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Association of Nurses' Sanctification of Work with Work-related Outcomes and Patient Satisfaction

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Association of Nurses' Sanctification of Work with Work-related Outcomes and Patient Satisfaction

By

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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.

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DEDICATION

This humble work is lovingly dedicated to my beloved husband, Jesse Ada, who I fondly called "Mahal," and who I lost 5 days after Thanksgiving, 2018. I still can remember during one of our "dream conversations" on our way to work, as we navigated the streets and freeways of Los Angeles, and out of nowhere you asked me, "Mahal, what's your ultimate dream?" And I responded, "to earn my PhD and be used in God's work. However, with kids going to school I don't think it's the right time." You then looked at me and enthusiastically replied, "Go for it! No one can take away the initials after your name. Follow your dreams and love your passion. I'm here for you."
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go and on with the wonderful times we spent together, and I can't thank you enough for everything that you've done for me and our family. Helping me earn my PhD is just one of the many great things you've done and sacrificed for me. I can't wait for the time when I can tell you the ups and downs, the turns and stops of my PhD journey. Till we meet again. I love you, Mahal.

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ABBREVIATIONS

AHRQ	Agency for Healthcare Research and Quality
AHWM	Adventist Health White Memorial
CMS	Center for Medicare and Medicaid Services
CNA	Certified Nursing Assistant
EMT	Emergency Medical Technician
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
IOM	Institute of Medicine
IHI	Institute of Health Improvement
LVN	Licensed Vocational Nurse
MBI	Maslach Burnout Inventory
MHW	Mental Health Worker
MOG	Manifestation of God
MT	Monitor Technician
RN	Registered Nurse
SoW	Sanctification of Work
SQ	Sacred Qualities

ABSTRACT OF THE DISSERTATION

Association of Nurses' Sanctification of Work with Work-related Outcomes and Patient Satisfaction

by

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Dr. Elizabeth Johnston Taylor, Chairperson

Nurses working in hospitals face many intrinsic stressors, including widespread job dissatisfaction, burnout, and frustration. These challenges, in turn, may affect patient care. Nursing often attracts individuals who wish to serve others, and some may find the expression of spirituality on the job helpful in finding meaning, satisfaction, and value in their work (Kociszewski, 2004).

Sanctification of work (SoW) is a promising facet of spirituality defined by researchers as an individual's experience of their work as a manifestation of God or sacred qualities that affects their effectiveness and engagement on the job (Walker, Jones, Wuensch, Aziz, and Cope, 2008). In the field of nursing, with its emphasis on positive outcomes and patient satisfaction, a study of sanctification of work could prove useful in improving the nursing environment, and thus, work-related outcomes. Thus far, little attention has been paid to how spirituality may influence nursing work-related outcomes and patient satisfaction. There is a need for further knowledge about sanctification as a facet of spirituality and its association with these important factors. This study sought to determine if sanctification of work was associated with job burnout, and other work

outcomes such as employee engagement, organizational commitment, turnover intention, and job satisfaction. In addition, the study also explored whether nurses' sanctification of work was associated with patient satisfaction, since there were no empirical studies on that area.

A quantitative, descriptive, cross-sectional, correlational research design was used to describe and measure the association between sanctification of work and work-related outcomes, patient satisfaction, and demographic factors. A group of 463 licensed and unlicensed nursing personnel participated in the study, conducted in a not-for-profit, faith-based teaching hospital in the Los Angeles area. A sample size of 435 achieved 80% power to detect an R^2 of 0.02 attributed to 1 independent variable(s) using an F-Test with a significance level (alpha) of 0.05. The variables tested are adjusted for an additional 15 independent variable(s) with an R^2 of 0.10 and 20% non-response rate. Participants answered an 82-item questionnaire comprised of several previously established scales and demographic items, including The Duke University Religion Index (DUREL), the Sanctification of Work Scale, The Maslach Burnout Index, the Overall Job Satisfaction Scale, and the Employee Engagement Scale, among others. Patient satisfaction was measured using data from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

Of the 463 participants of this study, 60% were Catholics, 81% were female, and nearly 45% had worked at least 5 years in the organization. The mean age of the participants is 42. Participants on average rated sanctification of work as a 5.7 on a 7-point scale. The linear regression results indicated that sanctification of work is a significant predictor of employee engagement, organizational commitment, and job

satisfaction. In addition, females are more likely to perceive work as sanctified than male respondents.

The study may influence nursing practice and nursing education. Study findings could help healthcare organizations promote positive patient experiences and inform nursing leadership decision making in recruitment and retention. Educators might also learn how to teach nursing students and nurses about the importance of sanctification of work, and consider adding the concept of sanctification to nursing curriculum and program frameworks.

CHAPTER ONE

INTRODUCTION OF THE STUDY

Preface

Nurses working in hospitals face many intrinsic intrapersonal stressors, including widespread job dissatisfaction, burnout, and frustration. These challenges, in turn, may affect patient care. McHugh, Kutney-Lee, Cimiotti, Sloane, and Aiken (2011) found in their study of 95,499 nurses that hospital work is more stressful than any other nursing work environment. Furthermore, patient satisfaction levels were lower in hospitals, with higher levels of nurses who were dissatisfied or burned out – possibly jeopardizing quality of care (McHugh et al., 2011). In this context, it is important to learn what helps nurses to overcome these intrapersonal stressors.

For many people, both nurses and patients, spirituality gives meaning to life (Pesut, 2013). Nursing, as a profession, is attractive to those who wish to serve others, and for some, this motivation is rooted in a strong religious belief. Spirituality is one way that individuals find divine significance (Clarke, 2009), value, and satisfaction in their work (Kociszewski, 2004). Sanctification of work is a promising facet of spirituality that has been recently explored by researchers in the field of psychology of religion. Walker, Jones, Wuensch, Aziz, and Cope (2008) defined sanctification of work as a deliberate psychological, emotional, and spiritual experience perceived by a person in their daily work responsibilities that involved a manifestation of God and/or sacred qualities that affect their occupational performance. Pargament and Mahoney (2005) theorized that individuals who see their work as sanctified are more likely to invest in their work and have a positive attitude about it than those who do not.

Researchers in the field of psychology of religion examined the concept of sanctification, an individual's perception of aspects of life as having divine significance and character. Initially, research focused on the sanctification of relational dimensions – marriage, parenting, and sexuality, among others – and only fairly recently have researchers started to examine the sanctification of work (SoW). Pargament and Mahoney (2005) asserted that individuals who achieve sanctification in their lives experience feelings of satisfaction, accomplishment, and positive attitudes; sanctified events serve as resources for individuals to draw upon for strength and support. How do some nurses come to see their work through a sacred lens? To answer this question, one must consider sanctification and its related field, sanctification of work, as relatively new constructs in the psychology of religion (Pargament & Mahoney, 2005). Other related terms used for sanctification of work in the context of spirituality are "calling," "meaningful work," and "ministry" (Riasudeen & Prabavathy, 2011; Pfeiffer, Gober, & Taylor, 2014; Pirkola, Rantakokko, & Suhonen, 2016).

Over the past 25 years, some nurse scholars and practitioners have increasingly focused on the concept of spirituality, debating its definition and examining its role in nursing therapeutics at the point of care (Taylor, 2008). Many nurses see themselves as spiritual, yet nurses as a whole are diverse in their spiritual beliefs and values. This spiritual diversity can cause differences, both positive and negative, in the way nurses relate to each other and how they deliver care to patients (Pesut, 2013). Many nurse researchers and practitioners interested in spirituality see it as an elastic phenomenon; that is, it cannot be "one size fits all." While sanctification has been studied in other work

environments, in this study we will introduce the concept of sanctification of work (SoW) to the field of nursing.

Background

Sanctification of Work

Employers who have an engaged, committed, satisfied, and happy staff understand the value of such a resource and often will work to sustain it by providing competitive benefits packages, staff development, and other perks. In return, healthcare organizations expect employees to provide the best care possible to patients to achieve a competitive advantage for the organization (Rich, LePine, & Crawford, 2010). Employee burnout, low levels of job retention, and patients dissatisfied with care are some of the realities of the modern healthcare industry. Material resources alone are not enough to achieve the goal of a stable, healthy organization; organizations need staff that value work and are engaged in it personally and professionally. According to Kahn (1990), employees' perceptions about their work may be translated into *how* they work (Kahn, 1990).

Nursing, with its historical roots in religious contexts, has traditionally been defined as a calling (Sawatzky & Pesut, 2005) -- a deep desire to devote oneself to serving people according to the high values of the task or profession (Raatikainen, 1997). Florence Nightingale is the epitome of the nursing profession. Though from a wealthy British family, Nightingale chose to follow her passion of serving others, including soldiers in the Crimean war, and worked to advance the profession of nursing (Egenes, 2010). Spiritual values have been embedded in the science and art of nursing for many

decades (McSherry & Jamieson, 2013). Historically, the nursing profession evolved from deaconesses who were chosen by the Roman Catholic Church for their nursing knowledge, gained from caring for their own loved ones, to present-day Catholic nursing sisters (Egenes, 2009).

Nurses often deliver care out of a sense of duty, compassion, and service to God (Sawatzky & Pesut, 2005). Investing in work is an aspect of life that some nurses see as filled with divine significance. Sanctified work helps nurses strive to reach the highest potential of service to others, sometimes resulting in spending more time on the job than in any other place (Pargament & Mahoney, 2005). This psychospiritual construct of interpreting work as sacred is called sanctification.

A meta-analytic review of 37 studies that included a measure of sanctification, an aspect of life having divine significance and character in relationship with psychological variables, found just four studies that focused on the sanctification of work, only three of which were relevant to this study (Pomerleau, Wong, & Mahoney, 2015). Walker and associates' (2008) groundbreaking studies on sanctification explored work among full-time employees in management, business, financial operations, and other related groups. Sanctification as it is experienced in everyday life was subsequently investigated empirically by Hall, Oates, Anderson, and Willingham (2012), who measured it among working mothers, and Carroll, Stewart-Sicking, and Thompson (2014), who studied it among educators and school administrators in the Catholic education system. In general, the body of evidence from these studies offers significant insight into how to view work or vocational pursuits and outcomes.

Other than the three studies mentioned, little research has been conducted to understand the influence of religious or spiritual beliefs on work-related outcomes, despite the recognition that religion and spirituality can be integrated into people's professional lives (Barnett, Duvall, Edwards, & Hall, 2005; Idler, Musick, Ellison, Krause & Pargament, 2003). Thus, this study will continue the efforts to examine how spirituality (i.e., sanctification of work) relates to various job-related outcomes among nurses.

