IMPACT OF A HEALTHY WORK ENVIRONMENT ON NURSE SATISFACTION

AND

RETENTION IN A NON-MAGNET FACILITY

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ABSTRACT

RESEARCH SUBJECT: Impact of a Healthy Work Environment on Nurse Satisfaction and Retention in a Non-Magnet Facility

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Nurse satisfaction and retention are critical issues for healthcare facilities. Nurse Managers are held accountable for nurse satisfaction and retention on a daily basis. The establishment of a healthy work environment has been identified as a key to both nurse satisfaction and retention. The majority of the research regarding healthy work environments has been performed in of Magnet facilities, which are recognized for their healthy work environments. The purpose of this research is to identify the perceptions of the work environment in non-Magnet facilities and to evaluate the nurse empowerment levels and retention in those facilities. This is a modified replication of Spence-Laschinger's (2009) study. The study population will be nurses from the Critical Care units of three hospitals in Northern Indiana. Nurses will complete the Essentials of Magnetism II tool to determine HWE; the Conditions for Work Effectiveness Questionnaire II to determine the level of empowerment; and critical care nurse retention statistics will be obtained from the Human Resource departments of the participating facilities. The findings of this study will identify the gaps in work environment and nurse empowerment in non-magnet facilities. The results of this study will be applied to improve the work environment and nurse empowerment in the critical care units of these non-Magnet facilities.
Introduction

Nurse satisfaction and retention are critical issues for healthcare facilities. Nurse Managers are held accountable for nurse satisfaction and retention on a daily basis. The establishment of a healthy work environment has been identified as a key to both nurse satisfaction and retention. Improving the retention rates of RNs is cost effective. Retention of newly licensed RNs is extremely important because there is a higher rate of turnover among new nurses. Retention is important so that adequate and safe staffing levels are maintained. It is also important because the turnover cost is high. It is estimated that the cost of RN turnover is approximately $80,000 per nurse, and even more for specialty areas (Kramer, Halfer, Maguire, & Schmalenberg, 2012). The American Association of Colleges of Nursing also projects an increase of 712,000 nurses in the workforce by 2020. There will also be a need to replace the aging nursing workforce. The AACN has also identified that there will be a projected shortage places for new baccalaureate students because of a lack of qualified faculty (Rosseter, 2012). These statistics demonstrate that hospitals must retain a dedicated, committed workforce. This can be done through improvements in the work environment and empowerment of nurses.
Background and Significance

The work environment has been identified as a determinant of retention. The environment must promote learning and excellence. A healthy work environment is positive and supportive of nurses. Communication is very important in a healthy work environment. In 2004, the Nursing Organizational Alliance identified nine elements of a healthy work environment: collaborative practice culture, communication rich culture, a culture of accountability, adequate number of nurses, expert, competent, credible, and visible leadership, shared decision making, encouragement of professional growth and development, recognition of the value of nurses’ contributions, and recognition by nursing of the value of their contributions to practice (Ritter, 2011). In 2005, the American Association of Critical Care Nurses consolidated these elements and identified six standards of a healthy work environment: communication, collaboration, Practice environment, professional advancement, and empowerment. Kramer, Halfer, Maguire, and Schmalenberg (2012) concluded that Healthy Work Environments are essential to retention of nurses.

An organization that has achieved Magnet designation has many of the same elements. Approximately 6.78% of all registered hospitals in the United States have achieved ANCC Magnet Recognition status (Magnet Statistics, 2012). Magnet status is a credential of organizational recognition of nursing excellence (Magnet Statistics, 2012). A Magnet environment is identified by nurses feeling valued by the organization, having standardized processes, staff empowerment, strong leadership, a sense of community, and strategic planning that reflects the missions and goals of the organization (Ritter, 2011).
Nurse administrators must monitor the work environment constantly for subtle changes that may lead to job dissatisfaction and burnout. Nurses must have a sense of empowerment and control over their work environment. Registered nurses in Magnet facilities are expected to work in a healthy environment and have a sense of empowerment. There has been little research to determine how nurse empowerment and work environment are related to retention in a non-Magnet facility.

**Problem Statement**

It is assumed that Magnet facilities have a firm handle on empowerment of nurses and healthy work environment. There have been many research studies performed in Magnet organizations to determine their level of nurse retention, which is expected to be high. Determining how the non-Magnet facilities rank in retention rates, nurse empowerment, work environment using the results from the Essentials of Magnetism II tool (EOMII) by Kramer et al. (2012), and Conditions of Work Effectiveness Questionnaire II (CEWQII) by Laschinger, Leiter, Day, and Gilin (2009) will help to identify areas requiring improvements. Once the areas needing improvement are identified, these organizations can create an action plan.

**Purpose of the Study**

The purpose of this research is to identify nurses’ perceptions of the work environment in non-Magnet facilities and to evaluate the nurse empowerment levels and retention in those facilities. This is a modified replication of the Laschinger et al. (2009) study.

**Research Questions**

What are nurses’ perceptions of the work environment in non-Magnet facilities?

What are nurse empowerment levels and retention in those facilities?
**Conceptual Theoretical Framework**

Empowerment is based upon Rosabeth Kanter’s theory which states when employees are not working in a stratified system, but have equal access to upper management they feel more committed to the organization (Fitzpatrick, Campo, & Lavandero, 2011). In nursing an empowering work environment will have potential for opportunity for growth, learning, and promotion (Fitzpatrick et al., 2011). An organization must also have formal and informal power structures present to provide information, support, and resources.

A healthy work environment is based upon research by Kramer et al. (2012). The Essentials of Magnetism II (Kramer et al., 2012) measures the healthiness of the work environment. The EOMII is based upon Donabedian’s conceptual paradigm and grounded theory for the eight essential elements of a magnetic work environment.

This study will combine the work of Laschinger et al. (2009) regarding nurse empowerment and the work of Kramer et al. (2012) on healthy work environment. This study will measure the work environment and nurse empowerment and determine the effect of these two elements on the retention statistics of the hospitals studied.

**Definition of Terms**

Healthy work environment (HWE) is an environment which supports excellence in nursing practice. The American Association of Critical Care Nurses (2012) has six requirements to define the healthy work environment: nurses’ use of skilled communication; collaboration between families and practitioners; appropriate staffing; effective decision making; meaningful recognition; and authentic leadership. The HWE will be measured by the results of the Essentials of Magnetism II (EOMII) tool developed...
by Kramer et al. (2012). The work environments will be classified as Very Healthy Work Environment (VHWE), Healthy Work Environment (HWE), and Work Environment Needs Improvement (WENI). The EOMII consists of eight subscales containing 58 items. The subscales are as follows (Kramer et al., 2012):

1. Work with nurses who are clinically competent.
2. Collegial/collaborative nurse-physician and interdisciplinary relationships
3. Autonomy and clinical decision making
4. Supportive Nursing Managers
5. Control of Nursing Practice
6. Support for education
7. Perception of adequate staffing
8. A culture where concern for patients is a priority.

