6-2017

Organizational, Nurse, and Patient Empowerment at a Magnet and Non-Magnet Hospital

Mai Yaseen

LOMA LINDA UNIVERSITY
School of Nursing
in conjunction with the
Faculty of Graduate Studies

Organizational, Nurse, and Patient Empowerment at a Magnet and Non-Magnet Hospital

by

Mai Yaseen

A Dissertation submitted in partial satisfaction of
the requirements for the degree
Doctor of Philosophy in Nursing

June 2017

Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

_____, Chairperson
Ellen D'Errico, Associate Professor of Nursing

_____
Iris Mamier, Associate Professor of Nursing

_____
Patricia Radovich, Director of Nursing Research, Loma Linda University Health

ACKNOWLEDGEMENTS

First and foremost, I would like to express my gratitude to God, the most Merciful and the All-Compassionate, for the grace, power, and strength to have the ability to accomplish this work. It is with profound gratitude that I acknowledge the people who helped me complete this study. Dr. Ellen D'Errico was my committee chair., Her mentoring, guidance, and support throughout the whole PhD journey motivated and enriched me to learn and grow personally and academically. I will always cherish her graceful humbleness and genuine caring that kept me strong and focused especially in difficult times. I would also like to thank the members of my dissertation committee, Dr. Iris Mamier for support throughout the journey and her insightful feedback on the research. Thanks go to Dr. Patricia Radovich and Dr. Margaret Beaman for providing support, guidance and forging a smooth path for data collection at their respective institutions. I would also like to express my greatest appreciation for Dr. Salem Dehom, for his statistical consultation and support. Without these special people, this research would not be possible.

I would to express my deepest gratitude and appreciation to my loving and supportive family for their unstoppable love and support. Starting with my father (Mohammed) who believed in me and brought me here in the first place, my mother (Samar) who supported me throughout my life and my sisters and brother for their support and love. A special thanks goes to Hanadi and Hala, my nurse sisters, for editing assistance and encouragement to accomplish this degree. My parents-in-law are my second family (Hesham and Dina). Their support and love enriched me throughout the journey. My best friend Wejdan who is far away but her love and encouragement was

with me spiritually to accomplish this degree; Sarah for all the support and love and feeling of having the family I missed while being away from home, and Ghaidaa for all the support and love we shared since arriving in the United States.

Last but not least, is my own little family, and especially the man who I chose to spend my life with, husband (Abdulaziz) for the love, sacrifices, and support he provided me in this journey with all the challenging circumstances we encountered. My precious son (Omar), came into my life as a grace with unconditional love. He empowered me to stay strong and accomplish this study so I could teach him what my parents taught me--the importance of education and knowledge.

To all I express my deepest appreciation and gratitude.

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ABBREVIATIONS

LLU	Loma Linda University
IRB	Institutional Review Board
PPPNBS	Patient Perceptions of Patient-Empowering Nurse Behaviors Scale
GES	General Self-Efficacy Scale
CWEQ-II	Conditions for Work Effectiveness questionnaire II

ABSTRACT OF THE DISSERTATION

Organizational, Nurse, and Patient Empowerment at a Magnet and Non-Magnet Hospital

by

Mai Yaseen

Doctor of Philosophy, Graduate Program in Nursing
Loma Linda University, June 2017
Dr. Ellen D'Errico, Chairperson

Purpose/Aims: To explore the relationships between organizational, nurse, and patient empowerment at a Magnet designated hospital versus a non-Magnet designated hospital. There are three aims to the study. Aim 1 examines the relationship between level of organizational empowerment and individual nurse self-empowerment (Self-efficacy). Aim 2 examines the relationship between individual nurse self-empowerment and patient empowerment. Aim 3 investigates if there are any differences in empowerment levels between a Magnet and non-Magnet designated hospital.

Background: Patients must feel empowered to make decisions and participate in their care however; it is the healthcare provider's role to prepare patients to make these decisions. Nurses spend more time providing care to patients compared to other healthcare providers. Nurse attitudes and behaviors influence patient empowerment and can result in improved patient satisfaction. Nurses must feel empowered in order to empower their patients. When nurses are satisfied with their job, those work environments generally have high levels of organizational empowerment allowing individual psychological empowerment to flourish. An empowered work environment enhances positive outcomes for both nurses and patients.

Methods: A descriptive, correlational design employing a quantitative survey method was used in this study with a sample of 102 nurses and 100 patients from a non-Magnet hospital and 98 nurses and 100 patients from a Magnet hospital. The Conditions of Work Effectiveness Questionnaire (CWE-II) and the General Self-Efficacy scale (GSE) was used in an online survey to explore nurses perception of their organization's effectiveness, personal nurse empowerment and self efficacy. A separate patient survey using the Patient Perception of Patient-Empowering Nursing Behaviors Scale (PPPNBS) was used to explore patient perception of nurses' empowering behaviors among Medical/Surgical nurses and patients.

Results: Findings of this study revealed a significant relationship between organizational empowerment and nurse self-empowerment. In addition, nurses perceived higher organizational empowerment and self-empowerment at the Magnet hospital compared to the non-Magnet hospital. There was no significant relationship between nurse and patient empowerment at either hospital setting. Patients reported high levels of empowerment and satisfaction at both hospitals possibly indicating professional fidelity of the nurses despite different empowerment levels between Magnet and Non-Magnet nurses.

CHAPTER ONE

INTRODUCTION

The Oxford Dictionary definition of empowerment (2016) is ‘to give someone the authority or power to do something, and to make someone stronger and more confident in controlling their life and claiming their rights’` (Empowerment, 2016). The notion of empowerment is a construct comprised of multiple concepts including political, community, organizational/managerial, and individual empowerment.

As referred to in the dictionary definition, empowerment can have political connotations in terms of permitting self-determination and activism. For example, feminist empowerment involves changes in the distribution of power and the breakdown of ridged hierarchical social and cultural structures (Rodwell, 1996).

Community empowerment refers to the general sense of confidence in the ability of people in the community to make a decision and improve their lives by gaining knowledge and understanding of how to control forces including individual, social, community, economical, and political (Israel, Checkoway, Schulz, & Zimmerman, 1994).

From an overall organizational/managerial perspective, empowerment means self-actualization in the work environment by having enough resources for the worker to do a good job (Laschinger, Gilbert, Smith, & Leslie, 2010). Organizational/managerial empowerment provides structures (e.g. policies, decision support, governance) allowing people the authority and control to be involved in decision-making as a human right and social justice imperative (Rodwell, 1996).

Individual empowerment, known in the literature as psychological empowerment, refers to the individual’s ability to take action and control his life situation. The notion of

individual empowerment is similar in the literature to self efficacy and self esteem, which emphasizes personal positive development and competence (Israel et al., 1994). However, individual empowerment also involves the personal ability to gain knowledge and understanding of social and political forces (Israel et al., 1994).

In the nursing literature, empowerment is discussed within three identified contexts: community, organizational, and individual psychological empowerment (McCarthy & Freeman, 2008). Empowerment is an important component to the delivery of optimal healthcare and has been studied in terms of the organizations and clinicians delivering care, and the patients receiving that care. Empowerment is a key value in the profession of nursing particularly in the discourse regarding nursing workforce shortages, and the establishment of healthy work environments. Although recognized as a desirable attribute of both the work environment and the individual nurse, a straightforward understanding of the notion can be challenging.

A systematic review by Kennedy, Hardiker & Staniland (2015) stated there is a lack of clarity and difficulty in achieving empowerment within a particular context because of the lack of agreement on the elements of the construct, and lack of clarification as to the essential concepts of an empowerment theoretical framework (Kennedy, Hardiker, & Staniland, 2015). For example, the notion of "individual empowerment" can be measured using multiple questionnaires each capturing different concepts such as self-efficacy, personal control, participation, self-esteem, and competence, each guided by different theoretical frameworks. Scholars have explored the elements of empowerment, (Laschinger & Fida, 2015; Laschinger, Wong, Cummings, & Grau, 2014; Wong & Laschinger, 2013) yet there is an absence of agreement on a

coherent view of what makes a person empowered (Barr, Scholl, Bravo, Faber, & Elwyn, 2015; Kennedy et al., 2015). There is agreement that empowerment is an ongoing process of mutual participation, active listening, and sharing knowledge between the empower-"er" and the empower-"ee" (Dowling, 2011). In a concept analysis of empowerment by Gibson (1990), empowerment can be viewed in two ways; as a process, and an outcome.

An example of empowerment as a process would be the steps followed to get a bill such as California mandated nurse to patient ratios through the state legislature. The sponsor of the bill (United Nurses Association of California) must garner support and engagement from a state legislator and do what is necessary to decrease opposition. There are set procedures and rules of order to be followed, which involve empowering processes (e.g. lobbying, initiating letter writing campaigns, raising awareness through publicity) in order to achieve passage of the bill. Empowerment as an outcome is the successful passage of the bill, the tenets of which can enrich the empowerment of supporting stakeholders. Both the processes and outcomes of empowerment are of importance to nurses.

Nurses perceive a strong relationship between the work environment and the quality of patient care. The level of organizational nurse empowerment is a factor in the work environment that nurses reported influenced their work behavior (Fackler, Chambers, & Bourbonniere, 2015). For example, a nurse with many years of experience might have had greater opportunities to develop empowering behaviors both personally and in the workplace, which can benefit patient care (Fackler et al., 2015).

Safe, effective, quality patient care is a priority to frontline nurses; therefore, empowerment is an important tool for an organization to foster to increase positive

patient outcomes (McCarthy & Freeman, 2008). Jerofke, Weiss, and Yakusheva (2014) conducted a study illustrating the relationship between high quality care and empowerment. The researchers examined the linkage between empowering nursing behaviors and patient outcomes during hospitalization and after discharge. The results yielded evidence to support the relationship between nursing's empowering behaviors during hospitalization and positive patient outcomes post discharge (Jerofke, Weiss, & Yakusheva, 2014).

Individual empowerment is also referred to as psychological empowerment in the literature, defined as an individual's ability to enable and share power with others. In order for nurses to be satisfied in their job, they need to work in environments with high levels of organizational empowerment so that individual psychological empowerment can flourish. When nurses are highly empowered within an organization, such empowerment levels are believed to lead to better quality of care and the empowerment of patients (Fackler et al., 2015). Conversely, symptoms of low levels of organizational empowerment are nurses' frequent heavy workloads and limited participation in the decision-making process, which can adversely affect patient care (Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010).

Because of its diverse nature, empowerment can be viewed from different angles depending on the context. The focus of this chapter is on the exploration of empowerment and on the question of how empowerment relates to healthcare in terms of organizational, nurse, and patient empowerment.

Definition of Empowerment Concepts in HealthCare

Organizational Empowerment

Organizational empowerment in healthcare exists when leadership and management ensure staff has access to information, support, resources, and opportunities to learn and grow professionally (Cicolini, Comparcini, & Simonetti, 2014). Organizational empowerment is linked to nurses' job satisfaction, commitment, trust, quality of care, productivity, lower levels of burnout, and other positive nursing outcomes (Laschinger & Fida, 2015). When the organization is empowered, management will support staff by empowering and enabling them to achieve positive workplace outcomes, which can result in nurse psychological empowerment (Kanter, 1993; O'Keefe, 2014).

Nurse Empowerment

Nurses' psychological empowerment exists when nurses have the ability to share and transfer power to patients, enable patients to set their own goals, speak up for patients, collaborate with healthcare providers, and strengthen relationships with patients (Fackler et al., 2015; Rao, 2012). Psychological empowerment is defined at the individual level as a mediator between the self-control, self-efficacy, and the willingness to take a stand and make a decision (McCarthy & Freeman, 2008). The term psychological empowerment has been used extensively in the literature referring to nurse empowerment. Empowered nurses share the following qualities (a) high moral principles (respect and honesty); (b) personal integrity (resourcefulness and courage); (c) expertise (competence and autonomy); (d) future orientation (promoter and innovator); (e) and sociability (collegial, supportive and openly communicative) (Kuokkanen, Leino-Kilpi, & Katajisto, 2003).

Nurses' degree of psychological empowerment influences job satisfaction, retention, and commitment to work. It is also hypothesized that nurses' psychological empowerment influences levels of patient empowerment (Dowling, 2011). When nurses feel empowered individually, they are more likely to employ professional behaviors to empower patients (e.g. providing effective communications and surrendering control to patients) (Dowling, 2011).

Patient Empowerment

Patient empowerment exists when patients possess a sense of self-efficacy, an inner strength to be willing to engage in their plan of care, and the freedom to take actions and make choices (McCarthy & Freeman, 2008; Rodwell, 1996). In dealing with chronic conditions, Small, Bower, Chew-Graham, Whalley, & Protheroe (2013), found that patient empowerment involves five dimensions from a conceptual model of the process and outcomes of empowerment: (a) identity and self-perception; leading to (b) desire for knowledge and information; which results in, (c) self-control and self-management strategies; (d) the ability to make a decisions; and (e) the ability to inspire and enable other patients with similar conditions (Small, Bower, Chew-Graham, Whalley, & Protheroe, 2013).

Purpose of the Study

The purpose of this study is to examine the relationship and linkage between organizational, nurse, and patient empowerment in an acute care setting of an acute care hospital without Magnet designation versus an acute care hospital with Magnet designation. In particular, the influence of an empowered work environment on the relationship between patient empowerment and nurse empowerment will be explored

(See Figure 1). Using that focus, the suggested three underlying hypotheses are: (1) an empowered work environment empowers nurses, (2) empowered nurses are more likely to employ behaviors that will empower patients, and (3) Magnet designation hospitals have higher levels of empowerment compared to non-Magnet designation hospitals.

Figure 1. The relationship between organizational, nurse, patient empowerment

Research Question

What is the level of organizational, nurse-related, and patient-related empowerment at a non-Magnet designated hospital compared to a Magnet designated hospital?

Significance of the Problem

The prevalence of life-style related morbidities, injury, chronic disease and long-term illness with corresponding increases in the cost of care in recent years have proven to be a burden for patients, their families, and society at large (Jerofke et al., 2014). One strategy for managing such a large disease burden is patient participation in managing their health through patient empowerment. Patient empowerment has been proposed as a crucial element in patient-centered care models and is a key feature of current health policy (Jerofke et al., 2014). Long-term illnesses are defined as conditions that cannot be

treated and cured, but can be managed with the use of medications and alternative therapy (Small et al., 2013). Patient-centered care is defined as the involvement of patients and their families in decision-making related to the patients' healthcare (Jerofke et al., 2014). One published study in the United States found the risk of adverse events was decreased by almost half, when patients participated in their care (Tobiano, Marshall, Bucknall, & Chaboyer, 2015). Patient participation is one of the results of patient empowerment, where patients have the right and responsibility to make important decisions about their healthcare (Barrie, 2011). Although individually, patients must feel empowered to make decisions, it is the healthcare provider's role to prepare patients. This preparation includes assistance with care planning by providing patients with the necessary information, support, resources and opportunities related to their disease that enable patients to make informed decisions regarding their health (Barrie, 2011).

Nurses' attitudes toward improving patient satisfaction and safety have been examined in many published research studies. The shortage of nurses is growing internationally, and the turnover rate of nurses has increased as a result of job dissatisfaction and burnout (Purdy et al., 2010). Nurses' intent to leave and turnover rates are rising in United States hospitals, as fifteen out of every one hundred nurses reported feeling disengaged toward the workplace (NDNQI, 2015). After surveying 2,600 nursing facilities in 2010, the average turnover rate was found to be 48.7% (AHCA, 2010). Hospitals and healthcare organizations must develop strategies to increase staff retention and job satisfaction, and deal with staff shortages, and high turnover rates.

Multiple research studies supported key strategies to deal with low retention and high turnover rates by improving overall levels of empowerment in the work

environment. Healthy work environments incorporate high levels of organizational empowerment, extending to staff access to support, information, resources, and opportunities to increase autonomy and job satisfaction. Hospitals with higher levels of organizational empowerment and healthy work environments qualify for Magnet Hospital designation (O'Keefe, 2014).

Overview of Remaining Chapters

The first chapter provides an overview of the rationale for exploring the influence of organizational empowerment on the relationship between nurse and patient empowerment. Chapter two provides the gaps in knowledge which will be identified by reviewing the relevant literature. Chapter three will introduce the tools and methodology for conducting the study specifying design, sample, and data analysis. Chapter four will introduce the statistical results and hypotheses testing findings. Chapter five will describe the findings, personal observation, conclusion, strengths, limitations, recommendations, and implications for nursing practice.

CHAPTER TWO

LITERATURE REVIEW

Search Strategy

Scholarly inquiry begins with clarifying, analyzing, organizing, and synthesizing the present state of the science. The purpose of this literature review is to determine current knowledge regarding the relationship between key empowerment contexts: organizations, nurses, and patients.

The literature review was conducted using multiple electronic search engines, including but not limited to, PubMed, CINAHL, EBSCO, and Google Scholar. Additional research was gathered from the reference lists at the end of articles on a snowball basis. The search strategy used the following keywords and combinations to identify relevant articles: *organizational empowerment, healthy work environment, Magnet designation, nurse empowerment, psychological empowerment, nurses' behaviors, patient empowerment, patient participation,* and *shared power*. The search yielded 284 articles. Research articles, either quantitative or qualitative were preferred for inclusion. Opinion, informational articles for continuing education credit, and editorials were generally excluded. Studies dealing with empowerment of nursing faculty in academia, and pre-licensure nursing students in nursing school were also excluded.

The search focused on the years between 1991 and 2016, as the decade of the 1990s inaugurated Magnet designation for hospitals. The definition of "Magnet designation" is a global credential to certify and recognize hospitals or healthcare institutions that provide a healthy work environment to promote nursing excellence, high quality patient care, and continuing nursing education (ANCC, 2016). Consequently,

much of the research on the characteristics that attract and keep nurses employed in acute care hospitals was studied, with empowerment being a major characteristic. The review does include some older, sentinel articles relating to empowerment in general, and in healthcare and nursing. Specific studies selected for inclusion are studies looking at empowerment from either the perspective of patients or nurses, studies that focused on patient empowerment through nursing care (particularly how nurses empower patients) and studies focusing on organizational empowerment and nursing outcomes. Preliminary results of the search were selected through an initial screening of the title and abstract in order to identify relevant information and shared similarity with the work being undertaken. After the screening, 56 articles that met the inclusion criteria were included in this review after combining the search strategies from different engines (Figure 2). Two studies looked at the influence of organizational empowerment on positive nurse and patient outcomes. There were six systematic reviews and four concept analysis articles on empowerment in healthcare. The literature contained within this review comes from different countries and presents a global perspective on the phenomena.

Three themes of discourse were noted in the literature: (a) power and empowerment from the patient and the nurse's perspective; (b) work environment and organizational empowerment in relation to nurse empowerment; and (c) the relationship between nurses empowering patients and positive patient outcomes. Under each thematic element, a literature synthesis of the articles, a theoretical framework, and strengths and limitations of the literature will be provided.