Work-related Outcomes and Patient Satisfaction

The healthcare industry is faced with diverse demands, from government to the private sector. To remain competitive, each healthcare organization must compare itself with other healthcare industries on employee, patient, and clinical outcomes (Echols, 2005). Increasingly, healthcare organizations are focusing on work-related outcomes (or occupational performance) due to its effect on the quality of patient care, institutional reputation, and reimbursement. Employee outcomes include job satisfaction, employee engagement, organizational commitment, job burnout, and turnover intention. Patient outcomes include how patients receive and perceive their care, as measured by the Center for Medicare and Medicaid Services' (CMS) Hospital Consumer Assessment of Healthcare Providers and Systems evaluation (HCAHPS) and other patient satisfaction surveys. In addition, some healthcare organizations are exploring issues of spirituality at work and the possible effect of clinicians' spirituality on work-related outcomes, and its subsequent effect on the healthcare system, including the patient experience (Kazemipour, Amin, & Pourseidi, 2012).

The Problem Statement

Given that meager evidence exists to inform how nurses' spirituality influences work-related outcomes and patient satisfaction, there is a need for further knowledge about the concept of sanctification as a facet of spirituality and its association with these important work outcome indicators. Thus, this study will determine if sanctification of work (SoW) is associated with job burnout and other employee outcomes such as employee engagement, organizational commitment, turnover intention, and job satisfaction. In addition, patient satisfaction will be explored, since little evidence exists on the association between nurses' perception of sanctification of work and patient satisfaction. This study will also extend the frontier of knowledge about sanctification in the workplace by investigating the concept in an as-yet unstudied population: nurses. This could help us better understand the sanctification of work in a high-stress, physically and emotionally demanding profession such as nursing.

Purpose Statement

The purpose of this study is twofold. Among licensed and unlicensed nursing personnel in a faith-based hospital in Southern California, this study will measure:

1. The relationship between sanctification of work and work-related outcomes (i.e., job satisfaction, employee engagement, organizational commitment, job burnout, and turnover intention).
2. The relationship between sanctification of work and patient satisfaction.

It is anticipated that measuring these relationships will provide an understanding of how the sanctification of work impacts employee outcomes and patient satisfaction in a hospital setting.

Significance of the Study

Significance to Theory

Sanctification theory (Pargament & Mahoney, 2005) is used as the conceptual framework for this study. Borrowed from the field of psychology of religion with a new concept for nursing research, sanctification of work may provide the nursing profession with new ways of perceiving work, which could contribute to the growth and health of the nursing profession. That is, when a nurse sees work with a sense of sacred duty and as a calling, then negative work-related outcomes such as low job satisfaction, poor employee engagement, job burnout, and intention to leave may improve. Some nurses may also come to see it as their responsibility to address patients' identified spiritual care needs as part of patient assessment and intervention (Pargament & Mahoney, 2005). Sanctification theory can be a framework for translating spirituality into the workplace.

Significance to Research

This study will provide empirical evidence to the research community about the sanctification of work within nursing. First, the *Sanctification of Work Scale* (Walker, et al, 2008) is introduced to the nursing research community as a measurement for a facet of spirituality. Use of the scale will provide knowledge about the scale's reliability among nursing personnel, which is presently unknown. Second, this study will provide insight

about which variables may be confounders to the study when it is examined in the context of work-related outcomes and patient satisfaction. Third, the findings of this study will help others determine the effect size for future research. Last, this study will add to previous evidence by including patient satisfaction, an area that has not been studied in relation to sanctification of work. In short, this study will add value to the small body of evidence about the influence of nurses' religious or spiritual beliefs on their professional work.

Significance to Practice

The influence of the sanctification of work on patient satisfaction may impact clinical outcomes. Satisfied patients are generally more cooperative with treatment, and loyal to their health care providers (Bleich, Ozaltin & Murray, 2009; Kupfer & Bond, 2012; Otani, Waterman, & Dunaga, 2012). Study findings will help healthcare organizations achieve a more positive patient experience through whole person-centered care provided by nurses.

In addition, knowledge generated by this study can support the design of a framework or curriculum for improving employee attitudes in the healthcare profession. Nursing burnout impacts work through a "loss of worthiness" and passion for one's job (Maslach & Jackson, 1981), reduced efficacy and feelings of incompetence, and negative attitudes toward fellow workers and patients (Canadas-De la Fuente, Vargas, San Luis, Garcia, Canadas, & De La Fuente, 2015). This study will provide evidence that can inform strategies in the recruitment and retention of nursing personnel. Findings could influence recruitment by adding sanctification of work into the interview process, educate

staff about ongoing available spiritual resources in the work setting, and provide perspectives for education and training programs on spiritual care. In summary, findings can provide evidence that could impact clinical nursing leadership decision-making about staff.

Significance to Policy Making

This study may contribute by re-conceptualizing the important factors on the national *Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey* questionnaire developed with funding from the Centers for Medicare and Medicaid Services, ([CMS], 2017). Currently, it is up to individual organizations to add a measure for patient satisfaction on spiritual care to surveys. The Institute of Medicine (IOM, 2001) urged healthcare organizations to provide holistic, patient-centered care, including spiritual care. This study will highlight how nurses who experience sanctification of work will influence the delivery of holistic care to the patients they serve.

Significance to Nursing Education

This study can also contribute a different perspective for nurse educators, whether in an academic or healthcare setting. If the degree to which a nurse perceives work as sacred and sanctified is associated with various positive outcomes, this suggests educators should consider teaching nursing students and nurses about the importance of sanctification of work, adding it to nursing curricula and program frameworks. For example, students in a Fundamentals of Nursing or Professional Issues course can be

asked to reflect on what prompted them to pursue a nursing career. Those who see it as a sacred calling can be encouraged to continue to do so, while those who do not recognize work as potentially sacred could learn how it may contribute to personal and patient outcomes.

Definitions of Major Constructs

Licensed Nursing Personnel

Licensed nursing personnel include job roles such as chief nursing officer, nurse director, nurse manager, nurse educator, charge nurse, nurse supervisor, staff licensed vocational nurses (LVN), staff Registered Nurses (RNs), or RNs in other roles in patient care or non-patient care areas within a healthcare organization.

Unlicensed Nursing Personnel

Unlicensed nursing personnel are defined as staff working closely with nurses in a different capacity. This includes certified nursing assistants (CNA), unit secretaries, monitor technicians (MT), emergency medical technicians (EMT), mental health workers (MHW), and nursing administrative assistants.

Sanctification

Sanctification is a psychospiritual construct. It is spiritual due to its point of reference - sacred matters. It is psychological in two ways, (a), it focuses on a perception of what is sacred, and (b) the methods for studying sacred matters are social and scientific rather than theological (Pargament & Mahoney, 2005, p. 183).

Sanctification of Work

Sanctification of work is defined as a deliberate psychological, emotional, and spiritual experience perceived by a person in their daily work responsibilities which possesses a manifestation of God and/or sacred qualities which affect occupational performance either positively or negatively (Walker, et al., 2008).

Job Satisfaction

Job satisfaction is defined as an attitude in a specific area of work, or a global feeling towards work in general that can have positive or negative undertones (Lu, Barriball, Zhang, & While, 2012).

Employee Engagement

Employee engagement is defined as bringing one's complete and true self to the performance of one's role, depending on the degree of personal engagement, through the psychological conditions of meaningfulness, safety, and availability (Kahn, 1990).

Organizational Commitment

Organizational commitment is defined through affective commitment; in other words, it is a psychological link between the employee and the organization through identification with, involvement in, and emotional attachment to the organization (Allen & Meyer, 1996), in which individuals willingly give of themselves for the good of the organization (Mowday, Steers, & Porter, 1979).

Job Burnout

Job burnout is a prolonged psychological response to chronic healthcare work-related stress – with individual and organizational consequences. It is comprised of three dimensions: emotional exhaustion, depersonalization, and lack of personal accomplishment (Maslach & Jackson, 1981).

Turnover Intention

Turnover intention is the precursor to leaving a job, in which the employee is considering looking for new employment (Coomber & Barriball, 2007).

Patient Satisfaction

Patient satisfaction is a multidimensional phenomenon and is viewed from many angles, including the elements of perception, expectation, and subjectivity (Bleich, et al., 2009; Linder-Pelz, 1982; Mahon, 1996; Newsome & Wright, 1999). Patient satisfaction focuses on the hospital care provided to patients, characterized by the continuity of care, timely feedback, effective coordination of care, and authentic connection with the patient and family (Kreitzer, 2015).

Overview of the Remaining Chapters

Chapter 2 reviews existing knowledge about the study concepts. These include spirituality, sanctification of work, and patient satisfaction, as well as the work-related outcomes of job satisfaction, employee engagement, organizational commitment, job

burnout, and turnover intention. Pertinent literature about each concept and the demographic variables are synthesized and critiqued. The gaps in current knowledge identified through the literature review are summarized at the end of the section discussing each concept. The chapter ends with the rationale for and description of the theoretical framework (i.e., sanctification theory) guiding the study. A conceptual schema showing how study concepts are related is also provided.

Chapter 3 describes the design and methods of the study. Topics addressed include: research aims, questions, and hypotheses; sampling and recruitment; measurement tools and data collection procedure; data management and analysis, and ethical considerations. The chapter concludes with the identification of the assumptions influencing the study.

Chapter 4 illustrates the findings on sanctification of work, and its relationship with work-related outcomes and patient satisfaction. Research questions are answered.

Chapter 5 discusses the findings as described in Chapter 4. Implications are made for theory, practice, research, nursing education, and social policies. Limitations of the study are acknowledged with recommendations. Finally, conclusions are made related to this dissertation.

Chapter Summary

This chapter introduced the rationale for why spirituality may be pivotal to supporting an effective nursing workforce. Specifically, the concept of the sanctification of work and its associations with work-related outcomes and patient satisfaction were discussed. Though an empirical study of sanctification of work on nursing is new, it has

been explored in different work contexts. Hence, this study can impact nursing by adding insight to the small body of knowledge about nurses' spirituality. Introducing the concept of sanctification of work in nursing practice may generate evidence that could affect recruitment and retention strategies, as well as strategies for improving patient satisfaction (e.g., through the integration of spiritual care on the HCAHPS survey)

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

This literature review aims to discover what is known and to identify gaps in knowledge specific to nursing about the associations between sanctification of work, work-related outcomes, and patient satisfaction, while considering other demographic factors that might also influence the relationships. Work-related outcomes include job satisfaction, employee engagement, organizational commitment, job burnout, and turnover intention. This review discusses literature about each study variable. These discussions begin with the definition of the concept, followed by a review of relevant studies, and a discussion of the concept's application to nursing. At the end of the review of each concept, a summative statement is offered, as well as an examination of gaps in knowledge that could be filled by this study.

Literature Review Methods

The review of literature was conducted mainly through digital database searches of Academic Search Premier and all EBSCO Databases, CINAHL, Science Direct, SocIndex, PsycINFO, PsycARTICLES, SocINDEX, ATLA Religion Databases, and Business Source Premier. Other sources came from the references of pertinent articles reviewed. The search strategies included using the Boolean AND with each of the variables (i.e., sanctification of work and each work-related variable, patient satisfaction, and nursing). In addition, the search strategy also included an independent search of terms. Research studies were confined to those conducted in English.