Nurse Empowerment is defined as nurses’ having an awareness of opportunities for growth, learning, and promotion (Fitzpatrick et al., 2011). Nurse empowerment will be measured by the results of the Conditions of Work Effectiveness II questionnaire (CWEQII). The level of empowerment will be measured by the CWEQ-II (Laschinger et al., 2009). The CWEQ-II consists of 19 questions regarding six subscale components of opportunity, information, support, resources, formal power, and informal power. There are three questions in each of the first four subscales. Three items will measure formal power of the job, four items for informal power, and two items for global empowerment Subscale. Each item in the six subscales uses a five point Likert Scale ranging from “none (1) to a lot (5)”. The responses to the global empowerment subscale range from “strongly disagree to strongly agree”. The empowerment score will be calculated by the
mean score of each subscale (6-30). Scores will be ranked as follows: 6-13 Low structural empowerment; 14-22 Moderate structural empowerment; 23 to 30 High structural empowerment. (Laschinger et al., 2009).

Retention statistics will be obtained from the participating hospitals. They will be evaluated for reason of turnover, whether it is work environment related, termination, or relocation for other reasons.

*Limitsations*

This study is small, consisting of Critical Care Nurses in three community hospitals within a twenty mile radius. These three organizations all utilize some of the same physicians, so the results of the physician/nurse interactions may be similar. It will be difficult to extrapolate the results to a larger geographic or national area. None of the hospitals have achieved Magnet Status, although it is part of the future plan for all of the facilities. There may be significant differences in the results depending upon where these organizations are in their Magnet journey. This will also make it difficult to get a clear picture of the empowerment and work environment situation.

*Assumptions*

1. Empowerment is necessary to improve retention of registered nurses.
2. A Healthy Work Environment is necessary to promote empowerment of nurses.
3. Magnet facilities are recognized to have better retention rates than non-Magnet facilities.
4. Magnet facilities are recognized for high levels of nurse empowerment and healthy work environments.
Summary

Retention of registered nurses is extremely important in a competitive work environment. A healthy work environment and nurse empowerment have been identified as key elements to organizational commitment and retention. Utilizing a combination of the work of Kramer et al. (2012) regarding work environment and the work of Laschinger et al. (2009) regarding empowerment, this study intends to identify whether it is possible to have a non-Magnet facility with the characteristics of empowerment, healthy work environment, and high retention rates. This study will determine areas the participating organizations may need to improve to reduce turnover of registered nurses.
CHAPTER II

Review of Literature and Research Evidence

Introduction

Nurse satisfaction and retention are critical issues for healthcare facilities. Nurse Managers are held accountable for nurse satisfaction and retention on a daily basis. There have been several studies regarding nurse turnover and the work environment. The establishment of a healthy work environment (HWE) has been identified as a key to both nurse satisfaction and retention. The review of literature regarding the HWE and nurse retention leads to the conclusion that a positive work environment leads nurses who have a sense of organizational commitment.

Review of Literature

Nursing turnover and retention will continue to be a significant challenge for administrators. Beecroft, Dore, and Wenten (2008) theorized the degree of turnover intent is the result of many factors, including personal characteristics and work environment characteristics. Nurse administrators must have an understanding of the effects of all variables on turnover intent, so that changes in the work environment can be made to improve retention rates. The problem is these variables affecting the turnover rate of novice nurses must be identified to decrease the turnover in the first 18 months of work.
The purpose of Beecroft et al. (2008) study was to determine the relationship among new nurse turnover intent with individual characteristics of age, educational level, prior work experience, choice of unit, skills and nursing competency and coping strategies. Work environment variables included control over practice (empowerment, autonomy, and decision making) and opportunities for advancement and promotion and organizational factors. The study compared new nurse turnover intent with actual turnover in 18 months of employment.

A prospective survey design with seven years of data collection was used for the analysis. Eight hundred and eighty nine new nurse graduates from the pediatric units of six California hospitals were included after completion of a standardized residency program. More than half were 23-30 years of age and had a baccalaureate degree or higher. Eighty-eight percent were assigned to their first choice of unit. All were employed at not for profit hospitals with similar bed sizes (Beecroft et al., 2008).

Over four years, the research instruments were reviewed to decrease the number of items respondents had to answer. Forty nine items were found to not be part of differentiating early leavers from non leavers, or had a low Cronbach alpha level were removed. The instruments used to measure Individual Characteristics were: The Skills Competency Self-Confidence Survey was a new instrument developed by the researchers. This instrument was a self rating tool which includes general skills for a pediatric RN developed from a competency profile (Beecroft et al., 2008).

The other instruments all of which were previously published with established reliability and validity included: Slater Nursing Competencies Rating Scale: Self-Report provided a self rating of performance it was adapted for pediatrics and reduced to a 76
item scale. The *professional subscale* was used to determine the dissonance between school preparation and actual work environment. The *Ways of Coping Revised* (WOCR) was used to assess cognitive and behavioral coping strategies used by nurses to deal with the role transition from new graduate nurse to staff nurse. The instruments used to measure Work Environment were: *Conditions for Work Effectiveness Questionnaire* (CWE) measured nurse perception of the workplace empowerment and included four subscales opportunity, job activities, coaching and support, and information. Respondents were given a list of items and asked to rank whether they “have” them now, or would “like” them (Beecroft et al., 2008). *Professional Nursing Autonomy Scale* (PNA) described clinical situations in which nurses must act autonomously. Eight items were deleted, and one reworded for clarity (total scale $\alpha = 0.86$) (Beecroft et al., 2008).

*Clinical Decision-Making Scale* (CDM) contains 33 statements about clinical decision making, regarding the nurse’s current practice. Items were deleted from the scale with a change in the alpha from 0.82 to 0.84. *Work Satisfaction Scale* (WS) and *Nurse Job Satisfaction Scale* (NS), were used to measure job satisfaction. Three subscales were revised in the NS giving a total change in $\alpha$ from 0.88 to 0.89. Four subscales from the WS scale were revised with a total change in $\alpha$ from 0.85 to 0.84 (Beecroft et al., 2008).

Organizational factors were measured using: *Leader Empowerment Behaviours Scale* (LEB). This scale was revised to 16 items, the $\alpha$ was unchanged at 0.95. *Group Cohesion Scale* (GC) determined the respondent’s opinion about their colleagues regarding productivity, efficiency, morale, personal feelings, belongingness, and working together (Beecroft et al., 2008). *Organizational Commitment Questionnaire* (OC)
measured the strength of the respondent’s identification and involvement in an organization, higher scores indicated stronger commitment.

Turnover intention was measured by a single item Likert question developed by “Do you plan to leave this facility within the next year?” Scores ranged from 1 (not at all) to 7 (I surely do). Actual turnover was defined as voluntary termination of employment. Length of tenure was the actual number of months from date of hire (Beecroft et al., 2008).

The researchers submitted the surveys to all nurses who finished the residency program. This was done during paid class time as an expectation of the residency program. The data were entered manually for the first four years, and then the Versant Voyager program was utilized (Beecroft et al., 2008).

Young respondents were more likely to indicate turnover intention (P=0.001). Other groups who more likely to indicate TI were nurses with a higher level of education (P=0.026), nurses who did not get their first choice of unit (P=0.012), or nurses who were older (>30) and did not get their first choice of unit (P=0.015). There was a statistically significant difference (P=0.011) between hospitals for TI, ranging from 25% to 46%.

