012 5:23 PM
To: Robert Ruh
Subject: Participative Decision Making

Dr. Ruh,

I am a nursing Phd student at Barry University and am completing my disseration titled: Selected Predictors of Empowerment among Nurse Managers. I recently reviewed an article titled "Job Involvement, Participation in Decision Making, Personal Background, and Job Behavior" authored by Alan L. Siegel and Robert A. Ruh.

Though the article identifies that Mr. Siegel should be contacted for further details abouthte questionnaire scale development, I have been unsuccessful in locating him. In as such, I would like to know if you would be willing give permission for me to use this scale and provide me with the instrument and related psychometrics.

I appreciate your time and look forward to your response.

Thanks,

Deborah Clarke, MSN, MBA, RN
Doctoral Student
Barry University
College of Health Sciences
Division of Nursing
[redacted]

APPENDIX N

PERMISSION TO USE PARCIPATIVE DECISION MAKING SCALE

RE: Participative Decision Making
Robert Ruh [redacted]
Sent: Monday, February 06, 2012 2:34 PM
To: Clarke, Deborah (Barry Student)

Hi Deborah,

You certainly have my permission to use the questionnaire but I am unable to provide the instrument or any psychometrics.

All the best,
Bob

From: Clarke, Deborah (Barry Student) [mailto:[redacted]
Sent: Wednesday, February 01, 2012 5:23 PM
To: Robert Ruh
Subject: Participative Decision Making

Dr. Ruh,

I am a nursing Phd student at Barry University and am completing my disseration titled: Selected Predictors of Empowerment among Nurse Managers. I recently reviewed an article titled "Job Involvement, Participation in Decision Making, Personal Background, and Job Behavior" authored by Alan L. Siegel and Robert A. Ruh.

Though the article identifies that Mr. Siegel should be contacted for further details abouthte questionnaire scale development, I have been unsuccessful in locating him. In as such, I would like to know if you would be willing give permission for me to use this scale and provide me with the instrument and related psychometrics.

I appreciate your time and look forward to your response.

Thanks,

Deborah Clarke, MSN, MBA, RN
Doctoral Student
Barry University
College of Health Sciences
Division of Nursing
[redacted]

APPENDIX O

HYPOTHESES TABLE

	Research Questions	Hypothesis	Instrument	Statistical Test	Result
1	Is there a significant positive relationship between contextual factors (perceived organizational support, leader-member exchange, participative decision-making) on psychological empowerment among nurse mangers?	H1. There will be a significant positive relationship between contextual factors (perceived organizational support, leader-member exchange, participative decision-making) on	Survey of Perceived Organizational Support (SPOS) Leader-Member Exchange Multidimensional Scale (LMX-MDM) Participative Decision Making Scale (PDMS) Psychological Empowerment Scale (PES)	Multiple Linear Regression	There will be a unique or combined significant effect on four contextual factors (perceived organizational support, leader member exchange, participative decision-making, role ambiguity) and one individual characteristic (core self-evaluation) on psychological empowerment among nurse managers.

		psychological empowerment among nurse managers.			
2	Is there a significant positive relationship between the individual characteristic (core self-evaluations) and psychological empowerment among nurse managers? women?	H2. There will be a significant positive relationship between the individual characteristic (core self-evaluation) and psychological empowerment among nurse managers.	Core-Self Evaluation Scale (CSES) Psychological Empowerment Scale (PES)	Two tailed Pearson correlation	The hypothesis was supported. Bivariate correlation analysis found that core self-evaluation was significantly correlated with psychological empowerment; the relationship was positive, $r = .53$, p (two-tailed) $< .01$, indicating that as the scores for core self-evaluation increased so did the scores for psychological empowerment. The effect was medium.

3	Is there a significant negative relationship between contextual factor (role ambiguity) and psychological empowerment among nurse mangers?	H3. There will be a significant negative relationship between contextual factor (role ambiguity) and psychological empowerment among nurse managers.	Role Ambiguity Scale (RAS) Psychological Empowerment Scale (PES)	Two tailed Pearson correlation	The hypothesis was supported. The linear combination of predictors was significantly related to psychological empowerment scores. Regression analysis found that 68.3% (R^2 = .683, adj R^2 = .668) of the variance in the dependent variable was explained by the model and that the relationship was significant, F (5, 104) = 44.87, p = .00.
4	Is there a unique or combined significant effect among contextual factors (perceived organizational support,	H4. There will be a unique or combined significant effect on four	Survey of Perceived Organizational Support (SPOS) Leader-Member Exchange Multidimensional Scale	Multiple Linear Regression	The hypothesis was supported. The linear combination of predictors was significantly related to psychological empowerment scores. Regression analysis found that 68.3% (R^2 = .683,

leader member exchange, participative decision-making, role ambiguity) and individual characteristic (core-self evaluation) on psychological empowerment among nurse managers?	contextual factors (perceived organizational support, leader member exchange, participative decision-making, role ambiguity) and one individual characteristic (core self-evaluation) on psychological empowerment	(LMX-MDM) Participative Decision Making Scale (PDMS) Role Ambiguity Scale (RAS) Core-Self Evaluation Scale (CSES) Psychological Empowerment Scale (PES)	adj R^2 = .668) of the variance in the dependent variable was explained by the model and that the relationship was significant, F (5, 104) = 44.87, p = .00.

	among nurse managers.

VITA

Employment History

1986	A.A.S. Graphic Arts & Advertising New York City Technical College Brooklyn, NY
1989	Print Analyst/Print Production Supervisor Metropolitan Life Insurance Company New York, NY
1998	Staff Nurse Columbia Regional Medical Center Hudson, FL
1999	Staff Nurse University Community Hospital Tampa, FL
2000	Staff Nurse Moffitt Cancer Center Tampa, FL
2004	Clinical Nurse Manager Staff Nurse Mount Sinai Hospital New York, NY
2006	Associate Director Patient Care Services Jackson Health System Miami, FL
2009 –	Chief Nurse – Surgery Quality Management Nurse - Surgery Miami VA Healthcare System Miami, FL-

Education

1986	A.A.S Graphic Arts & Advertising New York City Technical College Brooklyn, NY
1989	B.B.A. Business Marketing Baruch College New York, NY
1997	A.A.S. Nursing Hillsborough Community College Tampa, FL
2003	M.S.N and M.B.A. University of Tampa Tampa, FL
2013	PhD – Nursing Barry University Miami, FL

Awards/Certifications

2012	Honorable Mention Miami VA Research Week Miami, FL
2012	Florida Organization of Nurse Executives 2012 Research Award
2012	Florida Nurses Association Blanche Case Research Award
2009	University of Phoenix Faculty Certification

Professional Memberships

1998 -	Florida Nurses Association
1998 -	Association of Perioperative Nurses
2001 -	Sigma Theta Tau International
2002 -	Florida Organization of Nurse Executives
2012 -	South Nursing Research Society
2012 -	Council for Advancement of Nursing Science

1998 - Florida Nurses Association