Sanctification

Sacred and Sanctification

The concept of the sacred is the denominator of religious and spiritual life, and goes beyond, or is fundamental to, religion and spirituality (Hill & Pargament, 2003). What is sacred can include any object or event in life characterized with divine significance (Pargament, 1997; Pargament, 1999; Pargament & Mahoney, 2005). The idea of the sacred is specific to each person and develops as values, beliefs, and practices reflected in the interaction with God or divine entities and other persons (Mahoney, 1999). These values, beliefs, and practices may lead to discovering life's meaning and significance either subjectively or objectively, good or bad. Personal significance may include a sense of value and meaning, pride, and satisfaction to sacred phenomena such as marriage or work (Mahoney, et al., 1999).

Empirical Evidence about Sanctification

Initially, empirical investigations about the concept of sanctification explored the sanctity of life. Later, other researchers began investigating the relationship between sanctification and marriage (Mahoney, et al., 1999), and then expanded to address other aspects of life such as parenting (Murray-Swank, Mahoney, & Pargament, 2006), body image (Mahoney, et al., 2005), sexual activity (Murray-Swank, Pargament & Mahoney, 2002), and dreams (Phillips & Pargament, 2002). In 2008, Walker and associates explored sanctification of work in a study of 103 full-time employees from different fields (management, education, training, and library, office and administrative support, business and financial operations, sales and other related groups) in the U.S., and found a

positive association between SoW and job satisfaction, organizational commitment, and turnover intention. Similarly, Hall, et al. (2012) applied the construct of sanctification to working mothers' experiences at work, and found that higher levels of SoW predicted higher positive affect, lower inter-role conflict, and higher satisfaction with work. A 2014 study by Carroll, et al. (2014) investigated the perceptions of educators and school administrators in the U.S. Catholic school system; participants reported perceiving their jobs as sanctified, and that the sanctification of work was directly correlated with increased job satisfaction, organizational commitment, and less intention to leave (Carroll, et al., 2014).

Nursing

Spirituality in Nursing

Despite the many studies examining spirituality from a nursing perspective, there continues to be a wide range of definitions for spirituality in the nursing profession. The concept of spiritual care also varies widely (Martsolf & Mickley, 1998; Reinert & Koenig, 2013; Swinton & Pattison, 2010; Taylor, 2008). This lack of a universal and unitary definition of spirituality among nurses keeps the concept flexible and elastic, allowing nurses to provide spiritual care in a personalized, creative, and purposeful way (Taylor, 2008). The ambiguity of meaning for the concepts of spirituality and spiritual care brings with it innovation, strength, and value (Swinton & Pattison, 2010).

Sanctification of Nursing Work

For some nurses, spirituality in their work goes beyond the context of religiosity (Swinton & Pattison, 2010). Hence, the many facets of spirituality can provide unique

insight into the demands – and rewards – of nursing work. These facets can provide meaning and sacredness to different nurses in different ways. One lens which can be used to examine spirituality is sanctification and its related field, sanctification of work. These relatively new constructs in the psychology of religion, delineated by Pargament and Mahoney in 2005, asserted that individuals who achieve sanctification in their lives experience feelings of satisfaction, accomplishment, and positivity; sanctified events serve as resources for individuals to draw upon for strength and support.

Historical influences throughout the ages have shaped the nursing profession and its traditional "calling to serve." The role of the modern professional nurse began in the Roman Catholic Church in the early 19th century, through the role of a deaconess, described as a woman with some educational background selected by the Church to care for the sick in their homes. In alignment with Church standards, religious leaders (i.e. monks and nuns) later established what became the nursing ideals of charity, service, and self-sacrifice (Egenes, 2009). Historically, the concept of spirituality in nursing theory has been observed in different ways, either as a professional response to the needs of a patient, or the engagement and empathy exhibited by nurses who truly love what they do (Martsolf & Mickley, 1998).

Empirical Evidence on Meaningful Work/Sanctification of Nursing Work

Meaningful work that stems from individual spirituality arose as one of the most important factors in workplace spirituality, according to Pirkola, et al.'s (2016) integrative review of spirituality in nursing. Pavlish and Hunt (2012) studied the perceptions of meaningful work from 13 public health nurses and 13 acute care nurses

using a narrative design. Three primary themes emerged from this data which defined meaningful work for these nurse informants: connections, contributions, and recognition; making a difference in the lives of patients and connecting to others, and receiving acknowledgement for their efforts. The moments shared with patients gave the nurses a sense of their work as sacred, as well as imbued with positive feelings about their work environment. In summary, while spirituality and its influence on patient care delivery in nursing has been explored in various empirical studies, the concept of sanctification of work in nursing has not been studied.

Job Satisfaction

Job satisfaction, a work-related outcome, will be discussed in the following manner: we will provide a definition of the concept and its relationship with nursing, review relevant studies conducted in nursing, and discuss how spirituality or sanctification relates to job satisfaction.

Definition of Job Satisfaction

Job satisfaction is a complex group of an employee's attitudes towards work, which can be a general feeling about the job or a constellation of attitudes about different facets of a job (Lu, et al., 2012). Though complex, it can simply mean what an individual says it means (Garon & Ringl, 2004). Two theoretical approaches influence job satisfaction research: content theory and process theory. Most studies on job satisfaction, like the studies done by Blegen (1993), Zangaro and Soeken (2007), Lu, et al. (2012), and Saber (2014), were guided by content theory, particularly causal theories. The content

theory approach focuses on job satisfaction and its association with organizational needs (e.g., nursing shortages) and not the personal needs of the employee. Process theory, considered a holistic approach focusing on the needs of employees, is studied less often by researchers and includes individual factors such as values, expectations, and needs that the individual brings to work (Garon & Gringl, 2004; Chamberlain, Hoben, Squires, Estabrooks, 2016).

Nursing and Job Satisfaction

As members of a human service profession, nurses are surrounded with demands from personal, professional, or organizational entities. Nurses are striving to promote the health and wellness of the community (Garon & Ringl, 2004). In the acute hospital setting, nursing can be an action-packed, labor-intensive, physically and emotionally exhausting job. Frontline nurses are exposed to acutely ill patients with immediate needs in an unpredictable environment, along with work demands from physicians, management, and increasingly challenging regulatory mandates (Saber, 2014).

The notion of job satisfaction among nurses was measured on the first documented nurse job satisfaction study conducted by Nahm in 1940. The researcher found that in order to render the best possible care to their patients, nurses need to experience their job as interesting and meaningful from the beginning. The care provided depended not only on the nurse's knowledge and technical skills, but also on how highly they valued the nursing profession.

Empirical Evidence on Nursing and Job Satisfaction

Job satisfaction from a content theory approach is one of the most frequently studied variables in nursing research, due to its association with organizational needs, such as nurse turnover and nursing shortages (Lu, et al., 2012). In addition, Lu and colleagues observed that job satisfaction was associated with the healthcare organization's clinical performance, such as patient satisfaction and patient safety (CMS, 2013; Choi & Boyle, 2013). However, as stated earlier, few researchers have used the holistic, nurse-focused process approach, although demographic information such as age and gender are collected.

Blegen's (1993) meta-analysis of 48 studies sought to describe the relationship between nurses' job satisfaction and the most frequent variables associated with it. Blegen found that stress and organizational commitment are the most strongly related factors to job satisfaction, followed by communication with supervisor, autonomy and recognition, routinization, communication with peers, fairness, and locus of control. Variables with low correlations were age, tenure, and professionalization. Zangaro and Soeken's (2007) findings from a meta-analytic review of 31 job satisfaction studies of 14,567 frontline nurses from 1991 to 2003 were similar to those found by Blegen; that is, job stress was strongly associated with job satisfaction, followed by nurse-physician collaboration and autonomy.

Saber (2014) likewise completed a meta-analysis of 62 studies conducted between 1980 and 2009 to examine how 27 variables predicted nurse job satisfaction. The strongest predictors of job satisfaction were task requirements, empowerment, and control, whereas autonomy and stress were moderate predictors.

One group of researchers used the process theory approach to study job satisfaction. Squires, Hoben, Linklater, Carleton, Graham, and Estabrooks (2015) conducted a systematic review of contributing factors to job satisfaction among care aides working in a residential long-term care facility. The team found that individual factors such as autonomy and empowerment were important factors, while other individual factors such as age, ethnicity, gender, educational level, education, and years of experience were not significant. In addition, organizational factors valued by care aides were facility resources and workload, while salary/benefits and job performance were not important. These findings differ from the systematic review of studies for over four decades (1996 to 2011) done by Lu, et al. (2012) among nurses, which revealed that working conditions, organizational environment, job stress, role conflict and ambiguity, role perception and role content, and organizational and professional commitment, were related to job satisfaction.

In summary, the content theory approach of job satisfaction was extensively studied among 55,004 registered nurses through three meta-analysis reviews by Blegen (1993), Zangaro and Soeken (2007), and Saber (2014). The reviews revealed that job stress, organizational commitment, task requirements, empowerment, and control were strongly related to nurse job satisfaction. In contrast, researchers explored the process theory approach of job satisfaction through a systematic literature review among care aides and nurses, with different results. For care aides, autonomy and empowerment were strong factors for job satisfaction (Squires, et al., 2015) while for nurses, job stress, role factors (i.e. conflict, ambiguity, perception and content), organizational and professional commitment were related to job satisfaction (Lu, et al., 2012).

Empirical Evidence on Nursing Spirituality and Job Satisfaction

Nursing scholarship suggests some linkage between spirituality and job satisfaction. After a conceptual analysis, Yusof and Mohamad (2014) hypothesized that spiritual well-being directly impacts job satisfaction. Lazar's (2010) correlational study of 120 female Jewish Israeli hospital nurses found an association between spirituality and job satisfaction. Duffy's (2006) literature review presented the links between spirituality and religion in the workplace and job satisfaction. The aspects of spirituality identified as being associated with job satisfaction included how well employees' personal beliefs and behaviors aligned with those of the employing organization. In addition, employees' relationships with each other empowered them to do their best and brought personal fulfillment and job satisfaction. Clark, et al. (2007) examined the prevalence of spirituality and its relationship with job satisfaction by surveying 215 hospice interdisciplinary team members (nurses, home health aides, social workers, chaplains, physicians, and others). The findings from the study suggested that integrating spirituality at work is significantly associated with job satisfaction.

Summary

Job satisfaction affects nursing performance in general. A group of empirical studies on job satisfaction were reviewed and categorized by the approached used – either content or process. In sum, three extensive meta-analyses using the content approach and two systematic literature reviews using process approach were discussed. Overall, the research findings from both approaches provided evidence that job stress, organizational commitment, and empowerment were found to be strongly related to job satisfaction. In

particular, associations between spirituality and job satisfaction were found in different work settings (Yusof & Mohamad, 2014; Lazar, 2010; Duffy, 2006; Clark, et al., 2007). However, no empirical studies were found using sanctification of work as a measurement of spirituality in nursing and its influence on nurses' job satisfaction.