Respondents who indicated TI rated lower on self confidence (P=0.021) and Slater nursing competencies (P=0.014) when compared with respondents who did not indicate TI. These nurses who indicated turnover intention also used positive reappraisal (P=0.029) and planful problem-solving (P≤0.001) coping strategies and escape-avoidance (P≤0.001) (Beecroft et al., 2008). Nurses with TI scored lower on all scales except for the CWE subscales of job flexibility, information, coaching and support, and work effectiveness. The final model of analysis includes data from each category of variables:
age grouping, older and not first choice and WOCR subscale of seeking social support from individual characteristics, OC and GC subscale of personal feelings from organizational factors and WS subscales of pay and professional status and NS subscale of enjoyment from work environment (Beecroft et al., 2008). It was found that respondents who were >30 were 4.5 times more likely to be in the TI group. High scores in work environment and organizational characteristics indicated a lower TI.

This very lengthy, complex study revealed three new facts regarding TI of nurses who had just completed their residency. When there is job satisfaction (including pay) and a sense of organizational commitment there is a lower TI. The study also found that increased use of social support to cope with transition to competent RN. It was also found that older graduates are more likely to be in the high TI group if they do not receive their unit of choice. These factors can all be modified to decrease the turnover in pediatric nursing units.

Laschinger, Leiter, Day, and Gilin (2009) identified empowerment of nurses as a key factor in the retention and maintenance of a healthy work environment (HWE). Work environments that are uncivil lead to a poor sense of empowerment and increase burnout, stress and turnover. The retention factors of job satisfaction, commitment, and intention to leave are related to empowerment and civility in the workplace (Laschinger et al., 2009). The purpose of this study was to determine the influence of empowerment in the workplace and workplace incivility on nurse retention factors of job satisfaction, commitment and intention to leave. The main research question is: Does a HWE predict incivility in the workplace, burnout and intent of nurses to remain in the current position?
The research tool was a survey questionnaire written by the researchers. A modified Dillman Total Design Methodology was utilized to increase the rate of surveys returned. The study took place in five organizations with 1,106 employees in two Canadian provinces. The 612 participants included in the study were staff nurses, the other respondents were excluded from the study. The average age was 41.3 years. The survey responders had various types of employment status (full time, part time, PRN, and temporary) and various years of work experience in their current facility (Laschinger et al., 2009).

The CWEQ-II was used to measure opportunity, information, support, and resources, the work empowerment structures defined in Kanter’s theory. The Workplace Incivility Scale, and the Emotional Exhaustion and Cynicism subscales of the Maslach Burnout Inventory-General Survey were also used (Laschinger et al., 2009). Items to determine organizational commitment were taken from the Affective Commitment Scale. Items from the Turnover Intentions measure were used to measure the intention to leave. The researchers collected the information from the surveys and then reduced the sample to include only registered nurses.

The Statistical Package for Social Sciences version 16.0 was used for descriptive and inferential statistical analysis. The authors performed hierarchical multiple linear regression analysis of the data and determined that empowerment, workplace incivility and burnout explained significant variance in the retention factors of job satisfaction, organizational commitment, and turnover intentions (Laschinger et al., 2009). The authors found that the work environment had moderate levels of empowerment. The authors also identified that workplace civility was low. The majority (77.6%) of nurses
had experienced some type of coworker incivility. Sixty seven percent of nurses had experienced some type of supervisor incivility. The results indicated that incivility did occur at a rate of less than 5% in both the supervisor and staff nurse groups. Almost half, (47.3%) of the nurses scored at a high level for severe burnout. Many nurses reported high levels of emotional exhaustion. The levels for cynicism were lower than for exhaustion. Nurses who were scored high on burnout were less likely to experience organizational commitment. Nurses did respond positively in terms of job satisfaction, organization commitment, and turnover intention. The factors of empowerment, incivility, and burnout were found to be predictors of the job satisfaction elements. Supervisor civility was found to be a predictor of retention. The highest predictor of turnover was related to emotional exhaustion, cynicism, and supervisor incivility (Laschinger et al., 2009).

The authors concluded that nurses who work in environments that encourage empowerment, are high in workplace civility, and low in burnout promote retention in the workplace. This conclusion helps to define the optimal environment characteristics that will aid in retention of staff nurses (Laschinger et al., 2009).

Differences between nurse manager and staff nurse perceptions of the work environment are another determinant of nurse turnover rates. The problem is that the differences in perception of work environment must be recognized to find some agreement. This agreement is essential to retention of nurses. The purpose of Gormley’s (2011) study was to examine and identify differences in the perceptions of work environment and quality of care between nurse managers and staff nurses and to
determine if there is a relationship between nurses’ perceptions of work environment and their intention to leave.

The sample population was 296 staff nurses and 40 nurse managers from two hospitals in the Midwest. One hospital was an urban 650 bed facility with a Level 1 trauma designation, the other was a suburban 96 bed facility. The urban hospital nurses were represented by a union, the suburban nurses were not. Eleven hundred nurses were employed by the urban hospital and 230 were employed by the suburban hospital. All full time and part time RNs employed as staff nurses and managers in acute and ambulatory care were included. LPNs, travel, agency, and PRN nurses were excluded from the study. A cross-sectional, non-experimental design to assess staff nurse perceptions and nurse manager perceptions of work climate, quality of care, and staff nurse turnover intention was performed (Gormley, 2011).

The instrument utilized was the Perceived Nurse Work Environment Scale (PNWE) which has seven subscales ranked 1-5 (strongly agree). The seven subscales were: opportunity for advancement (9 items), participatory governance (4 items), unit decision making (four items), nursing management (6 items), nurse–physician collaboration (4 items), positive scheduling climate (5 items) and job enjoyment. Staff nurses also took the Anticipated Turnover Scale (Gormley, 2011).

The findings indicated 88% of nurses in the study were staff nurses with a mean experience time of 15.8 years. Sixty seven percent of the staff nurses were represented by a union. The majority of staff nurses had associate and baccalaureate degrees (76%). The majority of staff nurses worked full time (78%) and worked on acute care units (82%). Nurse Managers were 12% of the sample. The mean years of experience were 12.7. The
majority of nurses were BSN and MSN 90% prepared. Pearson’s and Spearman’s correlations tested the relationships between demographic factors and study variables. No demographic factors were found to be related to the perceptions of the work environment, anticipated turnover, or perceptions of quality, except for membership in a union. Nurses who reported that they were a member of a union reported significantly lower mean scores on all key variable measurements (P ≤ 0.05) (Gormley, 2011).