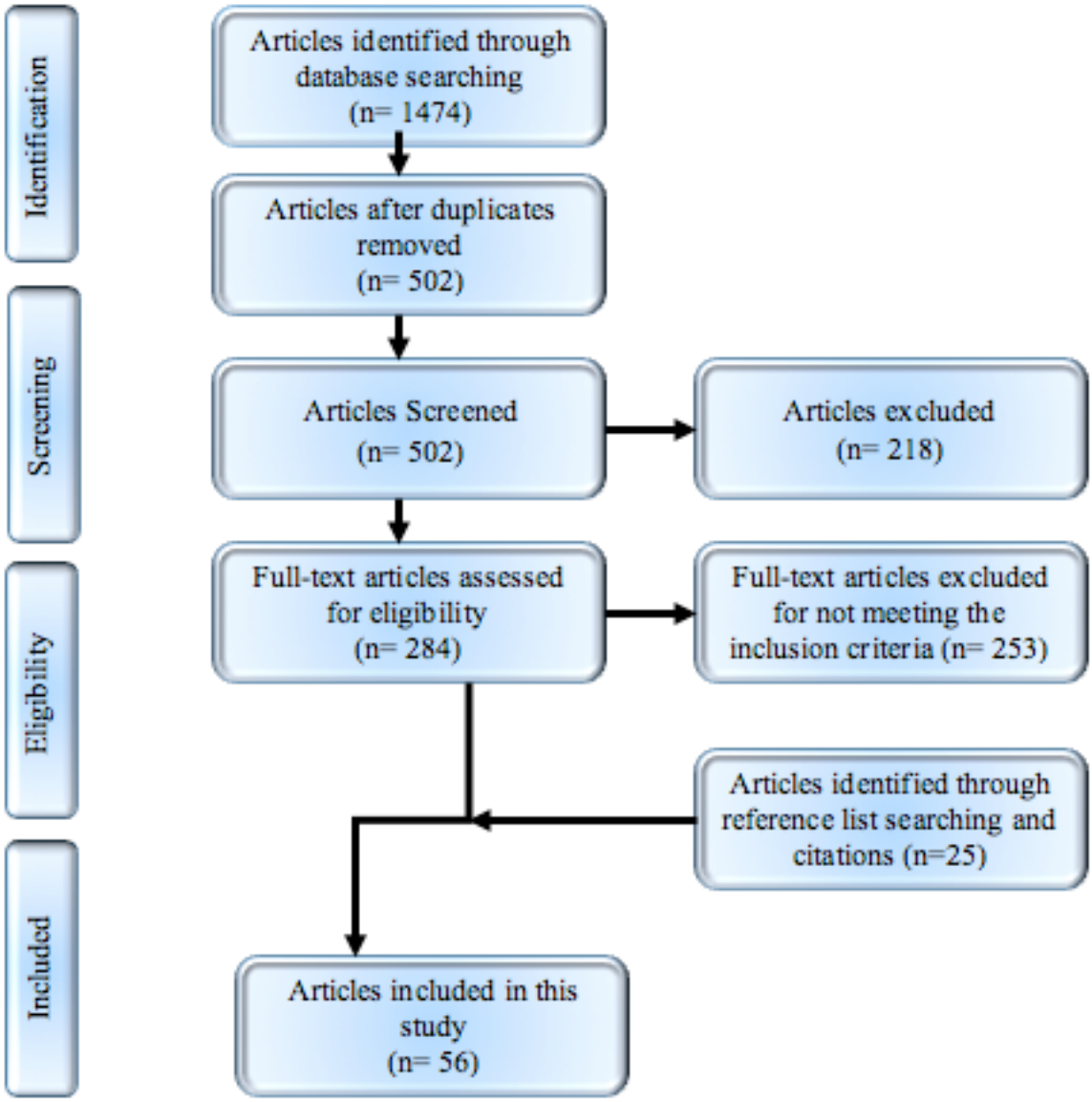

Figure 2. PRISMA flowchart of the search strategy employed**.**
Source: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi: 10.1371/journal.pmed1000097

Thematic Elements

Power and Empowerment

Power and shared power, shared care, and partnership between nurses and patients assist the nurse to empower patients and the patient to activate the empowered

role (Doss, DePascal, & Hadley, 2011; Morse, 1991). Nurses' power can be viewed as the degree of knowledge and expertise possessed (McCarthy & Freeman, 2008), whereas patients' power is the enhancement of the quality of their lives through the knowledge, behaviors and self-awareness regarding their treatment and care (Barrie, 2011).

Themes from a qualitative study using a grouned theory approach was conducted by Henderson (2003) with a sample of 33 nurses and 32 patients from teaching hospitals in Australia. Findings revealed that in general, nurses were willing to provide patients with information about their condition, but were less willing to share decision-making power with patients. Such paternalism is purported to perpetuate power inbalances in favor of nurses which can shut down communication in the patient-nurse dyad. Due to the vulnerability of patients at the times of nurse encounters, it can be difficult for patients to break through the nurse-controlled balance of power. Nurses' believe they have specialized knowledge to guide patients that patients do not possess. Patients quickly recognize where power resides, and many concede decision-making power to the nurse so they will not be labled as "difficult" (Henderson, 2003).

The etiology of empowerment begins with a way of thinking. Guilford (1956) identified divergent thinkers as people who look at a problem from a multitude of causes, and are willing to see that there are many ways to solve a problem. Conversely, the convergent thinker looks at a problem in search of a "one right answer" (linear thinking). In a study looking at nurse practitioner modes of providing health promotion, the divergent practitioner used various thinking strategies (*power-with-method*) in order to understand why a person engaged in a particular behavior, tailoring health promotion strategies based on the patient's needs and preferences. In contrast, the convergent nurse

practitioner assesses and, through linear thinking processes (*power-over-method*), decides a best strategy based on the nurse practitioner's judgment of what the patient needs and desires (Chambers & Thompson, 2009; Guilford, 1956). For example, the "*power-over-method*" strategy is where nurses claim that they are empowering patients by trying to manipulate and coerce patients to perform healthy behaviors, which is an inappropriate use of the empowerment concept (Chambers & Thompson, 2009).

Empowerment also involves attitudes and behavior. Davidson and Cooke (2014), identified two styles of nurse attitudes: Carer and trainer. Carer nurses provide little information to their patients, limiting shared care and decision-making. Conversely, trainer nurses provide broader education and encourage patients to be empowered resulting in genuine shared decision-making (Davison & Cooke, 2014).

Partnership between nurses and patients is one of the objectives in healthcare moving toward a patient-centered care model, where patients' participation in managing their health is a key feature of current health policy (Jerofke et al., 2014). Morse, (1991) identified four types of partnership relationships: Clinical, therapeutic, connected, and overinvolved.

The *clinical relationship* exists when the nurse-patient relationship is short term, the patient's malady minor, and the contact superficial. In these encounters, the patient can be viewed as a subordinate, rather than as an independent, equal individual. The *therapeutic relationship* exists when nurse-patient encounters are more involved and greater nurse engagement is necessary. In these partnerships, the patient can be viewed as a unique, independent person equal in human status. The *connected partnership* occurs when the nurse-patient relationship requires a long-term professional commitment (e.g.

chronic disease management). In this situation, nurses get to know the patient as a person and a friendly, reciprocal relationship based on mutual respect occurs. The *overinvolved relationship* occurs when professional boundaries between the patient as a person and the patient as a friend are breached. Complex conditions requiring on-going, involved, long-term management can result in nurse over-engagement in the patient's life drama that can "cross the line" and cease to be therapeutic (Morse, 1991).

In a broader sense, Fackler, Chambers, and Bourbonni (2015) discuss the notion that while Registered Nurses in the United States comprise a sizable aggregate workforce group (over four million), there is little accompanying discourse on how this potentially formidable group understands, relates and uses power in the workplace. In their phenomenological study of 14 Intensive Care and Medical nurses lived experience of "power" in acute care settings, the researchers discovered that nurses equate feelings of power with being respected, worthy of inclusion in team collaboration, having the ability to execute patient advocacy issues, and being perceived as competent by patients, families, physicians and other clinicians. Those individuals outside of the self, acted as a mirror into individual nurses' perception of themselves as powerful (Fackler et al., 2015).

The overall message of the power/empowerment theme in relation to nurse-patient relationships is overall, nurses are comfortable and feel justified in having more power than patients, as many believe it is in the patient's best interest for the nurse to maintain control. However, the literature suggests that nurses need to share their power using divergent thinking (*power-with-method)* to establish a connected partnership. A rigorous understanding of the appropriate use of empowerment using the "*power-with-method*" must take into account a nurse's level of education and experience as well as

trainer/carer attitudes for greater awareness of how nurses educate and advocate for patients.

Qualitative studies on this topic yield rich themes from nurses' and patients' perspectives describing empowerment and partnership. However, qualitatively designed studies are difficult to generalize. An increase in quantitative research, using surveys with larger sample sizes, will add to the body of knowledge on this important, but insufficiently explored notion.

Relationship between Organizational and Nurse Empowerment

Kanter (1993) described power as the capability to access information, resources and support to satisfy the organization's needs. Kanter's Organizational Empowerment Theory is a business theory adopted and used in the nursing discipline (Kluska, Laschinger, & Kerr, 2004). The theory's components are *system power factors* and *empowerment structures* (Kanter, 1993). System power factors are the permitted formal and informal power of individuals (Laschinger, 1996). An example of individual formal power is primarily focused on the individuals' ability to make independent decisions. For example, a system allows standing orders in a clinic whereby nurses can implement treatments immediately without consulting a physician first. An example of individual informal power is when a nurse who is not necessarily in a position of power/authority can build influential relationships with colleagues. *Empowerment structures* are that of opportunity, power, and proportions (Kanter, 1993).

The structure of *opportunity* relates to job conditions that provide individuals the chance to advance within the organization and to improve knowledge and skills (Purdy et al., 2010). The structure of *power* consists of the degree of access to information, support,

and resources (Purdy et al., 2010). The structure of *proportions* relates to the identifying characteristics of people in a social/work group, creating a unique workplace milieu (e.g. numbers of men versus women, older versus younger, experienced versus inexperienced, etc.) (Laschinger, 1996). The strength and level of empowerment structures in a particular organization determine the conditions for worker empowerment growth. When these conditions are active and justly distributed, employees are more likely to feel empowered. Kanter's theory as applied to nurse work settings can be summarized as follows: Nurses working for empowered leaders in empowering organizations tend to believe and act in empowering ways (Laschinger et al., 2010). Operationalization of empowerment structures are deeply embedded in the criteria needed for a healthcare organization to achieve Magnet recognition. In this study a redesigned theoretical framework is created by combining the two theories presented (Kanter's Organizational Empowerment Theory and Spreitzer's Psychological Empowerment Theory) with main findings of the literature (See Figure 3).

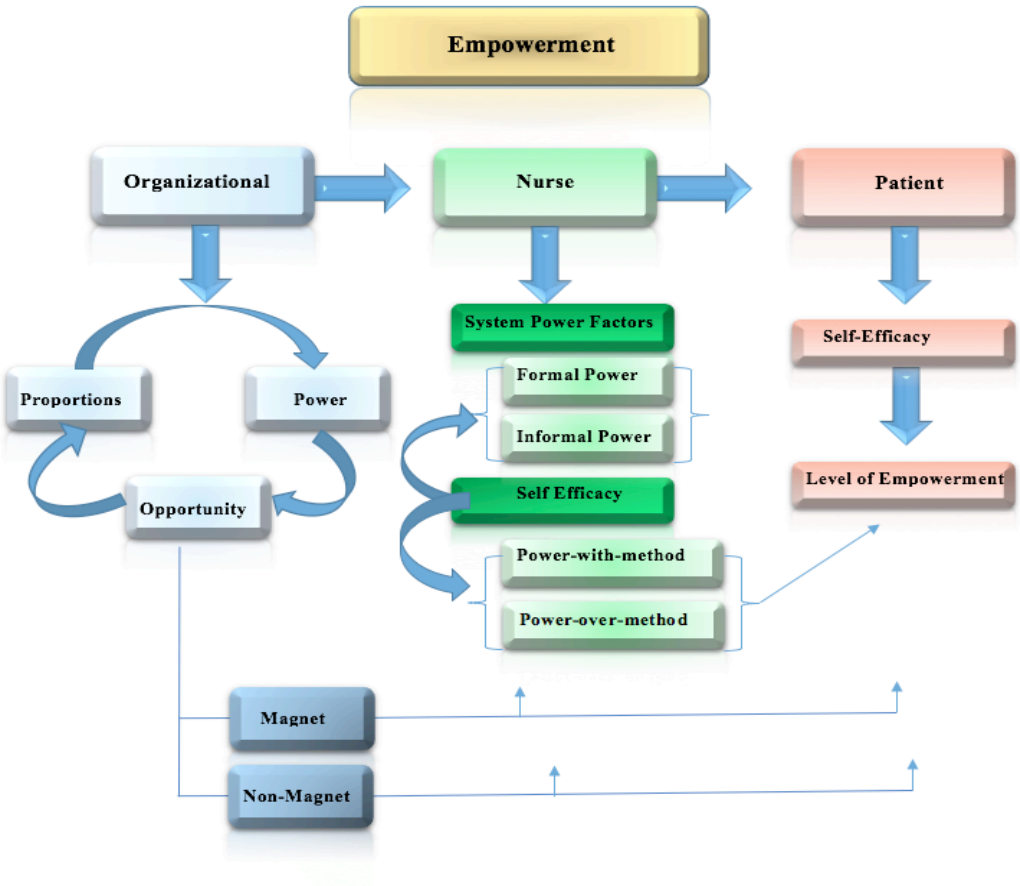

Figure 3. Redesigned Theoretical Framework

Magnet Designation

The Magnet Designation Program is a prestigious, nurse driven distinction established by the American Nurses Credentialing Center in the 1990s. Magnet Designation Recognition acknowledges excellence in nursing care and quality patient outcomes (ANCC, 2016; Armstrong & Laschinger, 2006). The Magnet designation has a philosophy promoting excellence in nursing care globally by valuing nursing staff, and opening communication lines between nurses and healthcare administration (Jerofke et al., 2014). Magnet hospitals are recognized as having ideal nursing practices as well as strong and empowered frontline nurses and nurse leaders, which is believed to lead to

more empowered and satisfied patients (Jerofke et al., 2014). Magnet designated hospitals value and promote access to opportunity, information, resources, and support to influence nursing care effectiveness (Upenieks, 2003).

Five characteristics have been identified as the basis for Magnet designation: transformational leadership, organizational empowerment, exemplary professional practice, and improvements including new knowledge, innovations, and empirical outcomes (Stimpfel, Rosen, & McHugh, 2015). Therefore, organizational empowerment is an important element that must be demonstrated in order to achieve Magnet designation.

Magnet designation hospitals have been known to have a positive, empirically significant relationship to high job satisfaction, increased staff retention, and patient outcomes; particularly nurse sensitive outcomes, and mortality (Stimpfel et al., 2015). Upenieks (2003) looked at 144 nurses working in two Magnet hospitals compared to 161 nurses working in two non-Magnet hospitals, using a mixed method design. In the quantitative portion, nurses were surveyed using the revised Nursing Work Index (NWI) and the Work of Effectiveness Questionnaire (CWEQ-II). In the qualitative portion, seven nurse leaders from Magnet hospitals and nine from the non-Magnet hospitals were interviewed. Results revealed that Magnet hospital nurses reported higher levels of empowerment and job satisfaction than non-Magnet hospital nurses. Magnet hospitals cultivate empowered work environments because nurses have access to opportunity, information, resources, and power (Upenieks, 2003). Consistent with the previous findings, Armstrong and Laschinger (2006) conducted a study in a small community hospital in Canada with 40 nurses, to test the linkage between the qualities of the work

environment and patient safety using the CWEQ-II, the Lakes' Practice Environment Scale of the Nursing Work Index, and the Safety Climate Survey. The results reported significant relationships between Magnet characteristics, organizational empowerment, and patient safety (Armstrong & Laschinger, 2006). Stimpfel et al. (2015) compared a matched set of Magnet and non-Magnet hospitals in the United States using a secondary data analysis to evaluate and compare the quality of nursing care. Similarly, results showed a significant association between Magnet status and higher quality of care, concluding that Magnet hospitals enrich their environments with empowerment structures to attract and retain nurses, leading to an optimization of quality nursing care (Stimpfel et al., 2015).

Laschinger and colleagues devoted considerable effort over the years to test Kanter's theory within a nursing context, and to measure organizational empowerment relating to where nursing care takes place. The synthesis of their findings suggests that authentic and empowered leaders positively influenced nurses' structural empowerment (mechanisms in place to advocate for and get tangible resources), work civility, job satisfaction, lowered burnout and increased self-rated performance (Laschinger & Fida, 2015; Laschinger, Read, Wilk, & Finegan, 2014b; Wong & Laschinger, 2013). Furthermore, abundant structural empowerment, authentic leadership, and an autonomous professional nursing practice environment could enhance interprofessional collaborative practice involving healthcare teams and patient partnerships to improve patient outcomes, nursing retention, and job satisfaction (Regan, Laschinger, & Wong, 2015). A common feature in their findings of empowerment is the effectiveness of transformational leadership, and the positive influence of leaders on nurses' empowerment.

Consistent with the effectiveness of transformational leadership on nurse empowerment, Lewis and Cunningham (2016) studied of 120 staff nurses' perception on the link between nurse transformational leadership to nurse staff engagement and burnout via work environment characteristics using several surveys including: the Rafferty and Griffin's scale, Areas of Worklife Scale (AWL) the Maslach Burnout Inventory-General scale, and the Utrecht Work Engagement Scale (UWES). Transformational leadership was described as leaders who inspire others by creating a positive work environment and providing feedback and support to nursing staff that can increase nurses' empowerment and self-esteem. The researchers concluded that transformational leadership influenced nurses' engagement and empowerment outcomes, and lowered burnout levels. Additionally, these results were conditioned by positive work environment characteristics (Lewis & Cunningham, 2016).

Two studies illustrate the importance of leadership's role in securing resources for adequate structural empowerment. Using a longitudinal design, researchers examined the effect of unit and individual level factors on the job satisfaction of 545 Canadian nurses. Researchers used multiple instruments including: CWEQ-II, the Practice Environment Scale, the Shortell Culture Scale, the Core Self-evaluation Scale (CSE), the Psychological Empowerment Scale (PSE), and job satisfaction questions adapted from the Job Diagnostic Survey. The results of this study found that on the unit level, organizational empowerment factors such as productivity and job satisfaction, significantly affected unit support for professional nursing practice, which acted as a proxy for unit effectiveness. On an individual level, self-evaluation has a direct effect on job satisfaction, and an indirect effect on psychological empowerment. High levels of psychological

empowerment predicted increased job satisfaction. Moreover, unit effectiveness was found to be correlated with increased job satisfaction, concluding that unit level factors combined with individual level factors shape how nurses perform and elevate the level of job satisfaction (Laschinger, Nosko, Wilk, & Finegan, 2014). A subsequent study of 525 Canadian nurses, looked at the influence of organizational empowerment on unit effectiveness and patient quality of care from the perception of nurses using the CWEQ-II and the Shortell Organizational Culture Scale. Nurses in this study were reported to be moderately empowered and had the perception they had the ability to provide a higher quality of patient care. The study concluded that work environment organizational empowerment predicts not only unit effectiveness, but also nurses' sense of the quality of care provided (Laschinger, Read, Wilk, & Finegan, 2014).