Employee Engagement

Employee engagement, a work-related outcome, is discussed below. The concept is defined and empirical studies explored in the general workplace as well as the nursing work setting. The lack of empirical studies between sanctification of work and employee engagement is also discussed.

Definition of Employee Engagement

Two major theories on employee engagement exist: one conducted by Kahn in 1990 and another by Maslach and associates in 2001.

Kahn's theory of engagement was based on an ethnographic study of summer camp instructors and workers in an architectural firm. Kahn's findings, drawn from observation and qualitative interviews, described workers' feelings of personal engagement and disengagement on the job. The degree of personal engagement or disengagement was rooted in three psychological conditions: meaningfulness, psychological safety, and psychological availability, which were applied to the employees' answers (Kahn, 1990). Employee engagement can be described as the degree of psychological meaningfulness an individual finds in their job role. This meaningfulness reflects the employee's ideals and standards as influenced by factors such

as job enrichment, job role fit, and co-worker relations. In addition, employee engagement can be identified as the degree to which an individual feels safe to perform a job without fear of retaliation. Furthermore, employee engagement can be characterized by the individual's self-confidence, readiness, and availability to fully invest in the assigned job role, which is influenced by individual resources, work role security, and other activities of work (May, Gilson, & Harter, 2004).

The second theory was influenced by the concept of burnout studied by Maslach, Schaufeli, and Leiter (2001), in which burnout was defined as the negative state of an employee's attitude, while employee engagement is the positive state of an employee's attitude. Employee engagement is the antithesis of burnout and is characterized by vigor, dedication, and absorption. Maslach, et al. (2001) further recommended that employee engagement should be used to help measure employees' well-being.

In conclusion, Kahn's theory of employee engagement focuses on bringing one's complete and true self to the performance of one's role. Employee engagement, in Kahn's model, simply means loving what you do and doing what you love (May, et al., 2004; Renn & Vandenberg, 1995; Saks & Gruman, 2014).

Empirical Evidence on Employee Engagement in General Workplace

A number of empirical studies on employee engagement, as well as non-empirical papers authored by organizational consultants, have been published in the last 10 years (Saks & Gruman, 2014; Mackay, Allen, & Landis, 2017). The focus of most of the research studies was job demands and job resources, as well as the influence of management practices on employee engagement (May, et al., 2004; Rich, LePine, &

Crawford, 2010; Saks & Gruman, 2014). Recent meta-analytic estimates and a path analysis of 49 published research studies of employee effectiveness indicators, representing a total of 22,090 participants, found that employee engagement is the most accurate and concise method to measure employee effectiveness (Mackay, et al., 2017). Employee effectiveness included factors such as job satisfaction, job involvement, organizational commitment, absenteeism, and turnover (Harrison, Newman, & Roth, 2006; Mackay, et al., 2017).

A few studies have tested Kahn's theory of employee engagement since it was introduced in 1990. May, et al. (2004) explored the mediating effects of Kahn's three psychological dimensions – meaningfulness, psychological safety, and psychological availability – on employee engagement among 213 staff from a U.S. insurance company in the Midwest. May's findings revealed that all three dimensions were significantly related to engagement, particularly meaningfulness. In addition, the researchers theorized that job enrichment, work role fit, and co-worker relations are dimensions that influence psychological meaningfulness. Research that further examined the etiology of Kahn's theory of employee engagement, a study of 245 firefighters and their supervisors, was conducted by Rich and colleagues in 2010. In this work, the researchers applied three antecedents of engagement: value congruence, perceived organizational support, and core self-evaluation. Findings showed that each antecedent was nearly equal in its effect on employee engagement. More specifically, firefighters who invested energy into their role tended to be more helpful, courteous, and involved in organizational activities. This study supported the unique value of engagement in relation to job involvement, job satisfaction, and inner motivation.

A cross-sectional study of 540 employees of a food and drink bottle manufacturing company in the United Kingdom examined personal engagement and disengagement at work as part of an organizational change process. The researchers evaluated an instrument, the *Intellectual, Social, Affective (ISA) Engagement Scale* (Soane, Truss, Alfes, Shantz, Rees, & Gatenby, 2012), and found positive associations between job engagement and various work outcomes, including task performance, organizational citizenship behavior, and turnover intention. This 9-item, ISA scale added validity to Kahn's theory by measuring three facets of engagement: intellectual, social, and affective engagement.

Nursing and Employee Engagement

Healthcare organizations measure success and industry edge by multiple indicators, including employee engagement. Because nurses comprise the largest workforce in the healthcare industry and are the closest to the point of care, there is a special need to focus on their engagement with the organization. Levels of employee engagement impact both patient and work-related outcomes, with positive or negative effects on an organization (Echols, 2005).

Summary

Research studies on employee engagement were presented to further understand how job engagement might impact nursing. A meta-analysis/path analysis study described the incremental validity of employee engagement, placing on it greater value than other factors such as job satisfaction, job involvement, organizational commitment,

absenteeism, and turnover (Mackay, et al., 2017). Furthermore, building on Kahn's theory of employee engagement, the three studies from different sectors (insurance, firefighting, and manufacturing) discovered that employees experience job engagement through feelings of worth, value, usefulness, personal growth, and internal work motivation (Rich, et al., 2010), and positive effects on job satisfaction, productivity, absenteeism, and turnover (May, et al., 2004). In short, Kahn's (1990) theory of employee engagement is more comprehensive than Maslach's (2001) theory of employee engagement, which focused more on job resources.

However, little research has been conducted on employee engagement and its relationship to any facet of spirituality. Sanctification of work as it relates to employee engagement can fill this gap. How and if spiritual significance inspires individuals to be more fully engaged at work is unknown. There is good reason to expect that seeing work as sanctified is likely to increase engagement or provide a deeper sense of fulfillment (Tribken, 2015). This study explored the influence of sanctified work on employee engagement.

Organizational Commitment

Organizational commitment, a work-related outcome, is discussed below. Definitions and empirical studies about organizational commitment are reviewed, and spirituality and its relationship with organizational commitment in the general work setting is discussed.

Definition of Organizational Commitment

Two distinct views of organizational commitment are found in the literature. One view was a 1979 study by Mowday, et al., which focused on attitudinal organizational commitment, later known as affective commitment (Meyer & Allen, 1984). The second view, by Allen and Meyer (1996), built upon a 1960 research study by Becker, who described organizational commitment as more commitment-related behavior, later known as continuance commitment (Allen & Meyer, 1996). Continuance commitment is exemplified when individuals are obliged to stay in a job due to rewards and benefits and not merely because they are happy in the job (McGee & Ford, 1987).

This study will adapt the first definition — attitudinal or affective — thought to be the best representation of organizational commitment (Milliman, Czaplewski, & Ferguson, 2003), which also is a very important determinant for dedication and loyalty (Rhoades, Eisenberger, & Armeli, 2001). Affective commitment is a psychological link between the employee and the organization through identification with, involvement in, and emotional attachment to the organization (Allen & Meyer, 1996). It is a kind of commitment in which individuals willingly contribute to the good of the organization (Mowday, et al., 1979).

Empirical Evidence on Nursing and Organizational Commitment

The 21st century has been hailed as a time of tremendous change in the world of work. That said, there is a paucity of interest about how changes in healthcare organizations affect employees, especially nurses (Herscovitch & Meyer, 2002). As a work-related outcome, organizational commitment is worth the attention of healthcare

administrators and scholars, since it greatly affects the health of the organization (Allen & Meyer, 1996; McGee & Ford, 1987). Organizational commitment is one of the most important factors linked to work attitudes and behavior, such as job performance, organizational citizenship and job satisfaction, intention to leave, and actual turnover (Allen & Meyer, 1996; Cho, Laschinger, & Wong, 2006; Lum, Kervin, Clark, Reid, & Sirola, 1998; Mowday, et al., 1979; Rhoades, et al., 2001). It is also linked to employee support for change initiatives (Herscovitch & Meyer, 2002) and intentions to recommend the organization to prospective employees as a good place to work (Paulin, Ferguson, & Bergeron, 2006). Current evidence about organizational commitment among nurses is discussed below.

In 2012, Rai investigated how job satisfaction, together with workload, facility size, and social support, affected organizational commitment among 363 long-term care staff. Rai found that job satisfaction and social support increased organizational commitment, while large-sized facilities and heavy workloads decreased organizational commitment. Other studies have focused on job burnout and its relationship to organizational commitment. For example, Cho, et al.'s findings (2006) from a study of 226 new nurse graduates with up to 2 ½ years of nursing experience in acute care hospital settings indicated that emotional exhaustion (a dimension of burnout) had a direct negative effect on organizational commitment. Lee and Ashforth (1996) likewise observed this in their meta-analytic review of 61 studies from 1982 to 1994. The reviewers identified 33 correlates in 56 independent samples of human service providers (including nurses) with sizes ranging from 34 to 906. The researchers found evidence that

emotional exhaustion and depersonalization (the other dimensions of burnout) were strongly associated with turnover intentions and organizational commitment.

Researchers like Welsch and La Van (1981) studied variables that affected organizational commitment among 149 staff and leaders in a large medical center. Role conflict and role ambiguity were found to be negatively related to organizational commitment while age, tenure, hierarchical level, and length of professional employment were positively related. Similarly, Vagharseyyedin (2016) performed an integrative review of 33 studies on the determinants of nurses' organizational commitment in a hospital setting from 2000 to 2013. The review revealed four categories of determinants, namely: (1) personal characteristics and traits of nurses, (2) leadership management style and behavior, (3) perception of the organizational context, and (4) characteristics of job and work environment. Personal characteristics and traits of nurses included two themes: biopsychosocial and personal family life. Of these, the following determinants were positively correlated with organizational commitment: extroversion; well-being/mental health; emotional intelligence; psychological empowerment; employee engagement; job satisfaction social rewards; professional commitment; preference of stability versus change; life satisfaction; met family needs; perception of better life for self and family, and plans for retirement from the organization. In contrast, the negative characteristics and traits determining nurses' organizational commitment included psychological distress; negative affectivity; emotional exhaustion, and surface acting, resulting in feelings of detachment from one's true feelings. Furthermore, age as a determinant had mixed results, with one study finding age to be negatively correlated with organizational commitment, while others found a positive relationship. Likewise, job tenure (i.e., length

of time in a particular job or with an employer) as a determinant of organizational commitment showed mixed results – positive, negative, and no correlation with organizational commitment.

The relationship between organizational commitment and nursing turnover or intent to stay was the focus of other researchers. Wagner (2007) systematically reviewed the findings of published studies to assess the impact of organizational commitment on nursing turnover. Wagner reviewed 25 studies between 1960 and 2006 and found that organizational commitment is a stronger predictor of nursing turnover than job satisfaction. Wagner recommended that it routinely be included in research studies on nursing turnover, particularly when mediating variables of intent to leave and intent to stay are included. In a 2015 survey of early-career Registered Nurses by Brewer, Chao, Colder, Kovner, and Chacko, the researchers found that organizational commitment had a significantly positive direct effect on intent to stay, though it did not have a significant effect on actual turnover. In addition, job satisfaction significantly, directly, and positively predicted organizational commitment.