There were mean score differences between staff nurses and manager on all subscales of the PNWE. There were significant F-ratios for all subscales of the PNWE (P ≤ 0.05) except for the subscale nurse–physician collaboration. Statistically significant findings were found with participative governance (F = 3.997; P ≤ 0.01), unit decision-making (F = 34.867; P ≤ 0.001), nursing manager (F = 14.846; P ≤ 0.001) and job enjoyment (F = 19.250; P ≤ 0.001) (Gormley, 2011). Mean scores were also significantly different between managers and nurses in perceptions of quality of care (F = 11.021; P ≤ 0.001) Pearson correlation was used to test relationships between the work environment, perceptions of quality of care, and staff nurse anticipated turnover. There was a negative correlation of anticipated staff nurse turnover with all work environment subscales. The relationships between the work environment and anticipated turnover were significant with low to moderate correlations (r = 0.149 to 0.291, P ≤ 0.05). Nurse–physician collaboration and scheduling environment were not significantly correlated with anticipated turnover. Perceptions of quality of care were moderately positively correlated to all aspects of the work environment (P ≤ 0.001) except for scheduling environment. The strongest correlations were with opportunities for advancement (r = 0.520, P ≤ 0.001), job enjoyment (r = 0.593, P ≤ 0.001), and participative governance (r = 0.430, P ≤
Nursing management was also moderately correlated ($r = 0.346$, $P < 0.001$) with perceptions of quality of care (Gormley, 2011). The author concluded that nurses and managers do not see the work environment the same way. This disconnect means that management may not use initiatives that will appeal to staff nurses. The author identified that staff nurses find that opportunities for professional growth and engagement in work activities are most important. Findings indicate that a shared governance environment, with staff nurse input regarding unit initiatives will aid in satisfaction and promote retention of nurses (Gormley, 2011).

MacKusick and Minick (2010) theorized that understanding why nurses leave practice will help in determining what changes can be made to retain them. Nursing studies have shown that 30% to 50% of new registered nurses (RNs) will change positions or leave bedside nursing within the first three years of practice (MacKusick & Minick, 2010). Retention of experienced nurses is a serious problem for health care facilities. The purpose of this study is to identify reasons nurses choose to leave clinical practice.

The sample was obtained through a referral from practicing RNs. The practicing RNs in southeastern hospitals were asked to refer friends who had left bedside nursing. The nurses were recruited by telephone to assess interest in participating. The sample population consisted of 10 participants who had worked in different southeastern hospitals, eight were female, seven Caucasian. The years of experience ranged from 1 to 18. The data was collected using a phenomenological research design (MacKusick & Minick, 2010).

The questions asked by MacKusick and Minick (2010, p. 336) were:
1. What does the term bedside nursing mean to you?
2. How do you define the role of the bedside or clinical nurse?
3. Can you explain the relationship that existed between you as the RN and your patients?
4. Can you talk about the reasons or a situation that may have brought you to the decision to leave bedside nursing?
5. Can you think of a situation that exemplifies the relationships that you had with co-workers while providing direct patient care?
6. Have you found career fulfillment in your current position? Can you describe what you would require to return to the practice of clinical nursing?
7. Why did you decide to participate in this research?
8. Is there anything else you would like to share with me?

Interpretive hermeneutic phenomenology techniques were used to evaluate the interviews (MacKusick & Minick, 2010). The interviews were taped and transcribed word for word. The participants then reviewed the transcripts to clarify information. The researchers reviewed the interviews as a group, then individually to identify themes. Contextual meanings were found during analysis. The researchers analyzed the interviews to identify themes related to leaving clinical nursing. As new themes were identified in an interview the researchers then reviewed all the prior interviews for the same theme. All possible reasons for leaving clinical nursing were explored in these reviews.

MacKusick and Minick (2010, p. 337) found three prevailing themes related to career changes for clinical nurses:
1. Unfriendly workplace identified by occurrences of sexual harassment, verbal or physical abuse from coworkers, managers, physicians in the workplace; and/or consistent lack of support from other RNs.

2. Emotional distress related to patient care as demonstrated by conflict regarding patient care decisions and frustration that patient and family decisions are being ignored.

3. Fatigue and exhaustion was identified by comments that related to emotional and physical exhaustion.

The three themes were then elaborated on by the researchers, using results of the interview. It was then determined that nurses felt the only way to change their situation was to leave bedside nursing. The moral dilemmas and conflicts caused emotional distress.

It can be inferred that many of the reasons nurses identified for leaving clinical practice can be prevented. If the work environment is unfriendly, a change in culture is necessary. Abuse should not be tolerated. Health care environments need to change if nurse retention is the goal. Conflict regarding patients is difficult to eliminate. Nursing will always experience conflicts about patient care. Patients, physicians, and families will not always have the same goals. These conflicts are a source of stress for nurses, perhaps support from management could help nurses deal with these difficult situations. The sense of exhaustion can be decreased by creating a more positive, supportive work environment.
Hospital administrators monitor turnover and retention rates of RNs on a monthly basis. This monitoring has resulted in changes in the orientation of new nurses and in the work environment. Nurse residency programs have been identified as a key to reduced turnover for novice registered nurses (RNs). A healthy work environment has also been identified as a factor in the retention of RNs. To determine where to place the most resources, both human and financial, administrators must identify how significant work environment and residency programs are to turnover intention. The purpose of the study by Kramer, Halfer, Maguire and Schmalenberg (2012) was to examine the effects of a healthy unit work environment and a nurse residency program on the retention rates of newly licensed RNs (NLRN). The research questions were (Kramer et al., 2012, p. 150):

1. To what extent is the aggregate of excellent, magnetic organizational structures as evidenced by Magnet hospital designation positively related to healthy, productive, clinical unit work environments as evidenced by the 8 work processes and relationships essential for quality patient care?

2. Do NLRNs working on clinical units with confirmed very healthy work environments (VHWE) have higher 3-year retention rates than do NLRNs working on units with less than healthy work environments (HWEs)?

3. Do NLRNs who have multistaged NRPs report smoother transition and higher retention rates than do NLRNs who experience transition stage only NRPs? Is there an interactive effect between NRPs and NLRN retention?
Forty Magnet hospitals were chosen to participate in this study. The hospitals were selected based upon ranking of “excellence”; type of hospital (community teaching, academic, community), geographical location, community size (<100,000, 100,000-500,000, 500,000-1 million, and >1 million); and parameters and strength of Nurse Residency Program (NRP) (Kramer et al., 2012). The goal was to choose the hospitals with the best NRPs, while still seeking representation from across the country. The criterion for individual selection was up to the participating facility. The option was to administer the EOMII to all nurses on all units or to units who have NLRNs. Only facilities with a 40% response rate were included in the final results for HWE. The experienced nurses' perceptions of HWE determined the classification of the specific unit. The NLRNs were then studied over three years to review retention rates, transfer rates, and reasons for leaving.

To evaluate the importance of HWE on retention of Newly Licensed RNs (NLRNs) the Essentials of Magnetism II (EOMII) tool was administered to 12,233 experienced nurses, on 717 units, in 40 hospitals. Responses from 10,752 nurses representing 540 units, in 34 hospitals, were included in the HWE part of the study. The Nurse Residency Program (NRP) questionnaires were completed by a facilitator in each hospital. The NRP group was broken down into two groups; four hospitals who had NRPs with a well defined two stage transition process and an integration of 7-12 months: 14 hospitals with an NRP lasting 8-12 months with transition program and some integration; and three hospitals with transition only programs. Retention data was collected over three years concerning 5,316 NLRNs from 28 participating hospitals. The data were collected by paper surveys completed by the nurses regarding the HWE. The
data regarding NLRNs was obtained by the researchers with cooperation from the Magnet facility's HR departments (Kramer et al., 2012).