A correlational study of 61 nurses, looked at the relationships between negative behaviors that create an unhealthy work environment (incivility, bullying, high stress, and compassion fatigue), nurse turnover and psychological empowerment. Researchers used five tools in this study including: the Perceived Stress Scale (PSS), the Maslach Burnout Inventory (MBI), the Uncivil Workplace Behaviors questionnaire, the workplace Incivility Scale (WIS), and the Psychological Empowerment Scale (PES). The findings revealed that healthy work environments that do not cultivate negative behaviors enable nurses to respect each other, and lead to reduced stress and burnout. Correlation results revealed a significant relationship between negative factors (burnout and incivility, respectively) relating to turnover intentions ($p = 0.005$ and $p = 0.000$, respectively) but none of the variables were related to psychological empowerment (Oyeleye, Hanson, O'Connor, & Dunn, 2013).

International Outlook

Organizational empowerment is a concept relevant in the global nursing arena in terms of nurse retention and job satisfaction. Egyptian studies conducted with primarily diploma educated nurses found that organizational empowerment makes important contributions in the ability of nurses to experience autonomy, self-determination, positive behaviors and job commitment (Ibrahem, Elhoseeny, & Mahmoud, 2013; Ibrahim, El-Magd, & Sayed, 2014). One study using a cross-sectional design tested the relationship between organizational empowerment, psychological nurse empowerment, and job commitment with 150 Egyptian nurses. The CWEQ-II, the Psychological Empowerment Questionnaire, and the the Commitment to the Organization instrument were used in this study. There was an intermediate direct relationship between organizational empowerment, psychological nurse empowerment, and job commitment (Ibrahem et al., 2013). Another correlational study with 550 nurses looked at using the Psychological Empowerment Instrument and Nurses' Autonomy Questionnaire to test the relationship between nurses' psychological empowerment and nurses' autonomy. Results demonstrated a significant positive relationship between nurses' degree of psychological empowerment and level of professional autonomy, and nurses' autonomy and the workplace (Ibrahim et al., 2014). Both of these international studies found no relationship between nurses' demographic/descriptive variables, and empowerment.

Yang, Liu, Huang, & Zhu (2013) examined the relationships between organizational empowerment, professional work environment, and organizational commitment among 608 Chinese nurses using the CWEQ-II, the Practice Environment Scale (NWI-PES), and the Organizational Commitment Questionnaire. Researchers

found that the professional work environment has a mediating effect between organizational empowerment and job commitment. Empowering work situations are necessary to increase a positive professional environment, which in turn, increases nurses' organizational commitment. Linking organizational empowerment to Magnet hospital characteristics will more likely ensure nurses' ability to commit and work in a healthy work environment, and increase the hospital's ability to attract and retain nurses (Yang, Liu, Huang, & Zhu, 2013).

Wang and Liu (2015) found that nurse empowerment mediates the relationship between work environment and work engagement. A study of 300 Chinese nurses was conducted using a predictive non-experimental design to test the influence of work environment and psychological nurse empowerment on work engagement. Instruments used in this study were the Utrecht Work Engagement Scale, the Practice Environment Scale (NWI-PES), and the Psychological Empowerment Scale. Results revealed a statistically significant relationship between work environment and psychological empowerment and that the work environment has an indirect influence on work engagement through nurses' psychological empowerment. It was concluded that nurses working for empowering and healthy work environments are more engaged in their work (Wang & Liu, 2015).

Kuokkanen, Leino-Kilpi, and Katajisto (2003) conducted a study on 416 Finnish nurses to examine how nurses assess empowerment and what factors and background variables promote or impede empowerment. Instruments used in this study were the Qualities of Empowered Nurse Scale, Performance of an Empowered Nurse Scale, Work Empowerment Promoting Factors Scale, and Work Empowerment Impeding Factors

Scale. Results indicated that job satisfaction ($p < 0.001$), organizational commitment ($p < 0.001$), and level of professional activity ($p = 0.042$) correlates strongly with nurse empowerment. The study concluded that nurses, particularly younger ones and nurses desiring career advancement need to be empowered by their organizations through the availability of ample resources and professional development opportunities. Even though these nurses reported high levels of satisfaction, their empowerment levels were low which seemed to lead them to change career or positions (Kuokkanen et al., 2003). Another study conducted by Kuokkanen et al. in Finland on 2,152 nurses measured how nurses perceived their work empowerment in terms of justice, work-related and demographic variables. Instruments used in this study were the Nurse Empowerment Scale, the Organizational Justice, Job Control, and Possibilities for Developing Work. There was a significant correlation between organizational justice and nurse empowerment ($p < 0.001$), specifically with nurses who were considered "entrepreneurial". The study concluded that nurses with higher levels of education, greater years of experience, and abilities in skill application had a higher level of empowerment (Kuokkanen et al., 2014).

The third thematic element explored in this study is the one between the empowering behaviors demonstrated by nurses towards patients, and patient empowerment.

Relationship between Nurse and Patient Empowerment

Spreitzer's Psychological Empowerment theory suggests four major components necessary for a person to feel empowered: meaning, competence, self-determination, and impact (Spreitzer, 1995). *Meaning* relates the individual's standard of beliefs, values and

behaviors to the value of work goals and expectations. *Competence* relates to the person's inner feeling and self-efficacy in the ability to perform and complete a task. *Self-determination* relates to the individual's feeling of autonomy and choice in the decision making process. *Impact* relates to the degree of influence a person can make on organizational outcomes (Kennedy et al., 2015; Spreitzer, 1995). If a person, either a nurse or a patient lacks one of these components, their sense of empowerment will be limited (Kennedy et al., 2015). Nurses cannot promote what they do not possess. Therefore, a weakly empowered nurse may have challenges promoting/teaching these aspects of empowerment to patients.

Literature Synthesis

Empowerment seen within the context of nurse empowerment involves access to information, support, resources, and opportunities to develop individual power through knowledge, experience, and enough self-esteem to make changes (Armstrong & Laschinger, 2006). A nurse's level of psychological empowerment determines behaviors in practice and the quality of care delivery (Kennedy et al., 2015).

In a prospective correlational design Jerofke, Weiss, and Yakusheva (2014) looked at the linkage between empowering nursing behaviors and patient outcomes during hospitalization and after discharge in a convenience sample of 114 postsurgical cancer and cardiac patients. The study was conducted in a Magnet hospital in the United States. Patients were asked to provide their perceptions about nurses empowering behaviors and self-management outcomes using the Patient Perceptions of Patient-Empowering Nurse Behaviors Scale (PPPNBS), the Patient Activation Measure (PAM-13), and the functional health status (SF-36). The results yielded a significant association

between nursing's empowering behaviors during hospitalization and post discharge positive patient outcomes (Jerofke et al., 2014).

Slatyer, Williams, & Michael (2013) proposed in a grounded theory study a theory linking nurses' disempowerment with coping responses that in turn, influence nursing practice by using semi-structured interviews and observations on a sample of 33 nurses and 11 patients. Nurses in this study reported feeling disempowered when their patients were in pain, even when pain medication was prescribed. In an effort to resolve feelings of disempowerment, exhaustion and stress, nurses sought greater empowerment to provide comfort for their severely ill patients through advocacy strategies such as building connections with colleagues that possessed power and resources to execute greater pain management options, and nurse implemented non-drug therapeutics to comfort patients (Slatyer, Williams, & Michael, 2015).

International Outlook

Nurses have the desire to empower patients; however, barriers related to achieving empowerment goals include patient willingness and a nurse's approach (Tobiano et al., 2015). Presence of a healthy work environment is also necessary for nurse and patient empowerment. In this type of environment, healthcare providers can fulfil the responsibility of preparing patients to become engaged in decision-making processes (Barrie, 2011).

Kyung, Fritschi, & Mi Ja (2012) compared the effect of nurses' empowering interventions applied to the care of 22 hypertensive patients using a quasi-experimental design in Korea with one group receiving lifestyle modification education, empowerment group discussion and physical exercise, and the other group received standard care.

Standard care consisted of periodic provider check-ups and basic education about medication, diet, and exercise. A quasi-experimental pre and post design was used. Nurses empowering interventions in this study were:

- Educate patients about lifestyle modification at eight weekly sessions using presentations and brochures about multiple educational topics such as alcohol and stress management, and disease self-management;
- Encourage participants during the eight weeks to share their experience in small groups to empower each other by sharing and evaluating each other's progress;
- Provide individual patients an exercise program developed for their needs by a physical therapist.

Results demonstrated that the empowerment group had the ability to improve their self-management behaviors, empowerment levels, and their overall health status, such as metabolic syndrome symptoms, compared to the standard care group (Kyung et al, 2012).

Tabiano, Marshall, Bucknall, & Chaboyer in a systematic review (2015) identified four nurse attributes that enhance patient participation and empowerment: (a) initiating active, mutual engagement with patients to encourage communication and planning care with identification of patient expectations; (b) establishing a strong patient-nurse relationship; (c) surrendering and sharing power and control with patients; and (d) respecting patients, providing timely information and knowledge to achieve greater patient involvement (Tobiano et al., 2015).

In a mixed methods study; Small, Bower, Chew-Graham, Whalley & Protheroe (2013) identified internal and external empowerment processes in their study of patient empowerment in a small sample of 16 elderly patients with different long-term conditions. Patients and practitioners were interviewed to explore the elements of patient empowerment and how the management of long-term conditions directly informed empowerment measurement development (Small et al., 2013). Results revealed empowerment dimensions from the patient perspective, which are, (1) an understanding of the definition of empowerment, (2) identity, (3) disease knowledge and understanding, personal control and disease management, (4) making decisions, and (5) enabling other patients with similar conditions. Based on these dimensions, the internal process refers to the change of self-perception after a diagnosis, and the external process of empowerment relates to the support and understanding of healthcare providers.

Quantitatively, items were generated based on the 5 dimensions provided in the qualitative study and a factor analysis was performed revealing two significant factors; a) "positive attitude and sense of control", and b) "knowledge and confidence in decision making". The study concluded that patients with numerous co-morbidities and certain ethnicities were related to to lower empowerment levels.

In a qualitative study using focus groups and in-depth interviewing on 332 patients, Vaartio-Rajalin, Leino-Kilpi, & Puukka (2014) identified two factors essential to the patient empowerment process: the level of patient expectations, and awareness of their own strength and personal power. Therefore, nurses who educate patients must provide appropriate information based on patient knowledge and expectations. Nurses must have the ability to modify their approach in order to create an equal partnership with

patients that can aid in patient self-management (Vaartio-Rajalin, Leino-Kilpi, & Puukka, 2014).

In examining this in Japan; Hara, Iwashita, Okada, Tajiri, Nakayama, Kato, Nakao, Tsuboi, Breugelm, and Ishihara (2014) developed a questionnaire on empowerment for diabetic patients, analyzing factors influencing patient empowerment on a sample of 338 patients. Age, gender, and disease-related symptoms significantly influenced patient empowerment. Gender and disease-related symptoms were particularly significant among female patients who felt disempowered compared to males. Empowerment improved with aging among diabetic patients for both genders. Despite the fact that there are cultural differences between gender roles in Japan, study participants that lived with family inferred greater external processes of empowerment and support. The developed tool showed a sufficient reliability between 0.695 and 0.89, which demonstrated acceptable construct validity (Hara et al., 2014).

Lastly, Chen et al. (2013) used a cross sectional study with a convenience sample of 144 participants to examine diabetic Taiwanese patient perceptions of the relationship between empowerment processes, positive health outcomes, and related factors, such as demographics and disease history. Instruments used in this study were the Chinese Diabetes Empowerment Process Scale, the Summary of Diabetes Self-Care Activities Scale, and the modified Diabetes Quality of Life Scale. Though the study reported healthcare providers' use of specific empowerment strategies to empower patients such as raising awareness, encouraging open communications and mutual participation and providing important resources, patients reported feeling only moderately empowered. In order to optimize patient empowerment processes, healthcare providers must consider

patients' perceptions on empowerment and tailor their empowerment strategies to individual patient types. Empowerment processes correlated significantly (strong association) with self-care management ($r = 0.582$, $p < 0.01$) and quality of life ($r = 0.486$, $p < 0.01$), and other factors such as the patient's demographic variables and disease history. For example, patients with history of diabetes complications are less empowered than patients with no previous complications (Chen et al., 2013).

Strengths

Three strengths were identified from the literature review. First, the empowerment literature shows depth with ample quantitative, qualitative, mixed methods, and systematic reviews sufficiently powered with strong hypotheses and statistically significant results. A second strength is the increased volume of literature over the last 20 years examining the relationship between organizational and nurse empowerment and the significance to the inauguration of Magnet designation. The review identifies the outcomes of organizational empowerment contributions to nurse empowerment and increased job satisfaction, nursing retention, and nursing shortage reduction. These findings have been shown to benefit the organization financially, functionally, and with higher quality outcomes. Studies concerning organizational empowerment were of interest not only in the United States, but also internationally. Magnet designation is sought in other countries as well as in the United States (Upenieks, 2003).

A third strength of the literature is a greater focus on the significant relationship between nurse and patient empowerment. There were factors found to be significant in influencing this relationship, such as patient gender, age, demographic variables, and disease related symptoms. Studies concerning the relationship between nurse and patient

empowerment used quantitative designs with varying sample sizes and provided more generalizable findings. International studies on nurse empowerment found similar results to studies conducted in the United States.

Limitations

A preponderance of the quantitative studies represented used small to medium sample sizes. On the first relationship presented between organizational and nurse empowerment, Magnet designation was found to be highly significant in the embracement of nurse empowerment. There are limited studies comparing Magnet to Non-Magnet hospitals in examining the relationship between organization and nurse outcomes. Therefore, there is insufficient evidence to state unequivocally that Magnet hospitals are superior to non-Magnet in the empowerment arena. Comparisons between Magnet and non-Magnet hospitals may lead to concerns of bias, especially if there is an obvious difference between hospital size and quality of care, given the assumption that Magnet hospitals have more positive nurse and patient outcomes (Stimpfel et al., 2015; Upenieks, 2003).

Results of studies on empowerment across countries may cause some concern due to cultural differences, the status of women and differing socio-political perspectives on empowerment. Countries with diverse cultural mores regarding gender role could perceive empowerment differently from countries where there is greater gender equity. Therefore, tools used to measure this notion need to be culturally congruent and well tested in target populations. This is an area in need of further development.

Qualitative studies were mostly from single sites, not easily generalizable to wider populations due to the lack of multi-site study designs. For example, studies conducted in

Magnet hospitals measuring empowerment reveal findings not generalizable to non-Magnet hospitals. Few studies were conducted in non-acute settings. Therefore, it would be difficult and inaccurate to extrapolate findings determined in acute care settings to non-acute care settings.

Summary

A nurturing and caring work environment is important for the empowerment process (Dowling, 2011). Work environments play a major role in terms of nurses' empowerment; an empowering work environment empowers nurses psychologically, which, in turn, has an influence on nurses' empowering behaviors, higher job satisfaction, and better quality of care (Purdy et al., 2010).

Organizational empowerment is incomplete unless the psychological empowerment possessed by individuals is considered (Cicolini et al., 2014). Empowerment in the work environment provides opportunities for nurses to fulfill their roles, which enhances their autonomy, accountability, and engagement (Ibrahim et al., 2014).

Lack of empowerment can worsen one's health status (Laschinger et al., 2010; Chambers & Thompson, 2009; Morse, 1991; Fackler et al., 2015). Evidence suggests that patient empowerment is a strategy that enhances health status (Laschinger et al., 2010). Patient empowerment may serve to enhance patient safety and knowledge through patient participation (Tobiano et al., 2015). The quality of patient care in the United States must include patient empowerment in order to achieve optimal patient outcomes soon to be linked to reimbursement for care and improved healthcare professional legal protection (Barr et al., 2015). However, there is limited evidence in the literature demonstrating

patients having been consistently empowered, and if that empowerment has a positive impact on the cost effective use of health services and overall health status (Barr et al., 2015).

Empowerment is viewed as a process or as an outcome (Gibson, 1991). Studies have examined psychological empowerment as a positive outcome, whereas only a few research studies have demonstrated the ability of nurses to empower patients as a developmental process (Jerofke et al., 2014). By contrast, some published studies (Laschinger et al., 2010) have reviewed the effect of the work environment on nurse empowerment, job satisfaction, and the quality of care (Purdy et al., 2010).

Although none of the studies reviewed addressed all elements of empowerment, Laschinger et al. (2010) proposed a model combining the theories of Kanter (1993) and Spreitzer (1995) thus expanding Kanter's theory of empowerment and applying it to nursing care delivery through the relationship with patients. Therefore, according to this model, organizational empowerment elevates nurses' psychological empowerment, which in turn increases patient empowerment and leads to better patient outcomes (Laschinger et al., 2010). There is insufficient evidence in the literature to link all these elements together simultaneously. An empowered work environment was shown to enhance positive outcomes for both nurses and patients (Purdy et al., 2010). Magnet hospitals embrace organization empowerment as essential to deliver the best nursing care. Linkages between organizational, individual psychological and patient empowerment levels need further study in both Magnet and non-Magnet hospitals.

CHAPTER THREE

THE STUDY METHODOLOGY

Purpose

The purpose of this study is to explore and compare the relationship between organizational empowerment, individual nurse psychological empowerment, and patient empowerment at a Magnet designated hospital versus a non-Magnet designated hospital. The three specific aims of this study are:

- To explore the relationship between the level of organizational empowerment and individual nurse psychological empowerment
- To examine the relationship between the level of organizational empowerment, individual nurse psychological empowerment and patient empowerment
- To investigate if there are any differences in empowerment levels between a Magnet designated and non-Magnet designated facility

Research Questions and Hypotheses

The overall research question: What is the level of organizational, nurse-related, and patient-related empowerment at a non-Magnet designated hospital compared to a Magnet designated hospital?

Research question 1: What is the relationship between nurse level of organizational empowerment and individual nurse psychological empowerment, and nurse and nurses' demographics? The underlying hypothesis is; an empowered work environment is associated with nurse empowerment.

Research question 2: What is the relationship between individual nurse psychological empowerment and nurse level of patient empowering behaviors, and

patient demographics? The underlying hypothesis is; empowered nurses are more likely to employ patient empowering behaviors.

Research question 3: Is there a difference in organizational, individual nurse psychological empowerment and nurse level of patient empowering behaviors at a non-Magnet designated hospital compared to a Magnet designated hospital? The underlying hypothesis 3 reads: In Magnet designated acute care settings, there is a greater likelihood of higher levels of organizational empowerment, individual nurse self-efficacy and patient empowerment than in non-Magnet designated acute healthcare settings.

Design

A descriptive, correlational design employing quantitative survey methods was used for this study.

Setting

The study was conducted in two large, suburban, regional acute care hospitals in Southern California, United States. One hospital was Magnet designated and the other a non-Magnet designated hospital. Both hospitals are acute care, one is a faith-based, tertiary care hospital, and the other is a general non-profit acute care hospital. The target populations were frontline nurses, and medical-surgical patients with an inpatient stay of at least two days.

Sampling

Patients

A sample of patients was selected using the following inclusion criteria: (1) participants must be 18 years of age or older, (2) stayed at the hospital for at least 2 nights, and (3) able to speak, read and write in English. The exclusion criteria were: (1)

patients who had undergone painful procedures or were too sick to participate, and (2) patients with mental, psychological or cognitive impairments rendering them unable to focus on the survey questions.

All eligible patients presented in the medical-surgical units at both hospitals during the selected days for data collection were approached and invited to join the study. If interested, an explanation of what was involved in the study was provided, and paper surveys given. The completion of a survey indicated patient consent to participate in the study.