In summary, positive factors to organizational commitment include job satisfaction (Rai, 2012; Brewer, et al., 2015; Vagharseyyedin, 2016); social support (Rai, 2012); hierarchical level and length of professional employment (Welsch & La Van, 1981), and intent to stay (Brewer, et al., 2015). Other positive variables included extroversion; well-being/mental health; emotional intelligence; psychological empowerment; employee engagement; social rewards; professional commitment; preference for stability versus change; life satisfaction; met family needs; perception of better life for self and family, and plans for retirement from the organization

(Vagharseyyedin, 2016). In contrast, the negative factors included emotional exhaustion (Cho, et al., 2006; Lee & Ashforth, 1996; Vagharseyyedin, 2016); depersonalization (Lee & Ashforth, 1996); large-size facilities and heavy workloads (Rai, 2012); and role conflict and role ambiguity (Welsch & La Van, 1981). Other negative factors included psychological distress, individual levels of negative affectivity, and surface acting (Vagharseyyedin, 2016). Factors with mixed effect to organizational commitment include age as a positive determinant (Welsch & La Van, 1981; Vagharseyyedin, 2016) and as a negative determinant (Vagharseyyedin, 2016). Tenure was found to have a positive effect (Welsch & La Van, 1981; Vagharseyyedin, 2016) and a negative effect or no correlation (Vagharseyyedin, 2016) to organizational commitment.

Empirical Evidence on Spirituality and Organizational Commitment in General Workplace

Organizations in both public and private sectors have focused some attention on spirituality at work and how expressions of spirituality affect work-related outcomes and patient outcomes. For example, Milliman, et al. (2003) surveyed 200 part-time, evening MBA students who were working full-time jobs and found that the three dimensions of spirituality (i.e., individual, group, and organizational) are positively related to the organizational commitment of the individual. The study demonstrated an overall strong reliability for each multi-item scale using Cronbach's alpha, with coefficient alphas ranging from 0.82 to 0.94. Individuals who experience greater purpose and meaning, a stronger sense of community, and alignment with an organization's values will be more committed to that organization. In a dissertation study of workplace spirituality, Trott

(1997) used a construct of spiritual well-being characterized by meaningfulness, purpose, and connectedness. A positive relationship between spirituality and organizational commitment was observed among 184 workers in a Fortune 100 company. Similarly, Rego and Pina e Cunha (2008) studied 361 individuals from 154 organizations in Portugal and Brazil and found that people who experience spirituality in the workplace had stronger commitment to the organization, and, ultimately, stronger intentions to stay. Affeldt and MacDonald (2010) used the *Expressions of Spirituality Inventory (ESI)* to measure the dimensions of Cognitive Orientation toward Spirituality (COS); Experiential/Phenomenological Dimension (EPD); Existential Well-Being (EWB); Paranormal Beliefs (PAR), and Religiousness (REL) among 446 employees from a multi-site, religiously-affiliated health care system. Findings from the study provided evidence that the dimensions EWB and REL are consistently related to work and organizational variables such as work ethic, job satisfaction, organizational commitment, and organizational citizenship behaviors.

Summary

Research studies on organizational commitment have been conducted in both general workplace and nursing environments, with positive, negative, and mixed findings. In sum, job satisfaction, social support, meaning and purpose in work, and intent to stay are positively related to organizational commitment, while heavy workload, emotional exhaustion, role conflict, role ambiguity, and large facilities have negative impacts on organizational commitment; age and job tenure have mixed results. Types of evidence ranged from literature reviews, cross-sectional studies, and meta-analytic

reviews and captured decades of individual studies related to organizational commitment. However, there is little research done on sanctification of work and its effects on employee attitudes. Furthermore, there is no evidence of research conducted specifically with nurses on the impact of the SoW construct and nurses' commitment to their employing organization. This study will further investigate this relationship.

Job Burnout

Job burnout, a work-related outcome, will be explored next. A definition and conceptualization of job burnout, as well as empirical studies about job burnout in the general workplace and nursing work setting, is reviewed. The sanctification of work and its impact on job burnout is also explored, specifically as it relates to nurses.

Definition of Job Burnout

Burnout is a prolonged psychological response to chronic emotional and interpersonal stressors on the job. It is comprised of three dimensions, according to Maslach, the pioneer who developed the most widely used measure for the concept. The dimensions of burnout include: emotional exhaustion (or the individual stress dimension of burnout); depersonalization (or the interpersonal dimension of burnout); and lack of personal accomplishment (or the feelings of ineffectiveness and lower productivity, considered as the self-evaluation dimension). Individual and organizational consequences of burnout include loss of worthiness and passion for one's job, which then can affect quality of work, and employee attitudes of absenteeism, job turnover, and low morale (Maslach & Jackson, 1981; Maslach, et al., 2001).

Maslach, et al. (2001) grouped the antecedents of job burnout into three multidimensional levels: organizational, occupational, and individual level. The organizational level is characterized by hospital regulations, policies and procedures, and the culture within the organization, whereas the occupational level includes teaching or human services. Finally, individual-level antecedents encompass an individual's personality traits, attitudes, and demographic characteristics, since everyone brings unique qualities to the work setting that influences and affects how they interact with others. In summary, these numerous and diverse factors, whether they are part of the essence of the worker, the job, or the environment, are antecedents of job burnout, according to Maslach.

Empirical Evidence on Job Burnout in the General Workplace

Empirical studies on burnout initially investigated workers in care-giving and service occupations, and mainly examined whether provider-recipient relationships resulted in either positive, rewarding experiences or negative experiences, setting the stage for burnout (Maslach, et al., 2001). In the 1980s, the work on burnout shifted to more empirical studies, using a clinical and social psychology approach, through the study of medical professionals such as nurses. A shift to industrial-organizational psychology followed, focusing on work-related outcomes. Combining clinical/social and industrial/organizational psychology, these two approaches brought a richer perspective to research studies on job burnout. Empirical evidence from research on burnout is extensive. Several meta-analyses conclude that there is a link between burnout and work-related outcomes such as increased absenteeism, decreased job satisfaction, job or

organizational commitment, turnover intention, and actual turnover (Maslach, et al., 2001). In relation to health outcomes, burnout is associated with mental dysfunction such as anxiety, depression, and decreased self-esteem (Maslach, et al., 2001). Indeed, a meta-analytic examination of research on burnout, whether conceptualized and measured by the *Maslach Burnout Inventory (MBI) scale* or the *Utrecht Work Engagement Scale (UWES)*, showed that both identified a similar pattern of association with such correlates (Cole, Walter, Bedeian, & O'Boyle, 2012).

A meta-analytic review of 231 empirical studies on burnout using the *Maslach Burnout Inventory* (MBI) in a work setting from 1981 to 2010, was conducted by Alarcon (2011), which showed that higher job demands such as role ambiguity, role conflict, and workload were positively related to the three dimensions of burnout ─ emotional exhaustion, depersonalization, and lack of personal accomplishment. Meanwhile, control and autonomy were negatively correlated. Turnover intention was positively associated to the dimensions, while work outcomes such as job satisfaction and organizational commitment were negatively associated.

Swider and Zimmerman (2010) conducted a meta-analysis of 115 empirical studies focused on the individual level of burnout, an under-studied area of burnout research. An association was revealed between the Five-Factor Model personality traits (i.e. neuroticism, extraversion, agreeableness, conscientiousness, and openness) and the three dimensions of burnout. The analysis revealed that job burnout was related to the work outcomes of turnover intention, job performance, and absenteeism. Thus, individuals who were experiencing burnout had greater absenteeism, increased turnover, and lower performance. Burnout also partially mediated the relationship between the

Five-Factor Model personality traits and turnover and job performance. Burnout also fully mediated the relationship between these personality traits and absenteeism.

Another meta-analysis of 183 studies was done by Purvanova and Muros (2010), focusing on gender differences in burnout, specifically the belief that women experienced burnout more often than men. Findings revealed that women are more likely than men to report the emotional exhaustion component of burnout, whereas men are likelier to report the depersonalization dimension of burnout than women.

Nursing and Job Burnout

Wherever nursing care is provided, nurses inherently spend time interacting with patients and their families. As a care-giving, human-service oriented profession, nursing is a demanding job, requiring nurses to respond within a specified time-frame to achieve results. The time spent with patients not only requires energy from nursing staff, but energy that is often charged with feelings of anger, fear, despair, and embarrassment (Maslach & Jackson, 1981). Nurses encounter patients who, in addition to physical needs, have an array of social, emotional and spiritual needs. Applying the dimensions of burnout to a nursing framework, emotional exhaustion arises from the physical and emotional demands from interactions with patients, co-workers, physicians, and others, whereas depersonalization is characterized by negative and impersonal attitudes toward peers, patients, and their loved ones. In addition, reduced efficacy or accomplishment adds to perceptions of incompetence and a lack of achievement or productivity. In delivering health care services, these manifestations of burnout result in poor work-related or patient outcomes (Canadas-De la Fuente, et al., 2015).

Empirical Evidence on Nursing and Job Burnout

Among human service professionals, burnout increases in proportion to the number and type of patient care encounters (Maslach & Pines, 1977) and the number of hours spent in direct patient interaction (Maslach & Jackson, 1982). In the 1970s, before the development of advanced research methodologies, burnout was linked to work-related outcomes such as intent to leave (Maslach & Jackson, 1979). For example, the researchers observed burnout to manifest when individuals spent less time with others (i.e. patients and co-workers) by taking frequent breaks, as well as increased tardiness and absenteeism.

International researchers have obtained similar findings. For example, a study of 862 hospital nurses in India provided evidence that emotional exhaustion and lack of personal accomplishment were responsible for decreased organizational commitment, whereas emotional exhaustion and depersonalization initiated intentions to quit a job (Kar & Suar, 2014). In Spain, a study of 676 nursing professionals explored the myriad factors associated with burnout (Canadas-De la Fuente, et al., 2015). Findings from that study revealed a high prevalence of moderate to high levels of burnout among nurses in general, although nurses working in maternal and infant services showed lower levels of burnout than those in other departments; also, nurses in managerial positions tended to have lower levels of depersonalization than nurses providing direct patient care. Furthermore, findings also revealed that as emotional exhaustion increased, the degree of neuroticism increased, and conscientiousness, agreeableness, extraversion, and openness to experiences decreased. Other demographic findings revealed that men had higher levels of depersonalization than women, while married nurses suffered greater emotional

exhaustion but also experienced higher personal accomplishment levels. Other factors such as parenthood, age, and type of work shift were associated with job burnout (Canadas-De la Fuente, et al., 2015).