The results of the demographics revealed that 3,188 (70%) of the nurses were BSN prepared. Forty-three percent of the NLRNs began careers on surgical units and 30% of NLRNs began in ICUs. Fifty percent of the NLRNS were assigned to VHWE units, 27 to HWE units, and 22% to work environment needs improvement (WENI) units. It was found that fewer NLRNs were placed on specialty units, such as ICUs with VHWE, than those specialty units designated as HWE or WENI (Kramer et al., 2012).

Magnet hospitals were found to have VHWE and HWE. In the confirmation study, 36 experienced nurses confirmed VHWE on 54% (n = 291) of the 540 clinical units in the 34 Magnet hospitals that submitted sufficient data (94.0% unit response rate). For valid, reliable data aggregation; 28% of the units (n = 150) were confirmed as HWE units; 18% (n = 99) were confirmed as WENI. In one hospital, all 28 clinical units were confirmed to have VHWEs. In seven additional hospitals, all clinical units surveyed were confirmed to have either VHWE or HWEs.

It was confirmed that NLRNs working on clinical units with confirmed VHWE have higher 3-Year retention rate than do NLRNs working on HWE or on WENI units. Almost 24% of NLRNs resigned during their first three years of practice. The rate of resignations on WENI units was 55% in the first six months after hire compared to 33% on HWE units and 14% on VHWE units. In the second six months resignation rates were about 24% for all types of units. The NLRNs on WENI Retention Rates were found to be significantly lower on WENI units than on HWE and VHWE units. Differences in retention are greatest at six months and one year from date of hire. Retention rates are
higher between years two and three on VHWE units. NLRNs practicing on WENI units resign with significantly greater frequency than do NLRNs on HWE and VHWE units.

There was no significant difference in retention rate and the number of stages in the nurse residency program. An analysis of variance indicated there was no significant difference in retention rate by number of stages in the residency program and the work environment \( (F = .749; P = .473) \). Retention rate alone was affected by the work environment \( (F = 40.606; P = .000) \) (Kramer et al., 2012).

It can be concluded that Healthy Work Environments are essential to retention of nurses. The nurses who worked on a unit with a VHWE had higher professional satisfaction and less reality shock. To increase retention nurses must feel be engaged in their practice, provide quality patient care, and feel fulfilled. Nurse Residency Programs increase the retention of NLRNs.

Empowerment is essential to retention of nursing staff. Determining what level of empowerment is necessary to retain nursing staff is important for administrators so they know where to allocate resources. The purpose of the study by Hauck, Griffin, and Fitzpatrick (2011) was to determine the level of structural empowerment among critical care nurses and the relationship of structural empowerment to anticipated turnover. The research questions were: “1. What is the perception of structural empowerment among critical care registered nurses? 2. What is the relationship between critical care registered nurses’ structural empowerment and their anticipated turnover?” (Hauck et al., 2011, p. 271).

The sample consisted of nurses who worked in one of five critical care units in a Northeastern University. Surveys were sent to 297 nurses and 98 surveys were returned.
The measurement tools utilized were:

1. **Background Data Questionnaire**: 11 questions regarding gender, race, age, years in nursing, years at hospital, certification status, highest degree held, and current salary.

2. **Conditions of Work Effectiveness Questionnaire II (CWEQ-II)**

   The CWEQ-II consists of 19 questions regarding 6 subscale components of opportunity, information, support, resources, formal power, and informal power. There were 3 questions in each of the first four subscales. To measure formal power the Job Activities Scale II (JAS II) consisting of 3 items was used. To measure informal power the Organizational Relationship Scale (ORS-II) consisting of 4 items was used. The CWEQ-II also has an additional 2 item Global Empowerment Subscale was used for construct validation. Each item in the 6 subscales used a 5 point Likert Scale ranging from “none (1) to a lot (5)”. The responses to the Global Empowerment subscale ranged from “strongly disagree to strongly agree”. The Empowerment Score was calculated by the mean score of each subscale (6-30). Scores were ranked as follows: 6-13 Low structural empowerment; 14-22 Moderate structural empowerment; 23 to 30 High structural empowerment. The construct validity of CWEQ-II had high correlation with the global measure of empowerment (r = 0.56). The Cronbach alpha from previous studies performed are as follows (Hauk et al., 2011, p. 272): Support 0.81-0.90; Information, 0.82-0.93; Resources, 0.78-0.86; Opportunity 0.79-0.88; Formal power, 0.78-0.82; Informal Power 0.70-0.72. The Cronbach alpha for the total empowerment scale ranged from 0.82 to 0.94 (Hauck et al, 2011).
The Anticipated Turnover Scale (ATS) is a self-report 12-item scale in Likert format. Each item has a seven-point scale ranging from strongly agree (1) to strongly disagree (7). Items scored are both negative and positive, so the numeric scale was adjusted accordingly. The totals scores are added and then divided by 12, a higher score equals higher anticipated turnover. The ATS has been tested many times over the years. The Cronbach alpha range for this instrument has been from 0.84 to 0.86 (Hauck et al, 2011). Construct validity was estimated by using principle component factor analysis; 2 factors explained 54.9% of the variation of the construct (Hauck et al., 2011).

Descriptive statistics analyzed background data of the 98 nurses who submitted eligible surveys. Pearson’s correlation coefficient was calculated to determine the relationship between structural empowerment and anticipated turnover. The mean age of respondents was 38 years (SD ± 8.12). The mean years of experience were 12.28 (SD±8.56). Fifty-five percent of the nurses had a BSN degree.

The total CWEQ-II Cronbach alpha was 0.89. The range for the subscales was from 0.60 for informal power to 0.90 for opportunity. The correlation between the mean GES score (M=3.29) and the mean of total structural empowerment (M=20.55), a moderate level of empowerment, provided construct validity for the structural empowerment measure. Construct validity for the total CWEQ-II score (r=0.79, P<0.0001) was acceptable.

The total CWEQ-II mean score was 20.51 (SD ± 3.04). The means scores and standard deviations for the subscales were (Hauck et al, 2011):

1. Opportunity M=4.17, SD=0.78
2. Information M=3.25, SD =0.77
3. Support M=3.31, SD = 0.78
4. Resources M = 3.08, SD =0.74
5. Formal Power M=2.97, SD=0.65
6. Informal power M=3.7, SD = 0.72

The mean score of the ATS was 43.39 (SD=15.44). The minimum score for ATS would be 12 and the maximum would be 84. The Cronbach alpha for the ATS was 0.88. The Pearson correlation between the ATS and the CWEQ-II scores demonstrated a significant negative correlation (r = -0.23, P=0.02). No significant relationships were found between the descriptive statistics of the sample and the ATS and CWEQ-II. The negative correlation indicates that there is an inverse relationship between structural empowerment and anticipated turnover. Nurses who have stronger perceptions of empowerment are less likely to leave the organization (Hauck et al., 2011).

The research questions were answered. It was concluded that empowerment affects an employee’s behavior and attitude, including intent to leave. If nurses’ perceptions of empowerment are low, perceptions of intent to leave are higher. Nurse leaders need to develop organizational structures that promote empowerment. Leadership behaviors that promote participative decision making, autonomy, and display confidence in employees encourage empowerment in nurses.