Nurses

The inclusion criteria for nurse participants were: (a) state-licensed Registered Nurse, (b) employed in either of the two study hospitals working in a medical-surgical setting, and (c) worked predominantly at the front line providing direct patient care. The exclusion criteria were: (a) worked temporarily in the department as a substitute or traveler nurse to cover staffing needs, and (b) being a nurse manager, administrator, or had other non-direct patient care roles. All the nurses working in both hospitals' medical-surgical units during the selected days for data collection received an invitation email with a link to access the surveys and consent their approval once they clicked on the link. A power analysis was conducted determining that a minimum of 100 subjects per group (nurses and patients) per facility (Magnet and non-Magnet) was required to detect a significant medium effect at power of 80%.

Measurement Variables

Patient Demographics

Patient demographics including gender, ethnicity, age, level of education,

insurance type, and days of hospitalization since admission were collected from patients at the time of enrollment.

Patient Empowerment

Patient empowerment was measured using the Patient Perceptions of Patient-Empowering Nurse Behaviors Scale (PPPNBS) short form (Jerofke et al., 2014). This tool developed by Jerofke was used with permission. Validity and reliability for the Patient Perceptions of Patient-Empowering Nurse Behaviors Scale has been established by a Cronbach's Alpha of .97 for the total scale. Jerofke et al. identified seven factors using a confirmatory bi-factor analysis yielding Cronbach's Alpha between .81 - .92.

The tool consisted of 22 items in Table 1 representing the following subscales: 3 questions on *initiation* (how the nurse introduces empowerment strategies to the patient), 3 questions on *access to information*, 5 questions on *access to support*, 3 questions on *access to resources*, 2 questions on *access to opportunities*, 3 questions on *informal power*, and 3 questions on *formal power*. The answers options reflected 11-point Likert-type scales (0 – 10) with the anchor points 0, indicating "not at all" and 10 indicating "a great deal." Thus, higher scores represented more empowering nurse behaviors.

Table 1. Patient Perception of Patient Empowering Nurse Behaviors Scale (PPPNBS)

Subscales	Items
Initiation	3 Questions
Access to information	3 Questions
Access to support	5 Questions
Access to resources	3 Questions
Access to opportunities	2 Questions
Informal power	3 Questions
Formal power	3 Questions

Nurse Characteristics

Nurse characteristics including age, gender, ethnicity, level of education, years of nursing experience, and duration of employment at the hospital were collected from participating nurses at the time of enrollment.

Nurse Empowerment

Nurse empowerment was measured using the General Self-Efficacy Scale (Schwarzer, Bäßler, Kwiatek, Schröder, & Zhang, 1997). The tool consists of 10 items measuring self-perception in terms of one's own self-efficacy, which was used as a proxy for a nurse's personal empowerment. The answer options were accompanied by a 4-point Likert-type scale ranging from 1 – 4 with 1 indicating "not at all true" and 4 indicating "exactly true". Higher scores indicate the strength of the nurses' self-efficacy belief and self empowerment.

The tool, which had established validity and reliability was obtained from the authors and used with permission. The General Self-Efficacy Scale (Schwarzer et al., 1997) has been used in more than 1000 studies with different languages in many countries. Cronbach's alpha ranged between .76 - .90 in 25 countries with the majority higher than .80 (Jerusalem & Schwarzer, 1992).

Organizational Empowerment

Organizational empowerment was measured using the Conditions for Work Effectiveness Questionnaire II (CWE II) (Laschinger, Finegan, Shamian, & Wilk, 2001). The tool was developed by Heather Laschinger, and was used with permission in this study. Cronbach's alpha reliability coefficient was .89 for the total scales and between .67 - .89 for the subscales.

Table 2. Conditions for Work Effectiveness questionnaire (CWEII)

Subscales	Items
Access to Opportunity	3 Questions
Access to information	3 Questions
Access to support	3 Questions
Access to resources	3 Questions
Formal power	3 Questions
Informal power	4 Questions
Global Empowerment	2 Questions

The questionnaire consisted of 21 questions that are themed into seven subscales representing the following constructs (Table 2): 3 questions on *access to opportunity*, 3 questions on *access to information*, 3 questions on *access to support*, 3 questions on *access to resources*, 3 questions on *formal power*, 4 questions on *informal power*, and 2 questions on *global empowerment*. The answer options were accompanied by a 5-point Likert-type scales ranging from 1 – 5 with 1 indicating "none" and 5 indicating "a lot". Higher scores mean there is greater organizational empowerment.

Data Collection

Nurses' data was collected electronically from both acute care facilities (Magnet and non-Magnet) using questionnaires posted on Qualtrics® over the course of 3-6 months (November 2016 - April 2017).

All the nursing staff on Medical Surgical Units received an email containing a cover letter explanation of the study and a clickable link. For the nurses, primary notification of questionnaire availability was provided through email in addition to such venues as staff meetings, and personal encounters with nurses by the researcher on the

units when collecting patient data, and at shift change. Steps to maintain confidentiality were communicated to all prospective participants, that information with no personal identifiers would go into a secure, encrypted database available to the researcher only. Small dessert treats were provided to participating units for all staff in break room areas to raise awareness of the study and show appreciation to nurses who may have completed surveys.

For the patients, the researcher collected the data personally every 3 to 5 days to recruit as many eligible patients as possible with explaining the study purpose and assurance to protect their information. Paper surveys were collected personally by the researcher and placed into large envelopes for confidentiality. Patients completing the survey were given a small incentive such as a bookmark.

Ethical Consideration

Permission to carry out the study was obtained from the institutional review boards governing both the Magnet designated and non-Magnet designated facilities respectively. The non-Magnet facility's Nursing Research Committee also reviewed the study methodology. All participants were informed of study aims, and were provided with information on the benefits and risks of participation. While there may have been no direct benefits to participating nurses or patients, study participants had the satisfaction of knowing their input could lead to a better understanding of the relationships between organizational empowerment, nurse self-efficacy and patient empowerment. An improved understanding may lead to interventions that will ultimately improve nurse job satisfaction and good patient outcomes. The primary risk for both nurses and patients to participate in the study was breach of confidentiality. This risk was minimal as no

personal identifiers were required for the survey. Each survey contained a cover letter explaining the purpose, risks and benefits of the study. The decision to proceed with completing the survey constituted consent. Nurse surveys were distributed electronically. The survey took approximately 15 to 30 minutes to complete. Paper and pencil patient surveys were distributed on-site, where the researcher approached eligible patients. Patients agreeing to participate were provided with the survey. The patient survey took approximately 15 to 30 minutes to complete. The researcher collected the completed surveys personally and placed each one in a large envelope for confidentiality. Completion the survey constituted consent to participate.

Both nurse and patient survey information was entered into a Qualtrics® database at Loma Linda University (LLU) School of Nursing that was secure and accessible only to the researchers. After data collection completion, information was transferred to a secure SPSS data file housed in the LLU School of nursing for analysis. The hard copy study information was stored in a locked, secure place at LLU in compliance with University policy**.**

Data Analysis

Descriptive statistics was provided for demographic variables. Specifically, measures of central tendency (mean ± standard deviation, mode or median) with minimum and maximum for continuous variables, and number followed by percentages for nominal and categorical variables. Cronbach's alpha was used to assess the internal reliability of the items for organizational empowerment, personal nurse self-efficacy (personal empowerment), and patient empowerment scale variables (See table 3).

Table 3. Analytical Descriptions of Main Variables

Variable	Measurement Tool	Level of measurement	Description
Nurse psychological empowerment (self-efficacy)	**General Self-Efficacy Scale**	Continuous	The tool measures general self efficacy and self empowerment. The questionnaire has 10 questions, followed by a 4 point Likert Scale (1 indicates not at all true and 4 indicates exactly true). Higher scores indicate higher self-efficacy belief and self-empowerment. Cronbach's alpha ranged between .76 - .90 in 25 countries with the majority higher than .80.
Organizational Empowerment	**Conditions for Work Effectiveness questionnaire II (CWE-II)**	Continuous	The tool measures organizational empowerment. The questionnaire consists of 21 questions reflecting seven subscales representing the following constructs: *access to opportunity*, *access to information*, *access to support*, *access to resources*, *formal power*, *informal power*, and *global empowerment*. Each question scored between 1 to 5 points and are added together. The higher the score the greater organizational empowerment. Cronbach's alpha was .89 for the total scales and between .67 - .89 for the subscales.
Nurse Descriptive Variables			
Gender	Male/female	Categorical (Nominal)	Binary variable
Degree	5 Categories	Categorical (Ordinal)	AS/Diploma/BSN/MS/Doctoral
Age	Age in years	Continuous	Mean age (SD)
Years of Experience	3 categories	Categorical (Ordinal)	Less than 2 years/2-5 years/more than 5 years
Race	6 categories	Categorical (Nominal)	White /American Indian or Native American/African American/Asian/Hawaiian or Pacific Islander/Other
Length of Employment	3 categories	Categorical (Ordinal)	Less than 2 years/2-5 years/more than 5 years

Variable	Measurement Tool	Level of measurement	Description
Time spent providing patient care	4 categories	Categorical (Ordinal)	Less than 36 hours/36-72 hours/72-80 hours/greater than 80 hours per pay period
Patient Empowerment	**Patient Perceptions of Patient-Empowering Nurse Behaviors Scale** (PPPNBS) short form	Continuous	The tool consists of 22 items representing the following subscales: *initiation*, *access to information*, *access to support*, *access to resources*, *access to opportunities*, *informal power*, and *formal power*. The answers are 11 Point-Likert type scales (0 – 10) where 0 indicates not at all and 10 indicates a great deal. The higher the score, the more positive the empowering behaviors.
Patient Descriptive Variables			
Gender	Male/female	Categorical (Nominal)	Binary variable
Insurance	4 categories	Categorical (Ordinal)	Medicare/Medi-Cal/Private or Commercial/other
Age	Age in years	Continuous	Mean age (SD)
Education	6 categories	Categorical (Ordinal)	Elementary school/high school/some college/college degree/graduate degree/other
Days in hospital	days of hospitalization	Categorical (Ordinal)	Mean hospitalization days (SD)
Reason for hospital stay	4 categories	Categorical (Nominal)	Accident or injury/ Medical Condition/Surgical condition/other
Race	7 categories	Categorical (Nominal)	White, Hispanic or Latino, Native American, African-American, Asian/Pacific Islander, Other, prefer not to answer.

Independent Samples *t*-test was performed to test if there was a difference in the continuous variables by the type of the healthcare facilities (Magnet designated and non-Magnet designated facilities). Independent Samples Mann-Whitney *U* test was used when the assumptions of Independent Samples *t*-test were not met. Pearson Chi-Square procedure was used in the analysis to assess the association between categorical

Table 4. Analytical Strategies for Each Research Question

Q1: Is there a relationship between the level of organizational empowerment and psychological empowerment of the nurse?			
Independent Variable [IV]	Level of Measurement	Dependent Variable [DV]	Analytical Strategy
Organizational Empowerment (CWEQ-II) Confounding variables: - Level of Education - Years of Experience	Continuous	General Self-Efficacy Scale (GSE)	Univariate Descriptive Statistics Bivariate: Pearson *r* correlation. Multiple Linear Regressions Analysis
Q2: Is there a relationship between psychological empowerment of nurses and patient empowerment?			
Independent Variable [IV]	Level of Measurement	Dependent Variable [DV]	Analytical Strategy
General Self-Efficacy Scale Confounding variables: - Level of Education - Days in Hospital	Continuous	Patient Empowerment (PPPNBS)	Univariate Descriptive Statistics Bivariate: Pearson *r* correlation. Multiple Linear Regressions Analysis
Q3: Is there a difference between the levels of organizational, psychological nurse empowerment and patient empowerment at Magnet versus non-Magnet designated hospitals?			
Independent Variable [IV]	Level of Measurement	Dependent Variable [DV]	Analytical Strategy
Magnet and Non-Magnet Designated hospitals	Continuous	CWEQ-II GSE PPPNBS	Independent Samples *t*-test for normally distributed variables Independent Samples Mann-Whitney *U* tests for not normally distributed variables

variables. Fisher's exact test was used in the analysis when the assumptions of Pearson Chi-Square were not met. Pearson correlation analysis was used to assess the relationship between the continuous variables. In Table 4, the analytical procedure for the study questions are presented.

Multiple linear regression analysis was used to explore the relationships between the dependent variables and independent variables after adjusting for the confounding variables. Statistical analyses were performed using IBM SPSS Statistics (Version 23; IBM Corporation 1989, 2014). Alpha was set at 0.05 significance level.

CHAPTER FOUR

RESULTS

This chapter presents the study findings, which include recruitment and response rates, descriptive analyses, scales internal reliabilities (Cronbach's alpha), correlational statistics among the quantitative variables, regression statistical analysis between the dependent and independent variables after adjusting for confounding variables, and *t* test to compare the variables between the Magnet and non-Magnet hospitals to address the study aims. Data was analyzed using IBM SPSS Statistics (Version 23; IBM Corporation 1989, 2014).

Findings are presented in response to the three research questions: (1) the relationship between organization and nurse psychological empowerment, (2) relationship between nurse and patient perception of nurses' empowering behaviors, and (3) the difference between Magnet and non-Magnet hospitals.

Recruitment and Response Rate

Data was collected from nurses and patients at both facilities. Nurses received an explanation of the study and a survey link using their work issued email at least one week before the researcher approached patients at the facility. Subsequent to the emails inviting the nurses to participate in an electronic survey, the researcher began collecting patient data. Patient recruitment began by approaching potential patients meeting the study inclusion criteria, explaining about the study, obtaining informed consent, and requesting them to complete a pencil and paper patient survey. This synchrony insured that both patient and nurse data was conducted in the same timeframe to validate the relationships between the two groups.

Data collection began at the non-Magnet hospital (A) at the beginning of December 2016. A total of 144 nurses received the questionnaires via email. Nurses were reminded weekly about the survey both by email and through personal interaction with the researcher. However, by the end of February, only 54 nurses completed the survey, rendering a response rate of 34.7%. An additional strategy to increase recruitment was implemented. Following submission and receipt of approval for a change in protocol to the Institutional Review Board (IRB), the researcher distributed pencil and paper nurse surveys on the units, and when permitted, at staff meetings. An Additional 50 surveys were distributed to staff nurses agreeing to participate after explaining the study. Verbal validation was obtained by the researcher that these nurses had not participated in the online survey prior to accepting the pencil and paper survey. After checking the questionnaires for completion, two surveys were found to be incomplete and therefore excluded. The total number of valid participants for Hospital A was 102 nurses.

The researcher was on-site at hospital A every 3 to 5 days to recruit newly admitted patients meeting inclusion criteria. After explaining the study to patients, surveys were given only to patients who were willing to participate and who had read the informed consent document. Fifteen to thirty minutes was allotted for patients to fill out the pencil and paper surveys, which was collected personally by the researcher. Upon collection, remaining participant questions were answered and the researcher verified that patients did not give or share their surveys with anyone. Following completion, questionnaires were placed in a large envelope to maintain confidentiality. After reviewing for completion, two surveys were excluded as patients were unable to complete the survey. The total number of valid patient participants was 100 patients**.**

Data was collected from the Magnet designated hospital (B) at the beginning of February 2017. Questionnaires were distributed to 270 nurses' work emails. The number of participants completing the nurse survey electronically reached 100 at the beginning of April 2017, yielding a response rate of 53.7%. After checking the surveys for completion and validation, two surveys were incomplete and excluded. The total valid number of participants was 98 nurses for hospital B.

For the patient group at hospital B, hard copy patient surveys were given only to patients meeting the inclusion criteria and were willing to participate and read the informed consent document. Fifteen to thirty minutes was allotted for patients to fill out the pencil and paper surveys, which were collected personally by the researcher and placed in large envelope for confidentiality. After checking for completion and validation, 100 completed patient surveys were utilized for data for hospital B.

Sample Characteristics

Nurse sample characteristics at both hospitals are presented in Tables 5 and 6, specifically, nurse participant demographic variables at both hospitals including: age, gender, country of birth, race, highest degree in nursing and where it was obtained, years of nursing experience, length of employment at hospital, and time spent providing direct patient care.

Table 5. Descriptive Statistics – Nurses' Sample Characteristics (Categorical)

	Hospital Type	
Variables	A *N* (%)	B *N* (%)
Age		
Baby Boomers	8 (7.8%)	32 (32.3%)
Generation X	30 (29.4%)	28 (28.3%)
Millennial	64 (62.7%)	39 (39.4%)
Gender		
Male	13 (12.6%)	11 (11.2%)
Female	90 (87.4%)	87 (88.8%)
Country of Birth		
USA	71 (68.3%)	64 (64%)
Other	33 (31.7%)	36 (36%)
Race		
White	43 (43.9%)	51 (53.7%)
Black or African American	4 (4.1%)	6 (6.3%)
Asian	23 (23.5%)	19 (20%)
Native Hawaiian or Pacific Islander	2 (2%)	4 (4.2%)
Other	26 (26.5%)	15 (15.8%)
Highest Degree in Nursing		
Diploma	3 (2.9%)	4 (4%)
AS	19 (18.3%)	23 (23%)
BS	78 (75%)	65 (65%)
MS	4 (3.8%)	8 (8%)
Country of highest degree		
USA	90 (86.5%)	81 (81%)
Other	14 (13.5%)	19 (19%)
Years of Nursing Experience		
< 2 years	22 (21.6%)	12 (12%)
2 - 5 years	39 (38.2%)	28 (28%)
> 5 years	41 (40.2%)	60 (60%)
Length of Employment at the Hospital		
< 2 years	30 (29.1%)	26 (26%)
2 - 5 years	40 (38.8%)	21 (21%)
> 5 years	33 (32%)	53 (53%)
Time spent providing Direct Care		
Part Time	65 (62.5%)	56 (56%)
Full Time	39 (37.5 %)	44 (44%)

The majority of nurse participants were female in both hospitals A (87.4%) and B (88.8%). The sample represented male nurses with 12.6% and 11.2%, respectively. Nurses' age was categorized based on three population cohorts groups used by market

researchers: baby boomers (aged 53-71), generation X (aged 38-52), and millennials (aged 22-37). In this study, the majority of nurses in both hospitals were the millennial group, however, there were more millennial nurses at hospital A (62.7%) and more baby boom nurses at hospital B (32.3%).

At both hospitals the majority of nurses were born and received nursing education in the United States. Nurses born in other countries such as Canada, Mexico, Asia, or Europe totaled 33 at hospital A and 36 at hospital B. In addition, nurses attaining a higher degree in nursing from countries other than the United States was 14 (13.5%) from hospital A and 19 (19%) from hospital B. The data reflected in Table 5 shows the race of nurses, with the largest percentage of nurses identifying as white at both hospitals (43.9%, 53.7%), followed by other and Asian. The nurses identifying with the option "other" indicated Hispanic/Latino, followed by a few African American and Native Hawaiian.

The highest level of education reported by nurses at both hospitals was the Masters degree in nursing. The educational level reporting the largest percentage was the Baccalaureate degree in Nursing at both hospitals (75%, 65%, respectively), followed by nurses with an associate degree and diploma prepared in nursing at both hospitals.

The majority of nurses at both hospitals worked in the nursing field for greater than 5 years, however, more nurses in hospital B worked for the hospital greater than 5 years. Only nurses working on medical/surgical units providing direct patient care were recruited for this study. In this sample, more nurses providing patient care worked part time at both hospitals.

Tables 7 and 8 present patient participant demographic variables from both hospitals including: age, gender, race, insurance type, highest level of education, hospitalization days, and reasons for hospitalization.