Maslach and Jackson (1981) suggested that burnout may be associated with the belief that one's work is not meaningful or worthwhile. Based on a study of nurses, social service and mental health workers using the *Job Diagnostic Survey*, Maslach's (1976) findings suggested that meaningfulness of work was associated with increased personal accomplishment, but not significantly associated with emotional exhaustion. Meaningful or sanctified work and the feeling of personal accomplishment are some of the facets of spirituality in nursing.

Summary

Extensive research on job burnout in the general work setting is reviewed in this section, as well as research on the nursing environment, both domestically and internationally. In the general workplace, job demands such as role ambiguity, role conflict, and workload, turnover intention (Alarcon, 2011), absenteeism, turnover, low performance, and neuroticism (Swider & Zimmerman, 2010) were positively related to burnout. Meanwhile job demands such as control and autonomy, work outcomes like job satisfaction and organizational commitment (Alarcon, 2011), and personality traits such as extraversion, agreeableness, conscientiousness, and openness (Swider & Zimmerman, 2010) were negatively related to burnout. In the nursing work environment, factors such as number of hours spent with patients (Maslach & Jackson, 1982), number of patients seen (Maslach & Pines, 1977); intent to leave, as shown by absenteeism, tardiness and

frequent breaks (Maslach & Jackson, 1979); and service area, direct patient care providers, and neuroticism (Canadas-De la Fuente, et al., 2015) were positively associated with burnout. In contrast, factors like organizational commitment (Kar & Suar, 2014), and personality traits such as conscientiousness, agreeableness, extraversion, and openness, and personal characteristics such as married status, increased age, and parenthood (Canadas-De la Fuente, et al., 2015) were negatively linked to burnout. The gender variable was both significantly linked to the general work setting (Purvanova & Muros, 2010) and the nursing environment (Canadas-De la Fuente, et al., 2015). Of interest, meaningfulness of work was positively associated with personal accomplishment (Maslach & Jackson, 1981). There are no research studies conducted on sanctification of work and job burnout, although meaningfulness of work was associated with burnout.

Turnover Intention

Turnover intention, a work-related outcome is discussed below. A definition and review of empirical studies specific to nurses is presented, and the relationship between spirituality, sanctification of work, and turnover intention is explored.

Definition of Turnover Intention

Turnover intention is the precursor to actual turnover (Coomber & Barriball, 2007; Hayes et al., 2006). Turnover is a multidimensional construct, with dimensions of organization, job, and occupation.

Nursing and Turnover Intention

Nurse turnover in the hospital setting is an ongoing challenge in the healthcare industry, affecting the health of the organization; turnover rates affect a hospital's daily operations, from staff productivity to patient outcomes. Employees experience the effect of turnover at the point of care, when patient needs are jeopardized due to short staffing while the expectation for staff to provide care remains the same. Hiring nurses, whether new or experienced, increases cost and uses many resources, from filling vacant positions to orienting new staff. With nursing shortages and ceaseless nurse turnover, organizations try to control the "bleeding" of staff loss (Coomber & Barriball, 2007; Hayes, et al., 2006; Lucas, Atwood, & Hagaman, 1993; Shader, Broome, Broome, West, & Nash, 2001). In nursing, occupational or professional commitment has a strong relationship with intention to leave the organization, the specific job, and the occupation or profession (Cohen, 1999). In this context, it is possible for nurses to stay in the organization, but in a different job (Cohen, 1993). Parry (2008) asserted that empirical studies on nurse turnover mostly report on employee intention of leaving the job, and fail to ascertain whether employees are leaving for a nursing job at another organization or intend to quit the nursing profession entirely.

Empirical Evidence on Nursing and Turnover Intention

The concept of employee turnover has been studied since the 1970s by personnel researchers, behavioral scientists, and management practitioners (Porter & Steers, 1973; Mobley, Horner & Hollingsworth, 1978; Bluedorn, 1982; Mobley, Griffeth, Hand, & Meglino, 1979; Hom, Griffeth, & Sellaro, 1984). The findings of these studies revealed

that behavioral intention is the precursor to the actual behavior, which means that intention to leave is the antecedent to actual turnover (Bruyneel, Thoelen, Adriaenssens, & Sermeus, 2016; Coomber & Barriball, 2007; Hayes, et al., 2006; Mobley, et al., 1978; Nei, Snyder, & Litwiller, 2015; Steel & Ovalle, 1984).

Many literature reviews, conceptual analyses, and meta-analyses were conducted aimed at determining and investigating antecedents, moderators, and predictors of turnover intention. In the last decade, Nei, et al. (2015) conducted a meta-analysis of 106 studies focused on nurse turnover between 1971 and 2010. The study examined the predictors (i.e. personal characteristics, role states, job characteristics, group/leader relations, organizational and/or environmental perceptions, and attitudinal reactions) of nurse turnover, including turnover intention. The findings of this meta-analysis revealed that older, female nurses who have been on the job and in the profession longer, and who felt committed, involved, motivated, and satisfied with their job had lower intention to leave their employing organization. In addition, nurses in a better role fit, in a positive organizational climate with greater organizational support from leaders who maintained open communication and valued teamwork, and fewer perceived job alternatives increased nurse intention to stay in the job. In contrast, nurses who experienced higher job strain, role tension, work-family conflict, lower job control, complex job, network centrality, and fewer rewards and recognition had higher intention of leaving the job. Organizational tenure and organizational size were not related to turnover intention. In sum, turnover intention is positively related to turnover.

In 1998, Lum and associates conducted a turnover intention study of 446 staff nurses from general care units and critical care units. Their findings showed that job

satisfaction had only an indirect influence on the intention to quit, whereas organizational commitment had the strongest impact on turnover intention. Other findings included demographic variables that showed that nurses with bachelor's degrees, with children, working 12-hour work shifts, and with more work experience were less likely to leave the organization.

Hayes and associates (2006) reviewed 130 research studies of nurses in the hospital, long-term, and community settings published in the late 1990s or afterwards. The team examined the determinants of nurse intention in leaving the organization and nursing profession. The study findings provided evidence that professional commitment was more predictive of intention to leave the profession. In addition, a one-year longitudinal study conducted by Li, et al. (2010) in China of 3,088 female RNs working in hospitals was on the psychosocial work environment and nurses' intention to leave the profession. The researchers showed that nurses who experienced decreased meaning of work, decreased commitment to the workplace, and decreased job satisfaction had more intention in leaving the nursing profession. Simply put, psychosocial factors influence nurses' intention of leaving the profession. Although not explicitly discussed, this implies that nurses who value and put meaning in their profession, a depiction of sanctified work, impacts nurses' loyalty in the nursing profession. With all these factors associated with turnover intention, Coomber and Barriball (2007) asserted that each unique working environment needs to be addressed individually.

Empirical Evidence on Spirituality and Turnover Intention

Human services organizations such as healthcare and the food industry are increasingly interested in exploring how or if spirituality affects work-related outcomes such as turnover intention. Gaydos (2004) discovered through co-creative aesthetic inquiry using transcribed narratives, that spirituality is one of the factors that motivated five hospice nurses to stay in hospice nursing. Spirituality was described by these nurses as active and relevant in their daily lives, at the deepest and most meaningful levels. Furthermore, deValpine (2014) interviewed 10 long-term nurses in Bristol Bay, Alaska, and found religion and spirituality to be one of the common themes among these nurses, who intended to stay in the remote Southwest "bush" of Alaska. Another study examined the relationship between workplace spirituality and intention to leave employment (Hong, 2012). In this study, 403 direct service workers at community mental health centers validated that Ashmos and Duchon's five dimensions of workplace spirituality (i.e., finding meaning at work, inner life, contemplation, organizational value, and the individual and organization), predicted the relationship with turnover intention. That is, the influence of the five dimensions on the intention to leave was stronger for the community mental health professionals with higher levels of spirituality than for their counterparts with lower levels. In contrast, Beehner and Blackwell's (2016) quantitative experimental study investigated the impact of a workplace spirituality program on turnover intention among food service employees (N=53) employed in a multiple-location food service organization. Using a modified and field-tested version of Beehner and Blackwell's *Spirituality and Healthcare Workshop*, and the turnover intention score for the *Work Environment Survey*, the results of the study suggested that the effect of the

workshop on turnover intention was not significant, and the restaurant work setting had no effect on the impact of a workplace spirituality intervention program. Hence, work settings should be considered when examining the impact of workplace spirituality.

Summary

The focus on turnover intention as a work-related outcome in human service professions is growing. As presented on this literature review, intention to leave may mean intention of leaving the organization or leaving the occupation (in this case, the nursing profession). The determinants of turnover intention can be individual, occupational, or organizational in nature, with positive, negative, or no influence at all. According to Hong (2012), there are few empirical studies that support the relationship between spirituality and work-related outcomes such as turnover intention. Empirical studies of nurses on sanctification of work and turnover intention are scarce, hence this study.

Patient Satisfaction

Patient satisfaction, one of the patient outcome indicators, and its relationship with nursing and spirituality is discussed in this section. A definition of patient satisfaction will be provided, as well as a review of empirical studies on patient satisfaction and nursing, patient satisfaction and spirituality in nursing, and a summary.

Definition of Patient Satisfaction

Patient satisfaction is a multidimensional phenomenon and is viewed from many angles, including the elements of perception, expectation, and subjectivity (Bleich, et al.,

2009; Linder-Pelz, 1982; Mahon, 1996; Newsome & Wright, 1999). Patient satisfaction focuses on the hospital care provided to patients, characterized by the continuity of care, timely feedback, effective coordination of care, and authentic connection with the patient and family (Kreitzer, 2015). The factors related to overall patient satisfaction include accessibility, availability of resources, continuity of care, efficacy of care, finances, humaneness, information giving or gathering, pleasantness of surroundings, and competence of providers (Cleary & McNeil, 1988; Fosbinder, 1994; Johansson, Oleni & Fridlund, 2002; Otani, et al., 2012; Wagner & Bear, 2009). Since 1970, patient satisfaction has continued to be crucial in healthcare delivery; currently it is on the national agenda under patient outcome initiatives.

In 2002, as part of its goal to improve quality care, CMS) in cooperation with the Agency for Healthcare Research and Quality (AHRQ), the research component of the Department of Health and Human Services (DHHS), developed and tested the first national and standardized survey of patients' perspectives of hospital care, called the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) The survey covers eight measures or dimensions of the patient experience: communication with nurses, communication with doctors, responsiveness of hospital staff, pain management, communication about medication, cleanliness/quietness of hospital environment, discharge information, and overall rating (HCAHPS Fact Sheet, 2013; Sellar, 2013).

The 2010 Patient Protection and Affordable Care Act mandated the use of HCAHPS results to calculate value-based incentive payment, which the federal government pays hospitals for providing healthcare to Medicare and Medicaid patients.

Thus, through this process of hospital consumer assessment, patient satisfaction influences Medicare reimbursement (Caramenico, 2011).