The studies regarding nurse empowerment and retention have most often occurred at Magnet facilities. Another dimension to empowerment and retention is whether the nurses have earned a professional certification. Do nurses who possess a professional certification have a higher level of commitment and empowerment? Fitzpatrick, Campo, and Lavandero (2011) conducted a study to determine the effect of certification on
empowerment and retention. The goal of this study was to determine whether nurses had an intent to leave current position (IL-CP), and intent to leave nursing profession (IL-NP). The research question asked if there was a relationship between American Association of Critical Care Nurses (AACN) certified staff nurses and staff nurses who are not certified in regards to sense of empowerment, IL-CP, and IL-NP?

An invitation to participate in the survey was issued to 44,143 members of AACN who provided email contact. A response rate of 15% (6589) was achieved, 4268 of those responding were staff nurses. The methodology was a survey completed online. The participants were given Laschinger’s Condition of Work Effectiveness tool (CWEQ-II), which consists of 19 questions regarding six subscale components of opportunity, information, support, resources, formal power, and informal power. There were 3 questions in each of the first four subscales. The total scale scores range from 6 to 30 and each subscale score ranges from 1 to 5. In previous research the Cronbach reliability coefficient for the CWEQ-II has ranged from 0.78 to 0.93 and the Cronbach alpha for this study as 0.91 (Fitzpatrick et al., 2011). Demographic questions regarding age, ethnicity, years of experience, type of certification (if certified), and education level were asked. The nurses surveyed were also surveyed about intent to leave their current unit or the nursing profession. If the respondent answered either affirmatively, they were asked if they intend to make this change within the year, or within the next 5 years.

Of the respondents, 2268 were AACN certified, 2000 were not AACN certified. The authors also identified 2873 of the total respondents had specialty certifications from organizations other than AACN (Fitzpatrick et al., 2011). There was no significant difference between the empowerment score of the AACN certified nurses and those who
were not certified. The informal power subscale was significantly for the AACN certified nurses \((t= -4.63, p = .001)\) and the entire group of certified nurses \((t= 2.83, p = .005)\) when compared to uncertified nurses. It was also determined that the nurses who were certified had no significant difference in IL-CP or IL-NP from uncertified staff nurses (Fitzpatrick et al., 2011).

This study demonstrates that certification may not lead to a sense of empowerment. It does provide information that is essential for further research. It would have been significant to find out what type of organizations the nurses worked for, Magnet or non-Magnet. This study offered no valid conclusions regarding certification and sense of empowerment, IL-CP or IL-NP, but the large number of respondents made this study significant.

Cost is another significant consequence of nurse turnover. Buffington, Fink, Zwink, DeVine, and Sanders (2012) determined the cost of hiring and orientation of a new staff nurse to be more than $50,000. The hiring medical facility wants to reduce nursing turnover so that nursing turnover does not become an unnecessary expense. Nursing administrators must understand the reasons for turnover and try to reduce the variables that affect turnover. Buffington et al. (2012) had several objectives for their study; they wanted to identify RNs perceptions of the work environment, professional development, mentoring, recognition, support, and encouragement (Buffington et al., 2012). The authors wanted to determine what factors determine nurse job satisfaction and measure the factors that influence nurse retention using a tool they designed (Buffington et al., 2012, p. 274). The nurses included in this study were 1,250 RNs employed for at least one year on an inpatient or ambulatory unit at a 3-time designated
Magnet facility in Colorado (Buffington et al., 2012). The revised Casey-Fink Nurse Retention survey was presented to these nurses to complete electronically (Buffington et al., 2012). There were qualitative and quantitative elements in this study.

The Revised Casey-Fink Nurse Retention Survey consists of six sections and takes about 15 minutes to complete. Buffington et al., (2012) stated the first section contains 33 items regarding the work environment, support, and encouragement, which were to be ranked on a 4 item Likert scale (1, strongly disagree, to 4, strongly agree). Factor analysis using the Kaiser criterion indicated that there were 4 subscales resulting from the Revised Casey-Fink Nurse Retention Survey: recognition/rewards, professional nursing role, mentorship, and scheduling flexibility. Each of these 4 subscales had 2 to 13 items. The Cronbach alpha for the total scale was .922, and the Cronbach alpha for the subscales ranged from 0.767 to 0.939 (Buffington et al., 2012). The second section had 2 items asking about stressors, the third section listed 13 items related to job satisfaction, using a Likert scale (1 very dissatisfied, to 5, very satisfied), the fourth section had three questions regarding professional development, mentoring, and goal setting, the fifth section asked demographic data; and the sixth section was 4 open ended questions related to praise, recognition, and retention (Buffington et al., 2012). The quantitative data from sections 1, 3, and 5 were analyzed using the Statistical Package for the Social Sciences (SPSS) 19. These items were analyzed using descriptive statistics. The alpha value was set at 0.05 (Buffington et al., 2012). The qualitative data was reviewed by the authors, key words were categorized, agreed upon by the research team, and themes were identified (Buffington et al., 2012).
The survey was completed by 699 respondents, 677 of these respondents met the criteria and were included in the study. The demographics identified the sample population as being primarily (91%) female, with an average age of 40. Seventy six percent of respondents had a BSN degree, 72% worked on inpatient units, the mean years of practice as an RN was 13, with 7.5 years in the same hospital (Buffington et al., 2012). No statistically significant relationships were found in the work environment/support/encouragement subscale; in the recognition/rewards subscale 99.3% of respondents felt they were respected and 99.9% believed their talents were appreciated, but 98.7% felt that their talents were not acknowledged, inpatient nurses felt more supported (71.9%) than ambulatory nurses (28.1%); in the professional nursing subscale, ambulatory nurses felt more respected by physicians than their inpatient counterparts; in the eight item mentorship category inpatient nurses reported a higher mentorship subscale score.

The findings of this study indicated that nurses were generally satisfied with their positions, and had little intent to leave. The retention rate of this facility was 3% with the national average being 12%, so the survey was done in a unique place. A magnet facility is assumed to have a healthy work environment because that is one of the items that allow it to achieve Magnet status. Inpatient nurses on a whole were more satisfied with their work environment than ambulatory care nurses. There must be more recognition for staff nurses to promote a positive work environment.

Retention of newly graduated nurses is extremely important for any organization. During the initial years of nursing critical thinking skills and patient care skills are developed. Incivility in the workplace from senior nurses and a weak sense of empowerment for these new graduates lead them to seek positions in other units and in
other careers. Smith, Andrusyszyn, and Laschinger (2010) conducted a study that was an extension of the research of Laschinger et al. (2009) regarding empowerment, incivility, and retention of staff nurses. It is important to determine what the effects of incivility and empowerment have on retention of newly graduated nurses so that issues can be corrected and a sense of commitment can be restored.

The authors utilized Kanter’s theoretical framework of empowerment in the workplace. Kanter stated that empowerment is dependent upon the presence of opportunity and power (Smith et al., 2010). Opportunity allows a nurse to advance and increase knowledge and skills (Smith et al., 2010). Power is dependent upon information, support, and resources (Smith et al., 2010). Access to information requires data, knowledge, and expertise; access to support is feedback and guidance from peers, managers, and others involved in patient care; access to resources is access to time, talent, and resources (Smith et al., 2010). There are two levels of power: formal and informal. Formal power is the work required to meet the goals of the organization (Smith et al., 2010). Informal power is identified by the relationships between peers, managers, and subordinates (Smith et al., 2010). Psychological empowerment consists of four dimensions: meaning, competence, self determination, and impact (Smith et al., 2010).