Table 6. Descriptive Statistics - Patient Sample Characteristics (Categorical)

Variables	Hospital Type A *N* (%)	Hospital Type B *N* (%)
Gender		
Male	44 (44.4%)	52 (53.6%)
Female	55 (55.6%)	45 (46.4%)
Insurance		
Medicare	27 (27%)	42 (42%)
Medi-Cal	35 (35%)	22 (22%)
Private/commercial	28 (28%)	27 (27%)
Other	10 (10%)	9 (9%)
Race		
White	45 (45.5%)	68 (68%)
Hispanic or Latino	28 (28.3%)	23 (23%)
American Indian or Native	1 (1%)	3 (3%)
African American	13 (13%)	3 (3%)
Asian/Pacific Islander	3 (3%)	1 (1%)
Other	3 (3%)	1 (1%)
Highest level of education		
Less than college degree	60 (60%)	54 (54%)
College Degree	26 (26%)	26 (26%)
Graduate Degree	14 (14%)	20 (20%)
Reasons for Hospitalization		
Accident/Injury	9 (9%)	7 (7%)
Medical Condition	57 (57%)	55 (55%)
Surgical Condition	26 (26%)	34 (34%)
Other	8 (8%)	4 (4%)

Table 7. Descriptive Statistics - Patients' Sample Characteristics (Continuous)

	Hospital Type A				Hospital Type B			
Variable	Range	Mean	*SD*	MED	Range	Mean	*SD*	MED
Age	18-88	49.68	17.41	50.5	18-90	61.76	15.82	64
Hospitalization days	2-37	6	5	4	2-41	6	6	4

Overall, patients were generally old, White, and have some or college degree. The age of patients ranged from 18-90. The average age of a medical/surgical patient at hospital A was 50, and 62 at hospital B. Overall hospitalization days were ranged from 2-41 days. The average length of stay at hospital A and B were similar (6 days).

The patient sample was divided in terms of gender, and varied in level of education and type of insurance. Sixty percent of the hospital A patient sample reported their highest level of education as some college education, and 54% at hospital B. Of the patients admitted to hospital A, 35% had Medi-Cal (Medicaid in California) insurance, 28% private insurance, 27% Medicare, and 10% other. At hospital B, 42% of patients had Medicare insurance, 22% Medi-Cal, 27% private, and 9% other. Patients who reported "other" specified other as out of pocket or travel.

The majority of the patients at both hospitals were white (45.5%, 68%) followed by Hispanic (28.3%, 23%). There were few Black/African American patients, Asian, Indian, and other. The majority of the patients at both hospitals were hospitalized due to medical conditions (57%, 55%) followed by surgical conditions (26%, 34%). Only a small percentage of patients reported hospitalization due to accident/injury or "other" specified as unknown.

Scale Reliabilities

To assess the internal reliability, Cronbach's alpha coefficient was calculated for each scale used in this study (refer to Table 7). The Conditions of Work Effectiveness (CWE-II) scale measured organizational empowerment and yielded a Cronbach's alpha coefficient of 0.89 for the total scale with the subscales scoring between 0.67 - 0.90. The General Self-Efficacy (GSE) scale measured nurse empowerment and self-efficacy at a

Cronbach's alpha coefficient of 0.85. The Patient Perceptions of Patient-Empowering Nurse Behaviors scale (PPPNBS) measured patient empowerment as perceived by nurses with the Cronbach's alpha coefficient scoring 0.98 for the total scale and between 0.86 to 0.94 for the subscales.

Table 8. Scales and Subscales Reliabilities

Scales and Subscales	Cronbach's alphas (α)
Organizational Empowerment (CWEQ- II)	0.89
Opportunity	0.78
Information	0.82
Support	0.79
Resources	0.79
JAS	0.75
ORS	0.67
Global Empowerment (GE)	0.90
Nurse Self Efficacy (GSE)	0.85
Patient Empowerment (PPPNBS)	0.98
Initiation	0.92
Access to information	0.88
Access to support	0.94
Access to resources	0.88
Access to opportunities	0.89
Informal power	0.86
Formal power	0.86

Summary Statistics of the Main Variables

Table 9 provides the scale statistics for each scale and related subscales, including mean *(*M), Standard Deviation (*SD*), Median (Med), and score range. The scores were similar between both settings, however, organizational empowerment and nurses' empowerment were slightly higher in hospital B.

Table 9. Conditions of Work Effectiveness Questionnaire (CWEQ-II), General Self Efficacy (GSE), and Patients' Perceptions of Patient-Empowering Nursing Behaviors Scales (PPPNBS) Scores

	Hospital Type							
			A				B	
Scales/Subscales	*M*	*SD*	Med	Range	*M*	*SD*	Med	Range
CWEQ- II	21.24	4.3	21.75	21.58	22.7	4.33	22.73	19.08
Opportunity	4.04	0.75	4.00	3.33	4.35	0.65	3.67	2.33
Information	3.61	0.75	3.67	3.67	3.61	0.82	3.67	3.67
Support	3.49	0.76	3.67	3.33	3.70	0.77	3.67	3.33
Resources	3.25	0.72	3.33	4.00	3.67	0.73	3.67	3.00
JAS	3.20	0.67	3.33	4.00	3.66	0.83	3.75	4.00
ORS	3.65	0.65	3.75	3.25	3.71	0.67	4.00	2.75
GE	3.54	0.87	4.00	4.00	4.11	0.80	4.33	3.00
GSE	3.20	0.34	3.11	1.44	3.34	0.41	3.33	2.00
PPPNBS	8.09	2.00	8.66	10.00	8.04	2.21	8.91	10.00
Total	177.97	44.12	190.5	220	176.95	48.55	196	220
Initiation	7.95	2.33	8.67	10.00	8.00	2.35	9.00	10.00
Information	8.28	1.92	8.67	10.00	8.43	2.07	9.33	10.00
Support	8.37	2.00	9.00	10.00	8.33	2.14	9.20	10.00
Resources	7.82	2.20	8.17	10.00	7.53	2.73	8.17	10.00
Opportunities	7.45	2.73	8.00	10.00	7.34	3.17	8.75	10.00
Informal power	8.01	2.31	8.67	10.00	7.87	2.57	9.00	10.00
Formal power	8.37	2.06	9.00	10.00	8.38	2.09	9.33	10.00

Questions and Hypotheses

Question 1: Is there a Relationship between The Level Of Organizational Empowerment and Psychological Empowerment of the Nurse and Nurses' Demographics?

The analyses related to this question involved assessing both nurse perception of the organizational empowerment (CWEQ-II) and nurse psychological empowerment (GSE) variables and associations with nurse demographics. Statistical correlation (*r*) between the CWEQ-II and GSE for the sample scores were analyzed using Spearman's Correlation and multiple linear regression was used to assess the relationship between the two main variables.

Nurses' Perception of the Organizational Empowerment

The first variable is organizational empowerment, measured with the CWEQ-II to measure the organizational empowerment level from nurses' perceptions. The total level of organizational empowerment from this tool was measured by the means of the main six subscales: opportunity, information, support, resources, job activities scale (JAS) and organization relationship scales (ORS). JAS refers to formal power, and ORS relates to informal power. In Table 10, Pearson correlations (r) between the six-subscales and the global empowerment subscale items, reveal that the total organizational empowerment (six subscales) correlates positively with global empowerment ($r = 0.68$), which is evidence of the scale's construct validity. Additionally, Pearson correlations between the subscales reveal that all subscales are positively correlated ($p < 0.05$).

Table 10. Pearson Correlations of CWE-II subscales

	Variable	1	2	3	4	5	6	7
1	Opportunity	-						
2	Information	0.32	-					
3	Support	0.39	0.55	-				
4	Resources	0.22	0.37	0.48	-			
5	JAS	0.38	0.46	0.59	0.45	-		
6	ORS	0.29	0.38	0.48	0.31	0.46	-	
7	Global Empowerment	0.34	0.38	0.59	0.58	0.59	0.46	-
8	Total Empowerment	0.60	0.73	0.82	0.67	0.79	0.67	0.68

Note: All correlations presented were statistically significant with $p < 0.05$.

The possible score range for this tool according to the six-subscales version is from 6 to 30. As seen in table 9, the range found at hospital A in this study sample was from 8.42 to 30, ($M = 21.24$, Median = 21.75, $SD = 4.3$), and the range of scores found at hospital B was from 10.9 to 30 (M = 22.7, Median = 22.73, $SD = 4.46$).

Perception of higher organizational empowerment levels was found at Magnet hospital B ($M = 22.7$) compared to non-Magnet hospital A ($M = 21.24$). In addition, subscale statistics demonstrated nurses at hospital B had higher access to opportunity ($M = 4.35$), access to support ($M = 3.7$), access to resources ($M = 3.67$), formal power ($M = 3.66$), and informal power ($M = 3.71$). However, nurses at both hospitals reported similar access to information ($M = 3.61$). Independent sample *t*-test results revealed a significant difference between the two settings in access to opportunity, access to resources, and informal power ($p > 0.05$).

CWEQ-II Associations with Nurse Demographics.

Analysis used to test the associations between organizational empowerment and nurse demographic variables was an independent sample *t*-test for dichotomous variables, and One-way ANOVA with other categorical demographic variables.

Independent sample *t*-test revealed that there was an association between organizational empowerment perceptions and country of birth, $t = -2.504$, $p = 0.013$, meaning a significant difference between nurses born in the United States compared to foreign born in terms of their perceptions on organizational empowerment. The country where nurses obtained their highest degree was also found significant, $t = -2.822$, and $p = 0.005$, indicating a significant difference between nurses obtaining their highest degree in nursing from the United States and nurses obtaining their highest degree from other countries in terms of how they perceive organizational empowerment. No association was found between all other nurse demographic variables and organizational empowerment ($p > 0.05$).

Table 11. Organizational Empowerment Scores by Nurse Characteristics: t-tests for Independent Samples

	CWEQ-II Scores					
Characteristic	*N*	*M*	*SD*	*t*	*df*	*p*
Gender				-1.515	195	0.131
Male	24	3.51	0.49			
Female	173	3.68	0.54			
Country of Birth				-2.504	198	0.013*
USA	132	3.59	0.53			
Other	68	3.79	0.52			
Highest Degree in Nursing				-1.112	198	0.267
Less than BS	49	3.59	0.52			
BS or Higher	151	3.68	0.53			
Country of Highest Degree				-2.822	198	0.005*
USA	168	3.61	0.52			
Other	32	3.89	0.56			
Time spent providing Direct Care				-0.271	198	0.787
Part Time	119	3.65	0.53			
Full Time	81	3.67	0.53			

* *p*-values significant at < 0.05 level

Table 12. Organizational Empowerment Scores by Nurse Characteristics: One Way ANOVA for Categorical Variables

		CWEQ-II				
Characteristic	*N*	*M*	*SD*	*F*	*df*	*p*
Age				1.098	192	0.339
Baby Boomers	40	3.70	0.67			
Generation X	58	3.76	0.52			
Millennial	103	3.58	0.53			
Race				0.949	126	0.603
White	94	3.61	0.55			
Asian	42	3.82	0.45			
Other	41	3.66	0.46			
Years of Nursing Experience				0.901	130	0.696
< 2 years	34	3.68	0.46			
2 - 5 years	67	3.63	0.54			
> 5 years	101	3.67	0.65			
Hospital Length of Employment				0.796	130	0.867
< 2 years	56	3.66	0.49			
2 - 5 years	61	3.66	0.56			
> 5 years	86	3.66	0.55			

Nurses' Self-Efficacy and Empowerment

The second variable, nurse self-efficacy, measures the approximate level of nurse empowerment and work satisfaction. The General Self-Efficacy Scale was used to measure this variable, with the possible score range for this tool from 10 to 40. As seen in Table 9, the range found at hospital A was 26-40, (M = 32, Median = 31, SD = 3.4), and the range found at hospital B was 20-40 (M = 33.4, Median = 33.3, SD = 4.1). By looking at averages, nurses reported higher self-efficacy and self-empowerment levels at Magnet hospital B compared to non-Magnet hospital A.

GSE Associations with Nurse Demographics.

An independent sample *t*-test to explore associations between nurse self-efficacy with dichotomous variables, and a one-way ANOVA with other categorical demographics variables was completed.

Table 13. Self-Efficacy Scores by Nurse Characteristics: t-tests for Independent Samples

		GSE Scores				
Characteristic	N	*M*	*SD*	*t*	*df*	*p*
Gender				0.535	196	0.593
Male	24	3.31	0.36			
Female	174	3.27	0.39			
Country of Birth				-0.979	199	0.329
USA	132	3.25	0.38			
Other	69	3.31	0.39			
Highest Degree in Nursing				0.155	199	0.877
Less than BS	49	3.28	0.40			
BS or Higher	152	3.27	0.38			
Country of Highest Degree				-1.491	199	0.137
USA	168	3.25	0.38			
Other	33	3.36	0.42			
Time spent in Direct Care				-1.384	199	0.168
Part Time	119	3.24	0.39			
Full Time	82	3.31	0.38			

Table 14. Self-Efficacy Scores by Nurse Characteristics: One Way ANOVA for Categorical Variables

		CWEQ-II				
Characteristic	*N*	*M*	*SD*	*F*	*df*	*p*
Age				1.148	14	0.320
Baby Boomers	40	3.25	0.44			
Generation X	58	3.36	0.40			
Millennial	103	3.22	0.34			
Race				0.832	14	0.634
White	94	3.29	0.39			
Asian	42	3.26	0.39			
Other	57	3.26	0.38			
Years of Nursing Experience				0.965	14	0.034*
< 2 years	34	3.09	0.32			
2 - 5 years	67	3.27	0.33			
> 5 years	101	3.33	0.42			
Hospital Length of Employment				0.971	14	0.485
< 2 years	56	3.20	0.34			
2 - 5 years	61	3.24	0.34			
> 5 years	86	3.34	0.43			

Results show no association between nurse psychological empowerment (self-efficacy) and all nurse demographic variables ($p > 0.05$), however, there was an association between years of nursing experience and nurse self-efficacy $F = 0.965$, and $p = 0.034$. These results indicated that nurses with greater years of experience are more likely to have higher levels of psychological empowerment and self-efficacy levels.

Hypothesis 1:

It was hypothesized that an empowered work environment empowers nurses. In Table 15, Spearman correlation between conditions of work effectiveness (organizational empowerment) and nurse psychological empowerment (self-efficacy) revealed a moderate positive correlation at $r = 0.36$ ($p < 0.05$) which explains 13% of the shared variance of organizational empowerment and nurse self-efficacy. The hypothesis that an empowered work environment empowers nurses was supported.

Table 15. Spearman Correlations between Main Variables CWEQ-II, GSE & PPNBS (Continuous)

	GSE	
Scale	*r*	*p*
CWEQ-II	0.36	<0.001
PPPNBS	-0.058	0.421

* *p*-values significant at < 0.05 level

Further analysis of the data to test hypothesis 1 using multiple regression in the first model presented in Table 16, was to test for a relationship between the perception of organizational empowerment and the psychological empowerment of the nurse. Results revealed a significant prediction of nurse self-efficacy, which was significantly associated with higher organizational empowerment $t = 5.54$, and $p < 0.05$.

Table 16. Model 1 Multiple Linear Regression between CWEQ-II and GSE Unadjusted and Adjusted for Nurse Level of Education and Years of Experience

Variable	β	Standard Error	*t*	*p*
CWEQ-II				
Unadjusted model	0.261	0.048	5.45	<0.001*
Adjusted model	0.263	0.048	5.52	<0.001*

Adjusted for nurse years of nursing experience and nurses' highest degree
* *p*-values significant at < 0.05 level

When adjusting for demographic variables, nurse years of experience and highest degree obtained were added to the model to test for a relationship between the level of organizational empowerment and psychological empowerment of the nurse while controlling for level of education and years of experience. Regression produced significant results for the organizational empowerment scale, $t = 5.52$, and $p < 0.05$. For every unit increase in the organization empowerment scale, general self-efficacy values increased by 0.263. This is accounting for the nurses' years of experience as well, as it

was a significant predictor in the model ($p < 0.05$), while nurses' level of education was not significant predictor ($p > 0.05$).

Question 2: Is there a Relationship between Psychological Empowerment of Nurses and Patient Empowerment and Nurse Demographics?

The analyses related to this question involved assessing both nurse psychological empowerment (GSE) and Patient Perception of Patient-Empowering Nursing Behaviors (PPPNBS) and patient demographics. Statistical correlation (r) between GSE and PPPNBS for the sample scores were analyzed using Spearman Correlation and multiple linear regression was used to assess the relationship between the two variables to test hypothesis 2.

Patients' Perception of Nurses Empowering Behaviors

The third variable, patient empowerment, measured nurse empowering behaviors from the patients' perception using the-PPPNBS. An overall satisfaction question added at the end of this scale measured patient satisfaction of the care received from nurses. The possible score range for this tool is 0-220. Both hospitals scored within the same range. In Table 9, patients perceived moderate to high empowering nurse behaviors at hospital A with a mean total score of 177.97 (Median = 190.5, SD = 44.12) and an item mean of 8.09 out of 10 (Median = 8.66, SD = 2). This was slightly higher than patients at hospital B with a mean total score of 176.95 (Median = 196, SD = 48.55) and an item mean of 8.04 out of 10 (Median = 8.91, SD = 2.21).

Patients reported a high perception of nurse empowering behaviors at both hospitals. Subscale means demonstrated similar averages on all subscales, however, patients at non-Magnet hospital A reported slightly higher formal power behaviors (M =

8.01) compared to hospital B ($M = 7.87$). In Table 14, all subscale correlations were positively correlated ($p < 0.05$).

Table 17. Spearman correlations of PPPNBS subscales

Variables		1	2	3	4	5	6
1	Initiation	-					
2	Access to Information	0.84	-				
3	Access to Support	0.89	0.80	-			
4	Access to Resources	0.84	0.82	0.83	-		
5	Access to Opportunities	0.75	0.75	0.72	0.85	-	
6	Informal Power	0.70	0.76	0.83	0.86	0.81	-
7	Formal Power	0.82	0.84	0.90	0.84	0.78	0.86

Note: All correlations presented was statistically significant with $p < 0.05$.

Table 18. Patient Satisfaction Percentages in the Both Hospitals

		Hospital Type			
		A		B	
Question	Scale	*N*	%	*N*	%
My Overall satisfaction about the care I receive	0	0	0%	1	1%
	1	0	0%	0	0%
	2	0	0 %	0	0%
	3	1	1%	1	1%
	4	2	2%	1	1%
	5	4	4%	3	3%
	6	2	2%	2	2 %
	7	5	5%	7	7%
	8	9	9%	7	7%
	9	17	17%	19	19%
	10	60	60%	59	59%

Additionally, patients reported similar satisfaction levels between the two hospitals, as they were asked about their overall satisfaction level with nurses' care provided during hospitalization. In Table 20, patients indicating a high level of satisfaction (scoring a 7, 8, 9, or 10) were 90% of the patients at the non-Magnet hospital and 92% at the Magnet hospital. Patients scoring at a moderate level of empowerment (4,

5, or 6) were 8% at the non-Magnet hospital and 6% at the Magnet hospital. Whereas 1% of patients who reported low satisfaction levels scored below 4 at the non-Magnet hospital and 2% at the Magnet hospital.

PPPNBS Associations with Patient Demographics.