Nursing and Patient Satisfaction

Patient satisfaction is, by law, deeply embedded in the healthcare delivery system. The CMS led the transformation of the delivery of healthcare in the U.S. (Blum, 2011). In addition, the Institute for Healthcare Improvement (IHI), with its focus on the health and well-being of the community while reducing healthcare costs, has as one of their triple aims, the patient experience of care, including quality and satisfaction (Stiefel, 2012). With nursing at the forefront for patient care, nurses collectively and individually can influence the patient experience. Facets of patients' experience of care are thought to include quality and satisfaction through continuity of care, timely feedback, coordination, and authentic connection with the patient and family. Indeed, nursing care is a major hospital service provided to patients (Kreitzer, 2015; Mahon, 1996).

Empirical Evidence on Nursing and Patient Satisfaction

In 2009, Kutney-Lee, McHugh, Sloane, Cimiotti, Flynn, Neff, & Aiken examined data from 430 hospitals to determine how nursing affected patient satisfaction. The researchers used three sources of data in their study – the national HCAHPS, a nurse survey of hospital quality conducted in California, Pennsylvania, New Jersey, and Florida, and the American Hospital Association (AHA) Annual Survey. Their findings provide evidence that nurses working in a positive work environment — a nurse-sensitive indicator of health care quality as measured by three of five subscales of the *Practice*

*Environment Scale of the Nursing Work Inde*x (PES-NWI; Lake, 2002 ― positively influence all HCAHPS patient satisfaction measures. Nursing leadership, nursing standards for high quality patient care, and nurse-physician relationships informed the PES-NWI. Another finding provided evidence that patients were more satisfied working at hospitals with a favorable patient-to-nurse ratio, which can vary by department or unit within a hospital, and also by state or region. For example, a nurse in California working on med-surg would have a patient-nurse ratio of 1:5, and a ratio of 1:2 in intensive care.

Empirical Evidence on Spirituality and Patient Satisfaction

One of the Institute of Medicine (IOM) aims for healthcare delivery system re-design is patient-centered care (IOM, 2001). Patient-centered care is envisioned as holistic care, or care for the body, mind, and spirit (Kreitzer, 2015). In 2005, Taylor reviewed the evidence from 60 nursing studies and observed that the following had the most evidence supporting their use in nursing care: recognizing one's spiritual well-being; being present, respectful, and loving; being sensitive with a patient's spiritual needs, and integrating spiritual care in other nursing interventions.

Several studies suggest that many, but not all, patients appreciate spiritual care from clinicians. These studies also link patient satisfaction with provision of spiritual care. For example, Astrow, Wexler, Texeira, He, and Sulmasy (2007) conducted a survey study of 369 cancer patients in an outpatient setting on the relationship between patients' spiritual needs and their perceptions of quality and satisfaction with care. The study findings showed that patients whose spiritual needs were met experienced higher quality and satisfaction of care. Williams, Meltzer, Arora, Chung, and Curlin (2011)

investigated the relationship between spiritual care and patient satisfaction among 3,141 patients admitted to the general internal medicine service; the researchers found that 41% reported that they wanted to receive spiritual care. The researchers showed that healthcare professionals who addressed patient spirituality reported greater satisfaction with their healthcare experience. A mixed methods study by Hilbers, Haynes and Kivikko (2010) showed that hospitalized patients felt that nurses need to respect and support their spiritual beliefs and practices. The researchers suggested that spiritual support could help the patients cope with the fear and anxiety caused by illness, resulting in satisfied patients. In 2014, Hodge, Sun, and Wolosin (2014) used Press-Ganey patient satisfaction data obtained from 805 Asian-Americans recently discharged from a hospital, and found that the relationship between patient satisfaction and a patient's spiritual needs being met was best explained by whether nurses provided spiritual care.

Summary

This literature review showed a positive association between meeting patients' spiritual needs in either outpatient or inpatient care settings and the overall hospital experience, including patient satisfaction. However, little is known about the relationship between spirituality in nursing and patient satisfaction, particularly sanctified nursing work and patient satisfaction. Research supports the desire by many patients for spiritual care provided by nurses, and that nurses should develop confidence about discussing spirituality with patients.

Summary of Literature Review

A substantial review of the literature is presented in this chapter, including sanctification of work and its related concept, meaningfulness of work or calling, spirituality, patient satisfaction, and work-related outcomes such as job satisfaction, employee engagement, organizational commitment, job burnout, and turnover intention.

Sanctification of work among nurses has yet to be explored, although Walker, et al. (2008), Hall, et al. (2012), and Carroll, et al. (2014) found associations in different work groups between sanctification of work and organizational commitment, job satisfaction, and turnover intention. Little is known about the relationship between sanctification of work and employee engagement, although research has shown that employee engagement is the most effective and concise method to measure employee effectiveness (Mackay, et al., 2017). Furthermore, though job burnout has been extensively studied in the general work setting, less scholarship has been done in the nursing environment specific to its relationship with meaningfulness of work or sanctification of work. There are also a significant amount of research studies on nurse turnover and its relationship with other work-related outcomes, reflecting organizational commitment as the strongest predictor (Lum, et al., 1998), but none exploring its relationship to sanctification or spirituality of work. Furthermore, patient satisfaction, a salient patient experience indicator measured by HCAHPS, is explored for its relationship with sanctification of work. Although some nurses feel that they provide spiritual care to patients, little is known about the association between sanctification of work and patient satisfaction, despite some research findings that showed patients had a better hospital

experience after their spiritual needs were met (Astrow, et al., 2007; Williams, et al., 201l; Hilbers, et al., 2010; Hodge, et al., 2014).

The study of sanctification of work is in its formative stage as observed in the literature review, despite numerous studies on job satisfaction, employee engagement, organizational commitment, job burnout, turnover intentions, and their relationships with each other. Conversely, there were few studies conducted on sanctification of work and work-related outcomes, none of which studied nurses. Hence, the study on sanctification of work and its relationship with work-related outcomes and patient satisfaction is an area that needs to be explored.

Theoretical Framework

Theoretical frameworks are used to guide the development of a study and to better explain, describe, and/or predict the phenomena of interest. A theoretical framework or conceptual framework evolves from a theory, theories, or research (Meleis, 2012). The theory of sanctification by Pargament and Mahoney (2005), which has evolved from research evidence, was selected as a foundation upon which to base this dissertation study.

Introduction of Sanctification Theory

Sanctification is a psychological process through which people perceive aspects of life as possessing spiritual character and significance (Mahoney, et al., 1999; Pargament, 1999; Phillips & Pargament, 2002; Mahoney, Pargament, Murray-Swank, & Murray-Swank, 2003). In 2005, Pargament and Mahoney revised the definition and

changed the term "spiritual" to "divine" to provide a more precise definition of sanctification. Their definition of sanctification offers that it is:

> "a process through which aspects of life are perceived as having divine character and significance. It is a psychospiritual construct. It is spiritual because of its point of reference – sacred matters. It is psychological in two ways: First, it focuses on a perception of what is sacred; second, the methods for studying sacred matters are social scientific rather than theological in nature" (Pargament & Mahoney, 2005, p. 183).

Sanctification simply means that any object or event, as ordinary as it may seem, can be understood and experienced as divine – and becomes extraordinary (Pargament & Mahoney, 2005). Therefore, sanctification is a process in which an individual perceives an aspect of life as a manifestation of God or a Higher Being. Sanctification possesses sacred qualities in various dimensions or moments of a person's life; it may affect human functioning at home, work, or the community, with the desire to reach higher fulfillment, deeper meaning, and ultimate purpose in life (Pomerleau, Pargament, & Mahoney, 2016).

Sanctification has two dimensions, namely relational and non-relational. The relational domain includes marriage or romantic relationships, parenting, pregnancy, and sexuality, while the non-relational domain is comprised of strivings, body, environment, forgiveness, dreams, and work (Pomerleau, et al., 2015). The process of sanctification can be viewed from two dimensions, theistic and nontheistic. The theistic dimension, simply called the manifestation of God (MOG) relates to how a person can perceive an object or event as a direct manifestation of one's images, beliefs, or experiences of God (Mahoney, et al., 1999). Meanwhile, the nontheistic dimension, also known as sacred qualities (SQ), is experienced when an individual's perception of an object or event is

defined by terms such as holy, miraculous, inspiring, blessings, or eternal. These terms, however, do not necessarily refer to God (Phillips & Pargament, 2002).

Applying the concept of sanctification to a work setting may mean that sanctified work could affect the way nurses invest in their profession by preserving and protecting, and experiencing a sense of duty and responsibility in their work. Nurses who see their work as sanctified may be better able to see their patient as a whole person, with both spiritual and physical needs (Swinton & Pattison, 2010). These nurses may experience positive work-related outcomes such as job satisfaction, employee engagement, organizational commitment, less job burnout, and lower intention to leave (Pargament & Mahoney, 2005).

Rationales for Selection of Sanctification Theory

There are several reasons why sanctification theory was selected for this study. First, sanctification enables individuals to see the different facets of their lives – parenting, marriage, sexuality, as well as work – as sacred. Work is one of the aspects of life in which individuals strive to be their best selves. When work is nurturing, individuals will thrive and be more likely to reach their goals (Pargament & Mahoney, 2005). Specific to nursing profession as a calling, Raatikainen's (1997) quantitative study of 176 Finnish RNs described nursing care as a calling in which nurses invest themselves in serving people according to the high values of the task or profession; nurses empathize with patients' journeys to health and illness, and provide holistic care through a collaborative team approach. With passion and dedication, nurses enrich themselves by growing individually and collectively in the nursing profession.

Second, a sanctified aspect of life is more likely to be protected and preserved (Pargament & Mahoney, 2005). Research studies have focused heavily on marriage and parenting as sanctified objects/events. For example, Ellison, Henderson, Glenn, and Harkrider (2011) investigated the role of marital sanctification with aspects of marital quality among 2,003 adult Texans, making a distinction between conventional religiosity and sanctification. The researchers showed that sanctification is a potent predictor of marital quality, and appears stronger when couples are under general or financial stress. This current study among nursing personnel may observe similar results, in that we may find that sanctification of work is associated with less job burnout and turnover intent, higher job satisfaction, engagement, and commitment, and increased patient satisfaction.

Third, a sanctified object likely brings spiritual emotions of duty, responsibility, obligation, and protectiveness (Pargament & Mahoney, 2005). In a sanctification of parenting study, the findings revealed fewer verbally disciplinary actions, consistent approaches to misbehavior, and increased mother-child interaction (Murray-Swank, et al., 2006). For sanctification of work, collectively, nursing work has been described as a calling, delivering care out of a sense of duty, compassion, and for the glory of God (Sawatzky & Pesut, 2005).