The authors hypothesized that nurses who have the highest levels of workplace empowerment and lowest levels of incivility will have the highest level of organizational commitment (Smith et al., 2010). A predictive non-experimental design was used. A random sample of 250 new graduates was obtained from the College of Nurses of Ontario registry. These nurses worked in acute care and had less than three years of experience.
Nurses who previously worked as diploma graduates or licensed practical nurses were excluded. A Dillman’s methodology was used to achieve the maximum response rate.

The instruments used were the: Conditions for Work Effectiveness Questionnaire-II (CWEQ-II), The Psychological Empowerment Questionnaire, Workplace Incivility Scale (WIS), and the Affective Commitment Scale (ACS) (Smith et al., 2010).

The CWEQ-II developed by Laschinger et al. (2009) consists of 19 questions regarding six subscale components of opportunity, information, support, resources, formal power, and informal power. There were three questions in each of the first four subscales. To measure formal power the Job Activities Scale II (JAS II) consisting of 3 items was used. To measure informal power the Organizational Relationship Scale (ORS-II) consisting of 4 items was used. The CWEQ-II also has an additional two item Global Empowerment Subscale was used for construct validation. Each item in the six subscales used a 5 point Likert Scale ranging from “none (1) to a lot (5)”.

The responses to the Global Empowerment subscale ranged from “strongly disagree to strongly agree”. The Empowerment Score was calculated by the mean score of each subscale (6-30).

Scores were ranked as follows: 6-13 Low structural empowerments; 14-22 Moderate structural empowerment; 23 to 30 High structural empowerment. The construct validity of CWEQ-II had high correlation with the global measure of empowerment (r = 0.56). The Cronbach alpha for the subscales ranged from 0.62 to 0.85. The Cronbach alpha for the total empowerment scale ranged from 0.78 to 0.94 (Smith et al., 2010).

The Psychological Empowerment Questionnaire developed by Spreitzer in 1995 measured psychological empowerment with a 5 point Likert scale (1 strongly disagree, 5
strongly agree) to respond to 12 items. Higher scores indicated empowerment. The Cronbach alpha of this tool in previous studies ranges from 0.62-0.89 (Smith et al, 2010).

The WIS measures incivility using a 4 point Likert scale ranging from 1 (never) to 4 (most of the time) which is divided into two columns one rating the immediate supervisor and one rating coworkers. Internal consistency from previous studies was 0.84-0.89 (Smith et al., 2010). The ACS is a six item survey ranked by 7 point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). A high score indicates high commitment. The reliability coefficient ranges from 0.85 to 0.87 (Smith et al., 2010).

The results of the questionnaire were analyzed by the Statistical Package for Social Sciences. Hierarchal multiple regression was used to test the hypothesis (Smith et al., 2010). Newly graduated nurses viewed the work environment as moderately structurally and psychologically empowering, Coworker incivility was greater than 90%, supervisor incivility was almost 78 %, but the incivility level was low (1.5 on a 4.0 scale). The results of commitment were also found to be moderate.

This study offers administrators a look into the perceived work environment of the newly graduated nurses. Changes must be made in the current work environment to decrease the occurrences of incivility and increase the sense of empowerment if organizational commitment is to be improved.

Conclusion

Retention of qualified, engaged Registered Nurses is an important part of a successful healthcare organization. It is extremely expensive to educate and complete competencies for a new nurse, whether a new graduate or experienced, only to have them
leave within a year after their date of hire. It is important that the success of these new nurses is not always based on the individual. The organization is also responsible for a successful orientation and socialization of a new staff nurse. The organization can improve the odds that a nurse will remain employed by assuring that a Healthy Work Environment (HWE) is present.

There were several frameworks presented in the studies, but Kanter’s theory of structural empowerment utilized by Laschinger et al. (2009) and Smith et al. (2010) is the most appropriate for the purpose of evaluating HWE and retention. Kanter recognized that empowerment is present in work environments that offer opportunity, support, and resources for workers (Laschinger et al., 2009). HWE is an environment where professionalism and education are promoted by administration, a concept very similar to Kanter’s framework.

The articles summarized in this literature review all reveal keys to retention of nurses. The articles varied in their depth and size. Beecroft et al. (2008) and Kramer et al. (2012) performed enormous, longitudinal studies which focused on work environments and nurse orientation programs. MacKusick and Minick (2010) performed a very small phenomenological study interviewing ten RNs. The other studies included were large and survey based. The largest population researched was 12,233 by Kramer et al. (2012).

There were a few research tools in common. The CWEQ-II scale was used in five of these studies. This scale has demonstrated its validity through several studies. The scales to measure retention or intent to stay were very similar. Each study reviewed had some way of evaluating the work environment. All of the tools had had similar
subscales. The obvious elements, such as compensation, residency programs, and leadership support were identified in most of the literature.

The characteristics of a HWE were also identified as an important part of nurse retention. These characteristics include opportunity for advancement, participatory governance, collaborative unit decision making, supportive nurse leaders, nurse-physician collaboration, positive scheduling, job enjoyment, and low burnout of nurses. The characteristics promote retention in the workplace. Kramer et al. (2012) identified three types of work environments: Healthy Work Environment (HWE), Very Healthy Work Environment (VHWE), and Work Environment Needs Improvement (WENI). The conclusions from this very large study confirmed that work environment is very important to nurse retention.

Laschinger et al. (2009) further identified workplace environment variables by integrating incivility, burnout, and empowerment levels with retention statistics. The authors concluded that nurses who work in environments that encourage empowerment, are high in workplace civility, and low in burnout promote retention in the workplace. Smith et al. (2010) replicated this study with newly graduated nurses and made the same conclusion. This conclusion helps to define the optimal environment characteristics that will aid in retention of staff nurses.

Gormley (2011) concluded that nurses and managers do not see the work environment the same way. This disconnect was only identified in this study, yet it is a very important factor in retention. If the leaders perceive that a HWE exists, they may not look for ways to improve. Unless leaders speak with their staff nurses their unit will
be set up to fail. Managers must be open and objective to the actual environment of their unit.

It can be inferred that many of the reasons nurses identified for leaving clinical practice can be prevented. An unfriendly work environment should not be present in a clinical setting. If the work environment is unfriendly, a change in culture is necessary. Abuse should not be tolerated. Health care environments need to change if nurse retention is the goal. The sense of exhaustion and burnout identified by Laschinger et al. (2009) can be decreased by creating a more positive, supportive work environment.

Kramer et al. (2012) confirmed that empowerment affects an employee’s behavior and attitude, including intent to leave. There is an inverse relationship between nurses’ perception of empowerment and their perception of intent to leave. All of the studies included empowerment in their research.