A Spearman correlation between patient empowerment with age and hospitalization days was conducted to explore any association. The patient empowerment scale and subscales were not normally distributed; therefore, independent Samples Mann-Whitney U test was used to explore association between patient empowerment with dichotomous variables, and the Kruskal Wallis test was used with other categorical demographic variables.

Results revealed that patient age, gender, highest level of education, days of hospitalization, and reasons for hospitalizations were not associated with patient empowerment ($p > 0.05$). However, there was an associations between type of insurance and patient empowerment $\chi^2 = 10.032$, and $p = 0.018$, which indicated a significant difference between Medicare, Medi-Cal, and private insurance in perceiving patient empowerment. That difference being patients with Medi-Cal insurance and private insurance reported higher patient empowerment compared to Medicare patients.

Table 19. Spearman Correlations between Continuous Variables and Patient Empowerment

	PPPNBS	
Characteristic	*r*	*p*
Age	-0.109	0.126
Hospitalization Days	-0.011	0.881

Table 20. Patient Empowerment Scores by Patient Characteristics: The Kruskal Wallis test for Categorical Variables

	PPPNBS						
Characteristic	*N*	*M*	*SD*	*Median*	*Chi-Square*	*df*	*p*
Gender					1.553	1	0.213
Male	96	7.91	2.23				
Female	100	8.24	1.97				
Race					7.740	2	0.021*
White	113	8.06	1.99				
Hispanic or Latino	51	8.61	1.79				
Other	28	7.15	2.86				
Insurance Type					10.032	3	0.018*
Medicare	69	7.74	2.08				
Medi-Cal	57	8.65	1.72				
Private/commercial	55	8.18	1.95				
Other	19	7.21	3.12				
Highest Level of Education					4.497	2	0.106
Less than College	114	8.27	2.01				
College Degree	52	7.45	2.41				
Graduate Degree	34	8.33	1.74				
Reasons for Hospitalization					0.050	2	0.975
Accident/injury	16	8.13	1.93				
Medical Condition	124	8.10	1.89				
Surgical Condition	60	7.98	2.32				

* *p*-values significant at < 0.05 level

Additionally, there was an association between patient race and patient empowerment $\chi^2 = 7.74$, and $p = 0.021$, which indicated Hispanic patients were more empowered compared to White patients and other groups. This finding triggered an interest as to whether Hispanic patients were more empowered than White patients and in

which hospitals. A stratified analysis was conducted based on the hospital type to test patient empowerment levels based on patient race. Results revealed that patient race at hospital A was not associated with patient empowerment; however, Hispanic patients at hospital B were more empowered compared to White and other race groups.

Table 21. Patient empowerment scores based on Race groups stratified by hospital type

			N	*M*	*SD*	Median	Chi-Square	*df*	*P*
Hospital Type	A	White	45	8.23	1.89	8.68			
		Hispanic	28	8.16	1.92	8.75	0.829	2	0.661
		other	20	7.61	2.55	8.32			
	B	White	68	7.94	2.06	8.52			
		Hispanic	23	9.16	1.48	9.77	12.58	2	0.002
		other	8	5.98	3.41	5.84			

Hypothesis 2

It was hypothesized that empowered nurses are more likely to employ empowering behaviors that empower patients. In Table 15, Spearman correlation between nurse psychological empowerment and patient perceptions of nurse empowering behaviors was negative. However, this negative relationship was not significant which rejects the hypothesis that empowered nurses are more likely to employ empowering behaviors ($p > .05$).

Further analysis of the data to test hypothesis 2 using multiple regression in the second model presented in Table 22, was to test for a relationship between the level of nurse psychological empowerment and patient empowerment. Results revealed that there was no significant relationship between nurse psychological empowerment and patient empowerment ($p > 0.05$). When patient level of education and days of hospitalization were added to the model, no significant relationship was found between nurse

psychological empowerment and patient empowerment, which is shown by the *p*-value of 0.323 ($p > 0.05$) for the self-efficacy variable.

Table 22. Model 2 Multiple Linear Regression Between the GSE and PPPNBS Unadjusted and Adjusted for Patient Level of Education and Days of Hospitalization

Variable	β	Standard Error	*t*	*p*
GSE				
Unadjusted model	-0.316	0.392	-0.81	0.421
Adjusted model	-0.389	0.393	-0.99	0.323

Adjusted for patients' level of education and days of hospitalization

Question 3: Is there a Difference between the Levels of Organizational, Psychological Nurse Empowerment and Patient Empowerment at Magnet Versus Non-Magnet Designated Hospitals?

The analyses related to this question involved testing the differences of all three variables - organizational empowerment (CWEQ-II), nurses' psychological empowerment (GSE) and patient perception of patient-empowering nursing behaviors (PPPNBS) between Magnet and non-Magnet hospitals. In addition to the difference between demographic variables between the two settings, an independent sample *t*-test, Mann-Whitney U test, and Chi square statistics were used to test the differences across the sample.

Table 23. The Difference of Nurse Characteristics between Magnet and non-Magnet hospitals: Chi-Square test (Categorical)

	Median	*Range*	Hospital Type *Pearson Chi Square*	*df*	*p*
Age			20.497	2	< 0.001*
Gender			0.093	1	0.760
Country of Birth			0.415	1	0.519
Race			1.875	2	0.392
Highest Degree in Nursing			0.955	1	0.329
Country of Highest Degree			1.153	1	0.283
Years of Nursing Experience			8.302	2	0.016*
Length of Employment at Hospital			10.813	2	0.004*
Time Spending in Direct Care			0.893	1	0.345

* *p*-values significant at < 0.05 level

Results revealed that nurse age, years of nursing experience and length of employment at current hospital were significantly different between the two settings ($p < .05$). More nurses in hospital B were of the baby boom generation, had greater years of experience and greater length of employment at the hospital compared to hospital A. All other nurse demographic variables were not found to be statistically significant between the Magnet and non-Magnet hospitals ($p > 0.05$).

Table 24. The Difference of Patient Characteristics between Magnet and non-Magnet hospitals: Mann-Whitney *U* test for Independent Samples (Continous)

Characteristic	Hospital Type		
	Mann-Whitney U	*Z*	*p*
Age	2926	-4.898	<0.001*
Hospitalization Days	4721	-0.690	0.490

* *p*-values significant at < 0.05 level

Table 25. The Difference of Patient Characteristics between Magnet and non-Magnet hospitals: Chi-Square test (Categorical)

			Hospital Type		
Characteristic	*Median*	*Range*	*Pearson Chi Square*	*df*	*p*
Gender			1.646	1	0.199
Insurance Type			6.297	3	0.098
Race			10.137	2	0.006*
Highest Level of Education			1.375	2	0.503
Reasons for Hospitalization			1.607	2	0.448

* *p*-values significant at < 0.05 level

Patient age was found statistically significant between the Magnet hospital and the non-Magnet hospital, $Z = -4.898$, and $p < 0.001$, with the patients at hospital B being older. Race was also found to be significantly different between the two settings, $\chi^2 = 10.137$, and $p = 0.006$. Hospital B had more white, less Hispanic and patients of other races compared to hospital A. There was no significant difference between other patient demographic variables between the Magnet and non-Magnet hospitals ($p > 0.05$).

Hypothesis 3

It was hypothesized that a Magnet designated hospital would have higher levels of empowerment compared to non-Magnet designation hospitals. In Table 26, results revealed that there was a significant difference of the organizational empowerment between the two settings, $t = -3.27$, and $p = 0.001$. Nurse self-efficacy was also statistically significant between the two settings, $t = -2.69$, and $p = 0.008$. Results indicated that nurses perceived higher organizational empowerment and had higher psychological empowerment in the Magnet hospital compared to the non-Magnet hospital in this sample, which supports part of the hypothesis. However, there was no significant

difference between the levels of patient empowerment ($p > 0.05$), which rejects the hypothesis related to empowered nurses empowering patients.

Table 26. The Differnece of Main Variables (CWEQ-II, GSE, and PPPNBS) between Magnet and non-Magnet hospitals: t-test & Mann-Whitney U test for Independent Samples (Continous)

			Hospital Type		
t-test	*M*	*SD*	*t*	*df*	*p*
CWEQ-II			-3.27	198	0.001*
A	3.54	0.48			
B	3.78	0.56			
GSE			-2.69	199	0.008*
A	3.19	0.34			
B	3.34	0.41			
Mann-Whitney *U* test	*M*	*SD*	*U*	*Z*	*p*
PPPNBS			4830	-0.42	0.678
A	8.09	2			
B	8.04	2.21			

* *p*-values significant at < 0.05 level

Summary

The results of this study indicate that with the nursing sample, psychological empowerment was statistically significantly related to perceived organizational empowerment. A moderate positive correlation was observed between organizational empowerment and nurse psychological empowerment *(*$r = .36$, $p < 0.001$). Additionally, multiple regression model 1 revealed a significant association between nurse psychological empowerment and organizational empowerment ($p < 0.001$). When adjusting for nurse demographic variables (years of experience and highest degree in nursing), regression produced significant results for the organizational empowerment scale ($p < 0.001$). In addition, years of nursing were significant in predicting nurse psychological empowerment.

However, patients at both study locations within the sample reported similar overall satisfaction and empowerment levels. Patients reported that nurses employ similar empowering behaviors at both hospitals despite nurse self-efficacy and empowerment level differences. There was no correlation found between nurse psychological empowerment and patient empowerment perceptions in this study ($p > 0.05$). Additionally, multiple regression model 2 found no significant association between patient empowerment and nurse psychological empowerment even after adjusting for patient demographics.

In response to the general research question on the differences of empowerment levels between the Magnet and non-Magnet hospitals, *t*-test results revealed that there was a significant difference in organizational empowerment and nurse self-efficacy between the Magnet versus the non-Magnet hospital ($p < 0.05$) but there was no significant difference between patient empowerment perceptions in both settings ($p > .05$).

CHAPTER 5

DISCUSSION

This chapter discusses the main study findings in the context of the literature. Finally, the study conclusion, strengths, limitations, recommendations and implications for nursing practice are discussed.

Discussion of Findings

This study examined the relationship between organizational empowerment, nurse empowerment (self-efficacy), and patient empowerment and compared these levels between a Magnet designated hospital versus a non-Magnet designated hospital. To investigate these relationships, 200 nurse participants (102 non-Magnet, and 98 Magnet) completed the Conditions of Work Effectiveness II (CWEQ- II) survey to measure organizational empowerment, and the General Self-Efficacy scale to measure nurse self-efficacy and empowerment levels. Additionally, 200 patients (100 Magnet and 100 non-Magnet) participants completed the Patient Perception of Patient-Empowering Nurse Behaviors scale. Overall, the main findings of this study showed a positive relationship between organizational empowerment and nurse self-efficacy, but no relationship between nurse self-efficacy and patient perception of nurses' empowering behaviors.

Further discussion of the analysis related to the three themes: (1) relationship between organization and nurse empowerment, (2) relationship between nurse and patient empowerment, and (3) the comparison of nurse and patient empowerment levels between Magnet and Non-Magnet hospitals will be presented.

Relationship between Organization and Nurse Empowerment

In this study, responses to the Conditions of Work Effectiveness II survey, explored nurses perceptions of organizational empowerment including enabling nurses to feel empowered, have access to support, resources, information, opportunities, and formal/ informal power. Organizational empowerment involves leadership behaviors, which translate to having better support including feedback and guidance from colleagues and superiors who may allow or encourage nurses to feel involved, fostering cooperation and collaboration. Access to better resources including materials, time, and supplies enable nurses to complete their work efficiently. To have better information including knowledge pertaining to skills, the organization's goals and polices, and opportunities to gain experience allows nurses to advance with the knowledge and expertise needed to accomplish goals and fulfill the organization's mission. Providing nurses with an empowering environment increases the chance of acquiring formal and informal power and provides the milieu for nurses to be more adaptive and creative allowing then to practice autonomy and individual decision-making. This environment can also encourage greater communication and cooperation among colleagues and other groups to improve social connections.

Individual nurse empowerment was presented as self-efficacy due to the lack of clarity on how to measure a person's self-empowerment in the literature (Kennedy et al., 2015). However, multiple studies defined individual empowerment as the mediator between self-efficacy and the willingness to make a decision (McCarthy & Freeman, 2008). Therefore, the General Self-Efficacy scale (GSE) was used in this study to

measure an approximate level of nurse empowerment and the ability to enable and share power with patients.

The literature supports the link between an empowered work environment and nurse empowerment, job satisfaction, self-efficacy levels, and the quality of care (Purdy et al., 2010). Consistent with the literature, the findings of this study revealed that nurse's perception of organizational empowerment and work effectiveness was positive and predicts nurse psychological empowerment. Nurses working for organizations with high levels of organizational empowerment may help to encourage nurse empowerment, as highly empowered organizations seem to contribute to elevated nurse self-efficacy levels. Nurses working in empowered organizations reported having better support, resources, information, and opportunities that elevates their formal and informal power, which in turn, may improve their self-efficacy and self-empowerment levels. However, one could interpret the finding to mean that nurses innately possessing higher levels of self-efficacy are drawn to and retained by highly empowering organizations.

In adjusting for demographic variables, when years of experience and highest educational degree in nursing attained were added to the regression model, it was found that nurse years of experience was a significant prediction for nurse psychological empowerment. It could be interpreted that nurses with greater years of experience have better psychological empowerment compared to nurses with less experience, indicating that nurses with greater experience and professional success gained higher levels of self-efficacy regardless of hospital status.

Nurse Demographics

Age

There was a weak correlation found between the age of nurse and organizational empowerment, indicating that older nurses perceived better organizational empowerment. Although it was a weak correlation, it might be related to the variability of the mean age of nurses in this study sample where nurses at hospital B were older than nurses a hospital A. Consistent with the literature, Kuokkanen, Leino-Kilpi, and Katajisto (2003) found that older nurses are more committed to work than younger nurses. Moreover, older nurses are more mature, with greater life experience and may be better able to cope with the existing organizational empowerment structures or lack thereof.

Country of Birth

There was an association between the country nurses were born and perception of organizational empowerment. Nurses born in the United States perceived better organizational empowerment compared to nurses born in other countries. It could be surmised that citizens born and educated in the United States benefit from the advantages of a democracy where personal freedom and self-expression is highly regarded. Citizens of the U.S. are socialized to speak up when concerns arise. There is the possibility that international nurses are not as readily socialized to demand a stronger voice in the workplace. It should be noted that the sample participants in this study were almost 68% United States citizens. The number of nurses who were born in different countries was too small to allow for a determination of whether the issue is cultural conflict or personal detachment to the organization.

Nursing continues to be a female dominated profession in the United States (Meleis, 2011). The women's movement of the 1970s and beyond has made women's empowerment issues a rallying cry for decades and may be a contributing factor to nurse perception of organizational empowerment and the nurses' role in seeing it established/improved in the workplace (Goodman & Epstein, 2008). Correlations between years of experience, years working for an institution, gender, and being an international nurse might be an area of future research.

Country of Highest Degree

Consistent with country of birth, nurses who obtained their highest degree in nursing from the United States perceived better organizational empowerment than did nurses obtaining their highest degree from other countries. According to the sample characteristics, almost 90% of the nurses obtained their higher degree from the United States. This may imply that some of the nurses born in different countries were either raised or educated in the United States. This may mean that nurses introduced to the American culture and who have been living for a while in the country feel may more attached, committed, and empowered by their organization.

Experience

In this sample, nurses with greater years nursing experience reported higher levels of psychological empowerment. This result may indicate that nurses with greater years of experience have gained mastery in the profession and are more independent and empowered compared to nurses with less experience. This finding is consistent with the findings of Kuokkanen, Leino-Kilpi, and Katajisto (2003) who found that nurses with higher levels of education and greater years of experience have higher levels of

empowerment. However, in this study, the level of education was not associated with nurse empowerment and self-efficacy. This finding may be as a result of the specific population participating in the sampling, as most of the nurses held a Baccalaureate degree in nursing at both hospitals (75%, 65%, respectively). Nurses with Associate degrees at both hospitals (18.3%, 23%, respectively) were much less a percentage of the sample. Therefore, it was not possible to determine if level of education was associated with either organizational empowerment or nurse self-efficacy because no significant differences were found between baccalaureate prepared and associate degree prepared nurses. There was no association between the remaining nurse demographic variables and organizational empowerment or perception or nurse self-efficacy.

Relationship between Nurse and Patient Empowerment

According to the theories guiding this study, the patient empowerment concept can be measured with the seven empowerment subscales. Providing patients with support, information, resources, and opportunities to improve their knowledge regarding health status, sharing formal and informal power with patients may make patients feel they are partners in their care and can have the autonomy to make decisions regarding their life.

The literature supports the link between nurse empowerment and satisfaction with patient empowerment and patient participation (Laschinger et al., 2010; Jerofke et al., 2014; Purdy et al., 2010). Inconsistent with the literature, the findings of this study revealed that there is no relationship and correlation between nurse empowerment or self-efficacy and patient empowerment at the organizations studied. The lower levels of self-empowerment in the nurses does not seem to influence their ability to empower their

patients. This triggered interest in the reasons why nurses are able to empower their patients despite their empowerment level or their work effectiveness environment. This could be attributed to the notion that a professional fidelity surpasses "self", illustrated in this study that even when nurses felt less empowered, it did not seem to affect their behavior towards patients.

Also, the relationship between patient and nurse could be as result of a key feature in current health policy for moving toward a patient-centered care model, where nurses developed partnerships with patients to improve patient participation in managing their health. Another possible explanation is that hospital A is a faith-based organization, where it may be more likely that nurses engage in empowering patient behaviors because it is part of the faith-based tradition and values.

Patient Demographics

Race

An association between race and patient empowerment was found, indicating a significant difference between how White and Hispanic patients perceived patient empowerment. The majority patient sample was White followed by Hispanic ethnicities. Therefore, it was theorized that White patients would probably report higher levels of patient empowerment. However, after stratifying the data, Hispanic patients were more empowered compared to White and other racial groups in the Magnet hospital only. This is inconsistent with the literature, where it is frequently reported that White patients are more empowered (Chen, Mulling, Noval, & Thomas, 2016). This result needs further investigation to assess why Hispanic patients were more empowered in the Magnet hospital compared to other groups and the non-Magnet hospital.

Insurance

Type of health insurance patients had during hospitalization influenced patient empowerment levels. Patients with Medi-Cal and private insurance reported better patient-empowerment nursing behaviors than Medicare patients, meaning that health insurance, including healthcare access and cost, can influence patient empowerment in seeking treatment or willingness to participate in care. Although, Medicare patients were older with greater life and hospitalization experience, their perception of nurses' empowering behaviors was less than Medi-Cal and private insurance patients. This finding needs further study. All other patient demographic variables were not associated with patients' empowerment perception.

The Difference between Magnet and non-Magnet

It is known that Magnet hospitals are recognized for promoting environments ideal for excellence in nursing practice (Jerofke et al., 2014). Magnet hospitals embrace organizational empowerment as essential to deliver optimal nursing care. Therefore, it was decided to compare nurse and patient empowerment levels at a Magnet hospital versus a non-Magnet hospital. The literature supports the notion that Magnet hospitals have a postive significant impact on nurse job satisafaction and the quality of nursing care (Upenieks, 2003; Stimpfel et al., 2015). There were limited studies comparing Magnet to non-Magnet hospitals in examining the relationship between organization and nurse outcomes. Therefore, there was insufficient evidence in the literature to state that Magnet hospitals are superior to non-Magnet hospitals in empowerment levels. There was insufficient evidence to support that patient empowerment levels are higher at Magnet hospitals given the assumptiont that Magnet hospitals have more postitive patient

outcomes (Stimpfel et al., 2015). Moreover, there was insufficient evidence to link all these variables together simultaneously.

In this study, findings revealed that nurses working at the Magnet hospital were more empowered and reported higher levels of self-empowerment and perceived higher organizational empowerment compared to the non-Magnet hospital. This finding was consistent with the finding of Upenieks (2003), that nurses at Magnet hospitals are more satisfied and empowered. However, nurses who have higher perceptions of organizational empowerment and self-empowerment levels treated patients similarly to nurses working at the non-Magnet hospital where there were lower levels of empowerenment and self-efficacy. Patients reported similar scores of moderate to high nurse empowering behaviors at both hospitals, and high levels of overall satisfaction. This finding can be as a result of either nurses overall professional fidelty or the similarities between the two organizations, as the Magnet hospital gained that status a few years ago and the non-Magnet hospital has just recently explored whether or not to take the Magnet journey. It could be that nurses in the Magnet hospital were new to employee empowering behaviors to patients, and nurses in the non-Magnet hospital were learning to empower patients. It could also be the result of nurses partnering with patients to implement the objective toward patient-centered care, or the religious and spiritual care provided at non-Magnet hospital (A).

Additionally, nurses the Magnet hospital were older, had greater years of experience and greater years of working in the hospital. This could be attributed to the Magnet positive environment that attracts nurses to work longer in the hospital, which can be an indicative of a commitment and satisfaction of working in the hospital.

Personal Observation Through the Data Collection Process

During the data collection process the researcher noticed differences between the two hospitals in facilitating the research process. The data was collected first from the non-Magnet hospital. The overall nurse response rate was slow, and recruitment could not be completed until a paper survey was administered. Even though numerous reminders were sent out to nurses, response times remained slow. When collecting data with paper surveys, the researcher made sure that nurses did not already complete an on-line survey, so they were asked about this verbally. Nurses participating in the paper survey confided that they were very busy, so much so that they did not have time to check their email account with any regularity. It took four months for nurses in the non-Magnet facility to complete the surveys. The unit directors were less involved in this research process, as some were taking paid leave during the data collection period. Unit directors have many responsibilities and a large span of control, with many initiatives competing for their attention.

Being a teaching hospital, the nurses get frequent requests to participate in all kinds of surveys. The policy at the institution was that survey participation could not be done during work time, as there was no mechanism to pay employees for the time needed to complete the on-line survey. Conversely, the Magnet hospital insisted that nurses complete all study related activities during work time, which was supported by all nursing directors and was a stipulation imposed by the hospital B institutional review board. Hospital B nursing directors were actively involved in the process and progress of the study, most likely because research is a condition of Magnet re-designation and this

study was seen as an opportunity benefiting their nursing unit's ability to meet Magnet requirements.

The data collection at the Magnet hospital was faster in terms of patient and nurse recruitment. Patient recruitment was most likely faster because the bed capacity in the Magnet hospital was larger than the non-Magnet hospital (148 bed capacity in the non-Magnet hospital, and 173 bed capacity in the Magnet hospital). Only four Medical/Surgical units were needed at the Magnet hospital to collect the data. Six units were needed at the non-Magnet hospital, demonstrating the difference in the size/capacity of the hospital units.

Nurses at the Magnet hospital knew right away about the study when the researcher approached them. All the staff and the unit directors were told about the research and the importance of their participation. The unit directors were eager to help and wanted updates on nurse participation every week. If the responses were low, they sent emails to staff encouraging participation. This observation illustrated the key Magnet status characteristics of nurse engagement and ownership.

Strengths

The primary strength found in this study was the sample acquisition and the response rate. Nurse surveys were mostly distributed online guaranteeing anonymity to nurses. The sample size met the power analysis.

Another strength of this study is the linkage of the three variabless together simultaneously. The literature supports the notion that Magnet hospitals have a postive significant impact on nurse job satisfaction and the quality of nursing care (Upenieks, 2003; stimpfel et al., 2015). However, there was insuifficient evidence in the literature to

state that Magnet hospitals are superior to non-Magnet hospitals in empowerment levels. There was insufficient evidence to support that patient empowerment levels are better at Magnet hospitals given the assumptiont that Magnet hospitals have more postitive patient outcomes (Stimpfel et al., 2015). Most importantly, there are few studies in the literature that link all three empowerment concepts together in the same study, which added this unique linkage to the body of knowledge in nursing.

Limitations

A major limitation in this study was the potentially inequitable comparison between the two settings. Each was a unique institution, foundationally different in that one hospital was operated by a faith-based organization and the other was a secular Magnet institution. All patient and nurse populations were specific to medical and surgical units intentionally, which resulted in a focused sample selection. Therefore, the results cannot be generalized to other nurse and patient populations.

Due to slow recruitment, some nurse surveys at the non-Magnet hospital were administered through paper and pencil questionnaire, causing a difference in data collection methodology with 50 of the non-Magnet hospital nurses. Potentially, nurses may have answered differently on paper than they would have electronically.

Administration of patient surveys had some limitations. Patients needed clarification on questions relating to after discharge and understanding the definition of "empowerment" in the Patient Perception of Patient-Empowering Nurses Behaviors Scale. It is assumed the tool was developed and used by the authors to pair with different tools to measure patient empowerment before and after discharge. All patients in this

study were surveyed pre-discharge. Some of the survey questions were about the discharge process, causing confusion to some patients who were not yet discharged.

Even though PPPNB used simple language, the researcher observed that older patients seemed to have an incomplete understanding between the concepts of nurse empowering behaviors and nursing care, which may have inflated nurse empowerment behavior scores.

After nurses completed the surveys online, it was noticed there was a missing category in the race question, as the Hispanic option was not available in the online survey for nurses. Therefore, the numbers of Hispanic nurses and their levels of empowerment was not measured. This was a missed opportunity because a correlation with Hispanic nurses and Hispanic patients could not be calculated. If we knew the empowerment levels of Hispanic nurses, could this have influenced Hispanic patient levels of empowerment? This finding needs to be explored in future studies.

The use of the General Self-Efficacy scale to measure psychological empowerment may have been too "blunt" a tool in terms of specificity to the concept. In the literature, nurse self-efficacy acts as a mediator between nurse and patient and may not have been the best predictor of patient empowering behaviors. Therefore, a different scale to measure empowerment and in particular using the six empowerment subscales to relate with the empowerment theories guiding this study and with the subscales in the other two scales (Conditions of Work Effectiveness scale and Patient Perceptions of Patient-Empowering Nurse Behaviors scale) would be in order. This could explain why there was no relationship between nurse self-efficacy and patient empowerment.

Recommendations for Future Study

In order to increase the generalizability of findings, a larger sample size from both the Magnet and non-Magnet hospital would be needed to have a more representative sample. Future studies should contain all race/ethnicities of interest in the demographic data of surveys (nurses and patients). A multi-site study of several Magnet and non-Magnet hospitals would increase demographic variations and generalizability. Nurses and patients from other than only Medical-Surgical units in both Magnet and non-Magnet hospitals should be included to generalize the findings in other populations and support the comparison.

Future studies should attempt a more homogeneous pairing of hospital types. For example, compare faith-based non-Magnet with faith-based Magnet institutions; and non-sectarian with non-sectarian institutions. One may even want to drill down to type of faith-based hospital (e.g. Catholic with Catholic).

If the plan is to use the Patient Perceptions of Patient-Empowering Nurse Behaviors Scale, it is recommended to use the scale with patients both before and after discharge to increase patients' ability to answer all the questions, as some of the questions are about nurse behaviors after the discharge process.

Moreover, from a personal perspective, a qualitative study design would explore nurse empowering behaviors and patient empowering levels with observation and interviews and/or focus groups adding more in-depth details to the content.

Implication for Nursing Practice

The nursing literature in this study emphasizes the importance of the work environment on nurse job satisfaction, self-efficacy, and quality of care. High levels of

organizational empowerment provide an environment that enhances both nurse and patient positive outcomes (Stimpfel et al., 2015). This trend in literature provides a linkage between the work environment and psychological empowerment, where organizational empowerment is incomplete unless the psychological empowerment of the nurse is considered (Fackler et al., 2015). Empowerment is a key value in the profession of nursing particularly in the discourse regarding nursing workforce shortages, and the establishment of healthy work environments. The study findings support this influence that organizational empowerment influences nurse self-efficacy and empowerment levels.

Additionally, nurse empowerment influences patient empowerment, as empowered nurses are more likely to empower patients. This relationship assumed and hypothesized based on the literature linkage between nurse psychological empowerment and quality of care, which is believed lead to better patient outcomes (Dowling, 2011; Jerofke et al., 2014; Purdy et al., 2010). Even though the results in this study revealed no association between nurse empowerment and patient empowerment, patient empowerment may lead to greater patient engagement in care and could be a strategy that increases overall health status, possibly reducing the risk of adverse events (Tobiano et al., 2015; Jerofke et al., 2014). However, to support this finding, a further investigation is needed as this study's findings contradict the literature and there is limited evidence that empowerment has positive impact on the cost of care (Barr et al., 2015). Finally, the results of this study provide information that may be useful to share with the hospitals and to the assigned unit directors to allow an opportunity to promote staff empowerment.

Conclusion

Empowerment is an important issue in today's health care arena. The notion of

empowerment can be defined as both a process and an outcome. Patient empowerment has been proposed as a crucial element in patient-centered care. Nurses who are providing direct patient care are in the frontline to empower patients. Therefore, work environments providing nurses with organizational empowerment necessary to fulfill nurses' needs may realize positive outcomes such as increased nurse job satisfaction, and personal psychological empowerment, which in turn, can lead to improved quality of care and better patient outcomes (Laschinger et al., 2010).

The aim of the current study was to explore the relationships between organizational empowerment as perceived by nurses, nurse self-efficacy and empowerment, and the patient's perception of patient empowering nurse behaviors. The findings of this study revealed that nurse perceptions of organizational empowerment were associated with nurse psychological empowerment. This finding supports all the previous literature, where the work environment influences nurse empowerment levels. Additionally, nurses perceived higher organizational empowerment and higher levels of psychological empowerment at the Magnet hospital compared to the non-Magnet hospital, which supports the literature and demonstrates evidence that empowered work environments (Magnet status) increases nurse self-efficacy and empowerment levels. Moreover, years of nursing experience was a successful predictor of nurse psychological empowerment, indicating that nurses with greater years of experience have higher levels of empowerment despite the hospital type, therefore may be more drawn to and stay on the job longer at a Magnet designated facility.

Nurse birth country and country where highest degree in nursing was attained were associated with higher perceptions of organizational empowerment. These two

variables were coded between the United States and other countries, indicating a significant difference between U.S. citizens and/or nurses obtaining their highest degree in the United States and nurses who were born and/or obtained their highest degree in other countries in how nurses perceived organizational empowerment. Moreover, there was an association found between nurse years of experience and nurse self empowerment. This result indicates that nurses with greater years of experience have higher self-efficacy and empowerment levels.

In relation to the level of patient empowerment and satisfaction, the findings of this study reveal no relationship between nurse empowerment and patient perception of nurse empowering behaviors. However, patient levels of empowerment and satisfaction were high and similar between the Magnet and the non-Magnet hospital as there was no significant difference between the two settings.

Selected patient characteristics were measured to explore if patient's demographic variables were associated with patient levels of empowerment. According to the findings, there was an association between type of insurance and patient empowerment levels. These results indicate a significant difference in how patients with Medi-Cal insurance and private insurance perceived nurse empowering behaviors (more empowering). All other patient demographic variables were not associated with patient perception of nurse empowering behaviors. Race was significantly associated with patient empowerment, where Hispanic patients were more empowered than other groups only at the Magnet hospital.

This research provides knowledge about empowerment levels at a Magnet versus non-Magnet facility in terms of nurse empowerment and the perception of organizational

empowerment. Similar to the findings of previous studies, the results need further investigation to provide a better understating of the empowerment notion. The results of patient empowerment were similar between the two settings, which demonstrated that patients were treated similarly at both settings, and they reported high levels of satisfaction and patient empowerment. This finding triggers further interest in how to measure patient empowerment, which needs additional knowledge to the current findings.

The importance of this research is necessary for organizations to help define the empowered environments staff need to be empowered, which may in turn, support the main goals of the hospital such as high patient satisfaction and high nurse job satisfaction (positive nurse and patient outcomes). Empowered work environments play an important role in nursing retention and nursing shortage reduction, which may ultimately benefit the organization with better quality outcomes financially and functionally. Therefore, research with such information using theoretical and evidence-based conclusions are useful to increase the awareness of the importance of empowerment in the organization and to help develop strategies that empower the workplace environment. These strategies might be an investment to reduce healthcare cost, increase the quality of care, and increase the sustainability of the nursing workforce.

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APPENDIX A.

THE GENERAL EFFICACY SCALE (GSE)

		Hospital Type			
		A		B	
		N	%	N	%
I can always manage to solve difficult problems if I try hard enough	1 = Not at all true	0	0 %	2	2%
	2 = Barely true	2	2%	3	3%
	3 = Moderately true	72	70%	54	54.5%
	4 = Exactly true	28	27.5%	40	40.4%
If someone opposes me, I can find the means and ways to get what I want	1 = Not at all true	5	4.9%	7	7.1%
	2 = Barely true	40	39.2%	29	29.3%
	3 = Moderately true	54	52.9%	52	52.5%
	4 = Exactly true	3	2.9%	11	11.1%
It is easy for me to stick to my aims and accomplish my goals	1 = Not at all true	0	0 %	0	0%
	2 = Barely true	4	3.9%	0	0%
	3 = Moderately true	67	65.7%	9	60%
	4 = Exactly true	31	30.4%	6	40%
I am confident that I could deal efficiently with unexpected events	1 = Not at all true	0	0%	0	0%
	2 = Barely true	6	5.9%	3	3%
	3 = Moderately true	66	64.7%	54	54.5%
	4 = Exactly true	30	29.4%	42	42.4%
Thanks to my resourcefulness, I know how to handle unforeseen situations	1 = Not at all true	0	0%	0	0%
	2 = Barely true	4	3.9%	6	6.1%
	3 = Moderately true	66	64.7%	51	51.5%
	4 = Exactly true	32	31.4%	42	42.4%
I can solve most problems if I invest the necessary effort	1 = Not at all true	0	0%	1	1%
	2 = Barely true	0	0%	2	2%
	3 = Moderately true	62	60.8%	40	40.4%
	4 = Exactly true	40	39.2%	56	56.6%
I can remain calm when facing difficulties because I can rely on my coping abilities	1 = Not at all true	0	0%	0	0%
	2 = Barely true	5	4.9%	3	3%
	3 = Moderately true	59	57.8%	48	48.5%
	4 = Exactly true	38	37.3%	48	48.5%
When I am confronted with a problem, I can usually find several solutions	1 = Not at all true	0	0%	0	0%
	2 = Barely true	3	2.9%	3	3%
	3 = Moderately true	74	72.5%	50	50.5%
	4 = Exactly true	25	24.5%	46	46.5%
If I am in a bind, I can usually think of a solution or something to do	1 = Not at all true	0	0%	1	1%
	2 = Barely true	2	2%	1	1%
	3 = Moderately true	74	72.5%	50	50.5%
	4 = Exactly true	26	25.5%	47	47.5%

No matter what comes my way, I'm usually able to handle it	1 = Not at all true	0	0%	0	0%
	2 = Barely true	3	2.9%	1	1%
	3 = Moderately true	64	62.7%	52	52.5%
	4 = Exactly true	35	34.3%	46	46.5%

APPENDIX B

CONDITIONS OF WORK EFFECTIVENESS (CWE-II)

		Hospital Type			
		A		B	
		N	%	N	%
How much of each kind of opportunity do you have in your present job?					
1- Challenging work	1 = None	0	0%	1	1 %
	2	3	2.9%	0	0%
	3 = Some	19	18.6%	15	15.3%
	4	43	42.2%	31	31.6%
	5 = A Lot	37	36.3%	51	52%
2- The chance to gain new skills and knowledge on the job	1 = None	0	0%	0	0%
	2	8	7.8%	2	2 %
	3 = Some	21	20.6%	12	12.2%
	4	40	39.2%	33	33.7%
	5 = A Lot	33	32.4%	51	52 %
3- Tasks that use all of your own skills and knowledge	1 = None	1	1%	1	1 %
	2	4	3.9%	1	1%
	3 = Some	19	18.6%	14	14.3%
	4	43	42.2%	29	29.6%
	5 = A Lot	35	34.3%	53	54.1%
How much access to information do you have in your present job?					
4- The current state of the hospital	1 = No Knowledge	1	1%	2	2%
	2	7	6.9%	5	5.1%
	3 = Some Knowledge	35	34.3%	26	26.5%
	4	46	45.1%	42	42.9%
	5 = Know A Lot	13	12.7%	23	23.5%
5- The values of top management	1 = No Knowledge	0	0%	5	5.1%
	2	9	8.8%	7	7.1%
	3 = Some Knowledge	33	32.4%	36	36.7%
	4	44	43.1%	34	34.7%
	5 = Know A Lot	16	15.7%	16	16.3%
6- The goals of top management	1 = No Knowledge	1	1%	4	4.1%
	2	12	11.8%	6	6.1%
	3 = Some Knowledge	33	32.4%	37	37.8%
	4	42	41.2%	36	36.7%
	5 = Know A Lot	14	13.7%	15	15.3%
How much access to support do you have in your present job?					
7- Specific information about things you do well	1 = None	1	1%	0	0%
	2	13	12.7%	6	6.1%
	3 = Some	38	37.3%	27	27.6%
	4	36	35.3%	37	37.8%
	5 = A Lot	14	13.7%	28	28.6%