The conclusions that can be made from this review are that a healthy work environment with empowered nurses and objective managers will retain both graduate and experienced nurses. It seems that a nurse residency program may also help the new graduate nurse receive a strong foundation at a facility which leads to organizational commitment. The studies reviewed encompassed all aspects of nurse retention and provide valuable information. The same conclusions resulted from the majority of the studies reviewed. There is opportunity to continue research and find the most effective ways to develop the healthy work environment, educate and develop transformational leaders, empower nurses, and increase the retention of nurses.
CHAPTER III

Applications and Implications

Introduction

The retention of qualified, engaged Registered Nurses is an important part of a successful healthcare organization. The organization is also responsible for a successful orientation and socialization of a new staff nurse. An organization can improve the odds that a nurse will remain employed by assuring that a Healthy Work Environment (HWE) is present. The conclusions that can be made from the literature review are that a healthy work environment with empowered nurses and objective managers will retain both graduate and experienced nurses. There is opportunity to continue research and find the most effective ways to develop the healthy work environment, educate and develop transformational leaders, and empower nurses. The majority of the research regarding healthy work environments has been performed in of Magnet facilities, which are recognized for their healthy work environments.

The establishment of a healthy work environment (HWE) has been identified as a key to both nurse satisfaction and retention. This project will evaluate the work environments of three facilities and determine how the influence they may have on retention and sense of empowerment. This project will identify areas of the work
environment in these non-Magnet facilities needs to be changed. Discovering the level of empowerment of the nurses surveyed will help to develop changes in the workplace to facilitate empowerment. The retention statistics should correlate with the results of the work environment and empowerment surveys. The purpose of this research is to identify nurses’ perceptions of the work environment in non-Magnet facilities and to evaluate the nurse empowerment levels and retention in those facilities. The information obtained through this research process will identify opportunities for improvement.

**Research Questions**

a. What are nurses’ perceptions of the work environment in non-Magnet facilities?

b. What are nurse empowerment levels and retention in those facilities?

**Population, Sample, and Setting**

The population of the study will be three hospitals in northern Indiana. An invitation to participate in the research study will be sent to all nurses working in the Critical Care Units (ICU, SICU, and PCU) of three hospitals in northern Indiana. One of the hospitals is part of a large health system and two of the hospitals are both part of a smaller system. These hospitals are not Magnet organizations. There are approximately 517 RNs working in these units eligible to take the survey. The invitation will be sent to the human resources department of each hospital and then sent via e-mail to the nurses working in the critical care units. This invitation will include a link to the survey site. The survey site will be secured and anonymous. A minimum sample of 100 RNs is acceptable. All nurses who have worked in the critical care units of these institutions for
at least one year will be included. Nurses with all levels of education, type of position (full time, part time, PRN), shift, gender, and ethnicity will be included.

Protection of Human Subjects

The survey and explanation of the methodology will be presented to the Institutional Review Boards (IRBs) of each organization. This process is expected to take two months. After approval by the IRBs, the RNs working in the Critical Care units will be recruited via electronic mail. The first email will be an invitation to participate and a brief explanation of the study. A second electronic mail will be sent two weeks later with a link to the electronic address of the website to access the survey. Weekly reminders including this address will be sent to the RNs for four weeks. These reminders will thank those who have participated and encourage those who have yet to respond to participate. At the end of the four weeks, the electronic address containing the survey will be inactivated. Confidentiality will be achieved by the random numbering of the surveys as they are submitted electronically. The entire process from introduction to completion of study will take six weeks. The Human Resources departments of the organization will be asked to provide retention statistics for the Critical Care Units.

Research Design

This study is a non-experimental, with correlational, predictive design. It will examine the relationship among work environment, nurses’ empowerment, and retention.

Instrumentation, Reliability, and Validity

Two instruments will be used to collect data. The survey will consist of demographic questions, the Essentials of Magnetism II (EOMII) by Kramer and Schmalenberg (Kramer et al., 2012) and Conditions of Work Effectiveness Questionnaire
II (CWEQII) by Laschinger (Laschinger et al., 2009). Permission will be obtained from
the developers of the tools before they will be utilized. The EOMII answers the question
about the work environment. The CWEQII describes the level of empowerment of
nurses.

The level of empowerment will be measured by the CWEQ-II (Laschinger et al.,
2012). The CWEQ-II consists of 19 questions regarding six subscale components of
opportunity, information, support, resources, formal power, and informal power. There
are three questions in each of the first four subscales. Three items will measure formal
power of the job, four items for informal power, and two items for global empowerment
Subscale. Each item in the six subscales uses a five point Likert Scale ranging from
“none (1) to a lot (5)”.

The responses to the global empowerment subscale range from “strongly disagree
to strongly agree”. The empowerment score will be calculated by the mean score of
each subscale (6-30). Scores will be ranked as follows: 6-13 Low structural
empowerment; 14-22 Moderate structural empowerment; 23 to 30 High structural
empowerment. The construct validity of CWEQ-II has a high correlation with the global
measure of empowerment ($r = 0.56$). The Cronbach alpha from previous studies
performed are as follows: Support 0.81-0.90; Information, 0.82-0.93; Resources, 0.78-
0.86; Opportunity 0.79-0.88; Formal power, 0.78-0.82; Informal Power 0.70-0.72. The
Cronbach alpha for the total empowerment scale ranged from 0.82 to 0.94.

The EOMII (Kramer et al., 2012) measures the healthiness of the work
environment. The work environments will be classified as Very Healthy Work
Environment (VHWE), Healthy Work Environment (HWE), and Work Environment
Needs Improvement (WENI). The EOMII is based upon Donabedian’s conceptual paradigm and grounded theory for the eight essential elements of a magnetic work environment. The EOMII consists of eight subscales containing 58 items. The subscales are as follows (Kramer et al., 2012):

1. Work with nurses who are clinically competent.
9. Collegial/collaborative nurse-physician and interdisciplinary relationships
10. Autonomy and clinical decision making
11. Supportive Nursing Managers
12. Control of Nursing Practice
13. Support for education
14. Perception of adequate staffing
15. A culture where concern for patients is a priority.

The EOMII has been supported to be a valid and reliable predictor of the work environment. The Cronbach alpha for the autonomy subscale of is 0.97 and 0.83 to 0.97 for the other seven elements of the tool.

Data Analyses

The Statistical Package for Social Sciences version 19.0 will be used for descriptive and inferential statistical analysis. Demographic and personal data will be obtained and their relationships to the study variables will be computed. Hierarchical multiple linear regression analysis of the data will be performed to determine whether empowerment and work environment affect retention of nurses. The evaluation and reporting of the data will take about four weeks. The final results of the research project will be available 10 weeks after initiation of the study. The organizations will not be
identifiable by the results. The results will then be presented to the participating organizations within three months of the study completion. Invitations will be sent to all nurses working in the Critical Care Units to invite them to attend presentations at their organization. These presentations will be offered at times that are convenient to the nursing staff.

Summary

This study will answer the research questions regarding the healthiness of the work environment and the level of empowerment that exists in these non Magnet facilities. The researchers will attempt to determine if a correlation exists between the perceived health of the work environment and the level of empowerment. An attempt to determine the correlation between the retention statistics and level of empowerment, retention statistics and perceived health of the work environment, and retention statistics and the health of the work environment including level of empowerment. The results of this survey will help to identify the most effective ways to develop and improve the health of the work environment, educate and develop transformational leaders, empower nurses, and increase the retention of nurses.
References