8- Specific comments about things you could improve	1 = None	1	1%	6	6.1%
	2	10	9.8%	5	5.1%
	3 = Some	43	42.2%	39	39.8%
	4	32	31.4%	37	37.8%
	5 = A Lot	16	15.7%	11	11.2%
9- Helpful hints or problem solving advice	1 = None	2	2%	0	0%
	2	12	11.8%	5	5.1%
	3 = Some	32	31.4%	34	34.7%
	4	46	45.1%	37	37.8%
	5 = A Lot	10	9.80%	22	22.40%
How much access to resources do you have in your present job?					
10- Time available to do necessary paperwork.	1 = None	2	2%	0	0%
	2	16	15.7%	10	10.2%
	3 = Some	45	44.1%	30	30.6%
	4	35	34.3%	43	43.9%
	5 = A Lot	4	3.9%	15	15.3%
11- Time available to accomplish job requirements.	1 = None	2	2%	0	0%
	2	11	10.8%	5	5.1%
	3 = Some	37	36.3%	27	27.6%
	4	49	48%	50	51%
	5 = A Lot	3	2.9%	16	16.3%
12- Acquiring temporary help when needed.	1 = None	3	2.9%	3	3.1%
	2	22	21.6%	10	10.2%
	3 = Some	42	41.2%	29	29.6%
	4	27	26.5%	38	38.8%
	5 = A Lot	8	7.8%	18	18.4%
In my work setting/job:					
13- The rewards for innovation on the job are	1 = None	8	7.8%	3	3.1%
	2	22	21.6%	14	14.3%
	3 = Some	44	43.1%	27	27.6%
	4	26	25.5%	36	36.7%
	5 = A Lot	2	2%	18	18.4%
14- The amount of flexibility in my job is	1 = None	1	1%	2	2%
	2	10	9.8%	8	8.2%
	3 = Some	44	43.1%	24	24.5%
	4	37	36.3%	38	38.8%
	5 = A Lot	10	9.8%	26	26.5%
15- The amount of visibility of my work-related activities within the institution is	1 = None	1	1%	3	3.1%
	2	19	18.6%	7	7.1%
	3 = Some	40	39.2%	30	30.6%
	4	39	38.2%	40	40.8%
	5 = A Lot	3	2.9%	18	18.4%
How much opportunity do you have for these activities in your present job?					
16- Collaborating on	1 = None	1	1%	2	2%
	2	8	7.8%	5	5.1%

patient care with physicians.	3 = Some	24	23.5%	29	29.6%
	4	43	42.2%	37	37.8%
	5 = A Lot	26	25.5%	25	25.5%
17- Being sought out by peers for help with problems	1 = None	0	0%	0	0%
	2	0	0%	1	1%
	3 = Some	16	15.7%	19	19.4%
	4	48	47.1%	41	41.8%
	5 = A Lot	38	37.3%	37	37.8%
18- Being sought out by managers for help with problems	1 = None	7	6.9%	4	4.1%
	2	17	16.7%	19	19.4%
	3 = Some	44	43.1%	32	32.7%
	4	28	27.5%	31	31.6%
	5 = A Lot	6	5.9%	12	12.2%
19- Seeking out ideas from professionals other than physicians, e.g., Physiotherapists, Occupational Therapists, Dieticians.	1 = None	7	6.9%	2	2%
	2	8	7.8%	11	11.2%
	3 = Some	32	31.4%	27	27.6%
	4	39	38.2%	43	43.9%
	5 = A Lot	16	15.7%	15	15.3%
How much of each kind of opportunity do you have in your present job?					
20- Overall, my current work environment empowers me to accomplish my work in an effective manner.	1 = Strongly disagree	4	3.9%	0	0%
	2	7	6.9%	3	3.1%
	3	27	26.5%	21	21.4%
	4	54	52.9%	41	41.8%
	5 = Strongly agree	10	9.8%	33	33.7%
21- Overall, I consider my workplace to be an empowering environment.	1 = Strongly disagree	3	2.9%	0	0%
	2	11	10.8%	5	5.1%
	3	30	29.4%	15	15.3%
	4	48	47.1%	38	38.8%
	5 = Strongly agree	10	9.8%	40	40.8%

APPENDIX C

PATIENTS' PERCEPTION OF PATIENT-EMPOWERING NURSES BEHAVIORS SCALE

		Hospital Type			
		A		B	
		N	%	N	%
The nursing staff helped me recognize that I am capable of making decisions about my health	0	3	3%	3	3%
	1	0	0%	2	2%
	2	0	0%	1	1%
	3	4	4%	2	2%
	4	3	3%	3	3%
	5	7	7%	3	3%
	6	7	7%	6	6%
	7	7	7%	10	10%
	8	15	15%	13	13%
	9	14	14%	18	18%
	10	39	39%	39	39%
The nursing staff helped increase my awareness of my treatment plan	0	3	3%	1	1%
	1	0	0%	0	0%
	2	2	2%	4	4%
	3	0	0%	1	1%
	4	1	1%	1	1%
	5	4	4%	2	2%
	6	5	5%	8	8%
	7	13	13%	10	10%
	8	20	20%	12	12%
	9	14	14%	18	18%
	10	38	38%	43	43%
The nursing staff helped me realize that I can participate in my treatment planning	0	5	5%	2	2%
	1	3	3%	2	2%
	2	3	3%	3	3%
	3	1	1%	3	3%
	4	1	1%	5	5%
	5	0	0%	4	4%
	6	7	7%	6	6%
	7	12	12%	10	10%
	8	17	17%	12	12%
	9	12	12%	18	18%
	10	39	39%	35	35%

The nursing staff provided me with useful information	0	1	1%	1	1%
	1	0	0%	0	0%
	2	0	0%	1	1%
	3	3	3%	1	1%
	4	2	2%	0	0%
	5	3	3%	4	4%
	6	6	6%	4	4%
	7	10	10%	11	11%
	8	16	16%	13	13%
	9	18	18%	13	13%
	10	41	41%	52	52%
The nursing staff provided me with clear answers to my questions	0	1	1%	1	1%
	1	1	1%	0	0%
	2	0	0%	0	0%
	3	0	0%	3	3%
	4	2	2%	1	1%
	5	6	6%	2	2%
	6	5	5%	5	5%
	7	9	9%	10	10%
	8	16	16%	14	14%
	9	18	18%	14	14%
	10	42	42%	50	50%
The nursing staff provided me with information I need to care for myself when I go home	0	4	4%	6	6%
	1	1	1%	0	0%
	2	1	1%	1	1%
	3	0	0%	2	2%
	4	1	1%	2	2%
	5	7	7%	6	6%
	6	6	6%	5	5%
	7	9	9%	6	6%
	8	17	17%	10	10%
	9	13	13%	17	17%
	10	41	41%	45	45%
The nursing staff listened to my concerns	0	2	2%	1	1%
	1	1	1%	1	1%
	2	0	0%	0	0%
	3	1	1%	1	1%
	4	2	2%	2	2%
	5	2	2%	3	3%
	6	3	3%	4	4%
	7	8	8%	9	9%
	8	15	15%	7	7%
	9	15	15%	17	17%
	10	51	51%	55	55%

The nursing staff helped me identify people who could offer me support at home (friends and/or family members)	0	7	7%	10	10%
	1	0	0%	2	2%
	2	3	3%	1	1%
	3	1	1%	1	1%
	4	4	4%	4	4%
	5	5	5%	5	5%
	6	8	8%	5	5%
	7	16	16%	8	8%
	8	16	16%	12	12%
	9	11	11%	18	18%
	10	29	29%	34	34%
The nursing staff respected my right to be the decision-maker in my care	0	4	4%	3	3%
	1	0	0%	0	0%
	2	0	0%	0	0%
	3	0	0%	3	3%
	4	4	4%	0	0%
	5	2	2%	6	6%
	6	5	5%	8	8%
	7	7	7%	5	5%
	8	14	14%	16	16%
	9	14	14%	13	13%
	10	50	50%	46	46%
The nursing staff offered encouragement for achieving my goals	0	1	1%	2	2%
	1	0	0%	1	1%
	2	1	1%	2	2%
	3	1	1%	0	0%
	4	1	1%	3	3%
	5	4	4%	6	6%
	6	8	8%	3	3%
	7	9	9%	8	8%
	8	18	18%	14	14%
	9	13	13%	16	16%
	10	44	44%	45	45%
The nursing staff created a supportive environment in order to make me a partner in my care	0	1	1%	3	3%
	1	1	1%	0	0%
	2	2	2%	3	3%
	3	2	2%	1	1%
	4	1	1%	1	1%
	5	5	5%	7	7%
	6	3	3%	6	6%
	7	10	10%	7	7%
	8	20	20%	9	9%
	9	14	14%	20	20%
	10	41	41%	43	43%

The nursing staff helped me focus on my strengths	0	4	4%	5	5%
	1	0	0%	2	2%
	2	2	2%	4	4%
	3	2	2%	2	2%
	4	1	1%	2	2%
	5	4	4%	7	7%
	6	8	8%	6	6%
	7	8	8%	8	8%
	8	22	22%	16	16%
	9	12	12%	14	14%
	10	37	37%	34	34%
The nursing staff gave me enough time to make decisions regarding my care	0	2	2%	4	4%
	1	0	0%	2	2%
	2	0	0%	2	2%
	3	2	2%	2	2%
	4	2	2%	1	1%
	5	4	4%	9	9%
	6	7	7%	4	4%
	7	12	12%	5	5%
	8	13	13%	15	15%
	9	17	17%	17	17%
	10	41	41%	39	39%
The nursing staff provided me time to practice new skills in caring for myself before going home	0	11	11%	12	12%
	1	0	0%	0	0%
	2	0	0%	4	4%
	3	1	1%	2	2%
	4	2	2%	1	1%
	5	10	10%	9	9%
	6	8	8%	2	2%
	7	12	12%	4	4%
	8	12	12%	13	13%
	9	14	14%	17	17%
	10	30	30%	36	36%
The nursing staff helped me use what I already knew to find answers to my questions or concerns	0	5	5%	8	8%
	1	0	0%	1	1%
	2	2	2%	3	3%
	3	2	2%	2	2%
	4	1	1%	4	4%
	5	8	8%	4	4%
	6	5	5%	5	5%
	7	12	12%	9	9%
	8	13	13%	10	10%
	9	17	17%	15	15%
	10	35	35%	39	39%

With my permission, the nursing staff answered the questions and concerns of my family and/or friends	0	4	4%	5	5%
	1	0	0%	1	1%
	2	1	1%	3	3%
	3	1	1%	1	1%
	4	3	3%	2	2%
	5	3	3%	6	6%
	6	7	7%	6	6%
	7	9	9%	4	4%
	8	10	10%	10	10%
	9	22	22%	16	16%
	10	40	40%	46	46%
The nursing staff encouraged me to include my family and/or friends in planning for my care	0	7	7%	6	6%
	1	2	2%	1	1%
	2	3	3%	2	2%
	3	0	0%	3	3%
	4	0	0%	1	1%
	5	7	7%	5	5%
	6	4	4%	10	10%
	7	8	8%	6	6%
	8	12	12%	8	8%
	9	19	19%	16	16%
	10	38	38%	42	42%
The nursing staff viewed me as an important member of the healthcare team	0	3	3%	5	5%
	1	0	0%	1	1%
	2	0	0%	2	2%
	3	3	3%	3	3%
	4	1	1%	2	2%
	5	7	7%	3	3%
	6	5	5%	6	6%
	7	7	7%	6	6%
	8	17	17%	14	14%
	9	14	14%	15	15%
	10	43	43%	43	43%
The nursing staff was flexible with my daily schedule of activities	0	3	3%	4	4%
	1	0	0%	1	1%
	2	1	1%	2	2%
	3	0	0%	1	1%
	4	1	1%	0	0%
	5	10	10%	6	6%
	6	3	3%	8	8%
	7	13	13%	6	6%
	8	12	12%	11	11%
	9	18	18%	14	14%
	10	39	39%	47	47%

The nursing staff was respectful of my needs	0	1	1%	1	1%
	1	0	0%	0	0%
	2	1	1%	1	1%
	3	0	0%	0	0%
	4	1	1%	1	1%
	5	4	4%	5	5%
	6	1	1%	3	3%
	7	10	10%	4	4%
	8	9	9%	10	10%
	9	17	17%	14	14%
	10	56	56%	61	61%
The nursing staff encouraged me to make decisions about my care	0	5	5%	4	4%
	1	0	0%	0	0%
	2	0	0%	1	1%
	3	2	2%	2	2%
	4	5	5%	2	2%
	5	4	4%	8	8%
	6	3	3%	7	7%
	7	8	8%	4	4%
	8	10	10%	11	11%
	9	18	18%	15	15%
	10	45	45%	46	46%
I feel as though the nursing staff and I were partners	0	3	3%	3	3%
	1	1	1%	0	0%
	2	1	1%	1	1%
	3	2	2%	2	2%
	4	1	1%	5	5%
	5	5	5%	4	4%
	6	5	5%	6	6%
	7	11	11%	3	3%
	8	11	11%	15	15%
	9	18	18%	14	14%
	10	42	42%	47	47%
My Overall satisfaction about the care I receive	0	0	0%	1	1%
	1	0	0%	0	0%
	2	0	0%	0	0%
	3	1	1%	1	1%
	4	2	2%	1	1%
	5	4	4%	3	3%
	6	2	2%	2	2%
	7	5	5%	7	7%
	8	9	9%	7	7%
	9	17	17%	19	19%
	10	60	60%	59	59%

APPENDIX D

PATIENT PERCEPTIONS OF PATIENT-EMPOWERING NURSE BEHAVIOR SCALE PERMISSION FORM

PERMISSION FOR USE AGREEMENT

PATIENT PERCEPTIONS OF PATIENT-EMPOWERING NURSE BEHAVIORS SCALE (PPPNBS)
Teresa Jerofke, PhD, RN author

You may use the PPPNBS for clinical practice or research purposes, with appropriate referencing to my original work, under the following conditions: You agree to provide me with

1. a brief description of the study and/or clinical population for which it is used

2. a summary of any results from use of the instrument; for example, reliability coefficients, differences among groups, correlations, predictors, and/or outcomes

3. a copy of PPPNBS data for inclusion in an instrument database for further analysis of psychometric properties

4. a copy of any translation of the instrument into a language other than English or any modifications to the instruments. I will make these available to others with appropriate reference to you.

5. a copy of any publications arising from use of the instruments.

Please complete the following questions:

1. Your name: Mai Mohammed Yaseen
2. Your organization: Loma Linda University
3. Your address: 25590 prospect avenue, Loma Linda, CA, 92354

4. Your telephone number: (619) 203 - 7232

5. Your e-mail address: myaseen@llu.edu

6. Purposes(s) for using the instrument(s):
   [ ] clinical practice
   [√] research, If yes, will you use the instrument(s)for [ ]master's thesis [√] PhD dissertation

7. Describe how you plan to use the instrument? (If research, please briefly describe the research questions and methods)

Research Question: "Is there a positive influence in relationships between organizational empowerment, personal nurse self-efficacy (personal empowerment) and patient empowerment in an acute care hospital with Magnet designation versus a non-Magnet designated hospital?"
Methods: Survey research using a correlational descriptive design will be used to explore and compare the relationship between organizational, individual personal nurse, and patient empowerment at a Magnet designation hospital versus a non-Magnet hospital to describe how the level of empowerment in these work environments actually empowers nurses that in turn, empower patients.

8. Describe the patients who will complete the instrument(s).
Medical-Surgical patients who are 18 years of age or older that hospitalized for at least 2 nights, and able to speak and write in English.

Signature: Mai Yaseen Date: Jun 7, 2016

Please e-mail this form to Dr Teresa Jerofke at teresa.jerofke@marquette.edu or mail to:
Dr Teresa Jerofke, Marquette University College of Nursing, PO Box 1881, Milwaukee WI, 53201-1881

APPENDIX E

CONDITIONS OF WORK EFFECTIVENESS QUESTIONNAIRE II

PERMISSION FORM

Western
Arthur Labatt Family
School of Nursing

I request permission to copy the Nursing Work Empowerment Scale as developed by Dr. G. Chandler and Dr. Heather K. Spence Laschinger. Upon completion of the research, I will provide Dr. Laschinger with a brief summary of the results, including information related to the use of the Nursing Work Empowerment Scale used in my study.

Questionnaires Requested:
Conditions of Work Effectiveness-I (includes JAS and ORS):
Conditions of Work Effectiveness-II (includes JAS-II and ORS-II): Yes
Job Activity Scale (JAS) only:

Organizational Relationship Scale (ORS) only:
Organizational Development Opinionnaire or Manager Activity Scale:

Other Instruments:
Please complete the following information:

Date: June 7, 2016
Name: Mai Yaseen
Title: The relationships between organizational empowerment, personal nurse empowerment and patient empowerment in an acute care hospital with Magnet designation versus a non-Magnet designated hospital

University/Organization: Loma Linda University School of Nursing
Address: 11262 Campus St. Loma Linda, CA 92354
Phone: 619-203-7232
E-mail: myaseen@llu.edu

Description of Study: The purpose of this study is to explore and compare the relationship between organizational, individual personal nurse, and patient empowerment at a Magnet designation hospital versus a non-Magnet hospital to describe how the level of empowerment in these work environments actually empowers nurses that in turn, empower patients. Looking at medical-surgical patients who have been hospitalized at least 2 nights in both hospitals and registered front-line nurses who work in both hospitals.

Permission is hereby granted to copy and use the Nursing Work Empowerment Scale.

Date: June 21, 2016

Dr. Heather K. Spence Laschinger, Professor
School of Nursing, University of Western Ontario
London, Ontario, Canada N6A 5C1
Tel: 519-661-2111 ext.86567
Fax: 519-661-3410
E-mail: hkl@uwo.ca

APPENDIX F

GENERAL SELF-EFFICACY SCALE PERMISSION FORM

Fachbereich Erziehungs-
wissenschaft und Psychologie
- Gesundheitspsychologie -

Professor Dr. Ralf Schwarzer
Habelschwerdter Allee 45
14195 Berlin, Germany

Fax +49 30 838 55634
health@zedat.fu-berlin.de
www.fu-berlin.de/gesund

Freie Universität Berlin, Gesundheitspsychologie (PF 10),
Habelschwerdter Allee 45, 14195 Berlin, Germany

Permission granted

to use the General Self-Efficacy Scale for non-commercial reseach and development purposes. The scale may be shortened and/or modified to meet the particular requirements of the research context.

http://userpage.fu-berlin.de/~health/selfscal.htm

You may print an unlimited number of copies on paper for distribution to research participants. Or the scale may be used in online survey research if the user group is limited to certified users who enter the website with a password.

There is no permission to publish the scale in the Internet, or to print it in publications (except 1 sample item).

The source needs to be cited, the URL mentioned above as well as the book publication:

Schwarzer, R., & Jerusalem, M. (1995). Generalized Self-Efficacy scale. In J. Weinman, S. Wright, & M. Johnston, *Measures in health psychology: A user's portfolio. Causal and control beliefs* (pp.35-37). Windsor, UK: NFER-NELSON.

Professor Dr. Ralf Schwarzer
www.ralfschwarzer.de

APPENDIX G

LOMA LINDA UNIVERSITY IRB APPROVAL

LOMA LINDA UNIVERSITY
HEALTH

INSTITUTIONAL REVIEW BOARD
RESEARCH PROTECTION PROGRAMS
24887 Taylor Street • Suite 202 • Loma Linda, CA 92350
(909) 558-4531 (voice) • (909) 558-0131 (fax)

Exempt Notice ***IRB# 5160374***

To: **D'Errico, Ellen**
Department: **Nursing Graduate Programs**
Protocol: **The relationship between organizational empowerment, personal nurse empowerment, and patient empowerment in an acute care hospital with magnet designation versus a non-magnet designated hospital**

Your application for the research protocol indicated above was reviewed administratively on behalf of the IRB. This protocol is determined to be exempt from IRB approval as outlined in federal regulations for protection of human subjects, 45 CFR Part 46.101(b)(2).

Stipulations of approval:
HIPAA authorization waived per 45 CFR 164.512 (i)(2)(ii).

Please note the PI's name and the IRB number assigned to this IRB protocol (as indicated above) on any future communications with the IRB. Direct all communications to the IRB c/o Research Protection Programs.

Although this protocol is exempt from further IRB review as submitted, it is understood that all research conducted under the auspices of Loma Linda University will be guided by the highest standards of ethical conduct.

IRB Chair/Designee — Date 11/17/10

IRB Chair:
Travis Losey, MD
Department of Neurology
(909) 558-4531, tlosey@llu.edu, Pager #4290 for emergencies

IRB Administrator:
Linda G. Halstead, MA, Director
Research Protection Programs
Ext 43570, Fax 80131, lhalstead@llu.edu

IRB Analyst:
Anuradha Diekmann, MPH, CCRP, CIP
Research Protection Programs
Ext 86215, Fax 80131, adiekmann@llu.edu