Fourth, sanctification draws on sacred resources. Feelings of satisfaction and accomplishment are likely to be experienced by individuals who achieve their search for significant events in their lives. Sanctified objects are likely to serve as resources for individuals to draw upon for strength and support (Pargament & Mahoney, 2005). Researchers' findings revealed that sanctification showed positive outcomes, including increased satisfaction with marriage (Mahoney, et al., 1999), body image (Mahoney, et

al., 2005), and sexual intercourse (Murray-Swank, et al., 2002). Specifically, with sanctification of work, Walker, et al.'s (2008) study found it to be positively related to the outcomes of job satisfaction, organizational commitment, and turnover intention among full-time employees. The 2012 study by Hall, et al. revealed greater levels of satisfaction among working mothers, as well as higher positive affect, lower inter-role conflict, and higher satisfaction with work. Furthermore, Carroll, et al.'s (2014) study among educators revealed that those who see their work as sacred are more satisfied, more committed to their organization, and at the same time less likely to think about leaving. Evidence suggests that findings for nurses are likely to be similar to those of empirical studies on the association between spirituality and job satisfaction, even though this study will examine spirituality using the concept of sanctification and will assess outcomes in a different work setting (Yusof & Mohamad, 2014; Lazar, 2010; Duffy, 2006; Clark, et al., 2007).

Fifth, if the search for significance of a sacred object or event is violated or not attained, the individual may suffer from loss. Negative events interpreted as violations of the sacred may have implications on an individual's health and well-being (Pargament & Mahoney, 2005). Although more empirical evidence is needed, some notable studies have been conducted, such as romantic relationships among college students (Magyar, Pargament, & Mahoney, 2000), spiritual loss or violation among community residents (Pargament, Magyar, Benore, & Mahoney, 2005), and the 2001 terrorist attack in New York (Mahoney, et al., 2002). These examples indicated that such loss can be shown in negative affect, poor physical and mental health, including anxiety, depression, and feelings of revenge. There are no studies in nursing literature to measure the relationship

between sanctification of work and job burnout, although Maslach and Jackson (1981) showed a positive relationship between meaningfulness of work and personal accomplishment, a dimension of burnout, in human service occupations, including nursing.

Application to the Current Study

Although many nursing studies have described and measured spirituality as it relates to nursing practice, the concept of sanctification of work, a facet of spirituality, is new to nursing. Nursing, as a human service profession, demanding yet rewarding, with a rich religious history, may benefit from applying the sanctification theory to the work setting. This study aims to describe and measure the degree or level of association between sanctification of work, work-related outcomes, and patient satisfaction.

Conceptual Model of the Study

Sanctification theory, developed by Pargament and Mahoney in 2005 and adapted for research by Walker and associates in 2008, served as a guide for this study. The conceptual model for this study added the patient satisfaction variable and other demographic variables suited to the nursing profession. The conceptual model is shown in Figure 1.

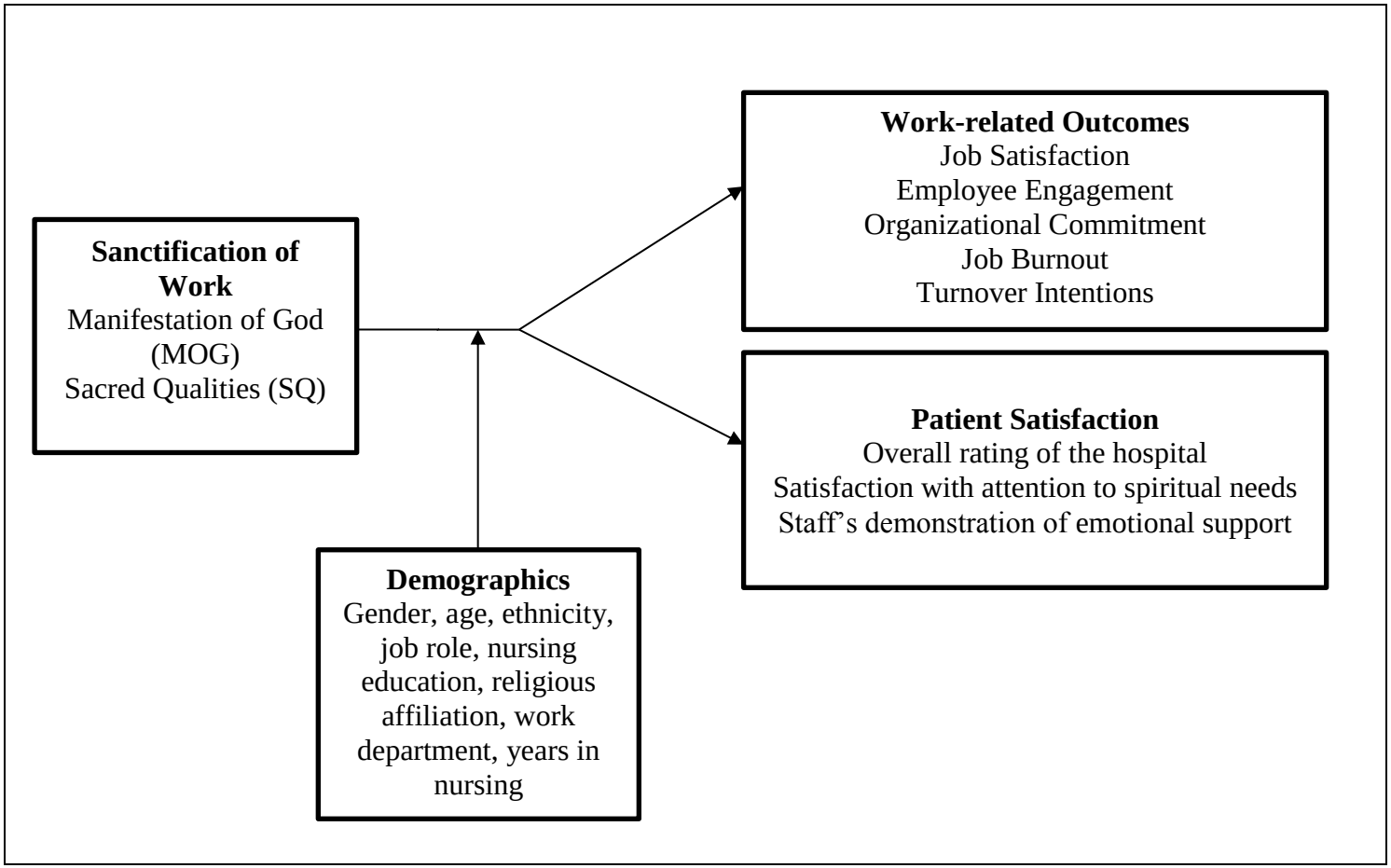

Figure 1. Conceptual model of the study based on Pargament & Mahoney's sanctification theory and Walker et al.'s sanctification of work study

Chapter Summary

This chapter reviewed the evidence about sanctification of work and its relationship with nurse work-related and patient outcomes. This review, based both on research conducted with nurses and with other groups, reveals associations between sanctification of work and various work-related outcomes. In the nursing population, there is a lack of research about sanctification of work and job satisfaction, employee engagement, organizational commitment, job burnout, and turnover intentions, as well as patient satisfaction.

The concept of sanctification has been applied in empirical studies on marriage, parenting, sexuality, body image, among others. Research on the sanctification of work, however, is rare and in its infancy. Describing sanctification of work in the nursing workforce and measuring its association with work-related and patient outcomes may provide insight for healthcare organizations, as it could create implications for staff retention and hiring strategies, as well as the promotion of patient-centered care and patient experiences. Further investigation of these variables will generate useful information to guide future clinical practice, research, education, and policy development in the sanctification of work in the nursing profession.

CHAPTER THREE

METHODS

Research Design

A quantitative, descriptive, cross-sectional, correlational research design was used to describe and measure the association between sanctification of work and work-related outcomes, patient satisfaction, and demographic factors and personnel characteristics.

Assumptions Pertinent to the Study

This study is guided by major theoretical and philosophical assumptions. Assumptions are the basic principles of theory development and testing, grounded from a philosophical paradigm that recognizes beliefs, values, and truths. Hence, it is important to discuss the theoretical and philosophical underpinnings of this study (Meleis, 2012).

Theoretical Assumptions of Sanctification Theory

Sanctification theory, a theory borrowed from the psychology of religion focuses on how people make aspects of their lives, such as work, sacred and sanctified, and as having divine character and significance (Pargament & Mahoney, 2005). Nursing science often utilizes theories borrowed from other disciplines to address nursing phenomenon. In this study, sanctification theory was adapted to describe, explain, and predict nursing questions (Meleis, 2012). Therefore, in this context, we explored the theory of sanctification with the purpose to gain new essence within a nursing perspective.

The five assumptions embedded in sanctification theory presented by Pargament and Mahoney (2005) set the foundation for researching the sanctification of work. These assumptions include:

1. Sanctification is defined as the perception of an aspect of life (an object or event) as having divine character and significance, either as a direct manifestation of God, or presence of sacred qualities, or both.
2. Sanctification is a process with potential relevance to both theists and non-theists.
3. Both theists and non-theists may vary in the aspects of life they hold sacred.
4. Sanctification (individual's perceptions of an aspect of life, object or event) can be examined by scientific methods.
5. Aspects of life (object or event) that represent manifestation of God or sacred qualities, or even both, are not disconnected from people. In fact, they are linked to people through feeling, action, and motivation; this linkage creates a relationship with the sacred and is expressed by example and how people treat others (Pargament & Mahoney, 2005).

These assumptions on sanctification can easily translate to the work setting, particularly in nursing.

Philosophical Assumptions of the Current Study

This study is guided by modern empiricism, also known as post positivism. This worldview incorporates a historical approach to science using empirical methods. It retains the empiricist elements of precision, deductive reasoning, objectivity, and

theoretical claims with valid data, while recognizing the impossibility of verification and the value-laden qualities of theory and observation. The value of the empirical approach focuses on the product or outcome; in this approach, we are able test hypotheses, produce generalizations and explicit measurements, quantify data, and describe results in statistical terms. Although no one study can ever verify a relationship, the data collected can offer strong support for the presence of a relationship that is essential and relevant for clinical practice. Generalizability is an important goal of empirical research, as it allows relationships to be extrapolated to a larger population or different situation. It also allows statistical methods to be used for both exploratory and confirmatory analyses of data; this allows for description of the data and search for potential relationships (Polit & Beck, 2012).

Research Aims, Questions, and Hypotheses

This study addressed the following aims and questions. Hypotheses for each are conjectured.

Aim 1: Determine the relationship between sanctification of work in a theistic view (MOG) and work-related outcomes such as job satisfaction, employee engagement, organizational commitment, job burnout, and turnover intention among licensed and unlicensed nursing personnel, and also demographic and personnel characteristics variables.

Question 1: What is the association between sanctification of work in a theistic view (MOG) and work-related outcomes such as job satisfaction, employee engagement, organizational commitment, job burnout, and turnover intention among licensed and

unlicensed nursing personnel, and also demographic and personnel characteristics variables?

Hypothesis 1: Sanctification of work in a theistic view (MOG) will be positively related to job satisfaction, employee engagement, and organizational commitment. In contrast, sanctification of work will be negatively related to job burnout and turnover intention.

Aim 2: Determine the relationship between sanctification of work in a nontheistic view (SQ) and work-related outcomes such as job satisfaction, employee engagement, organizational commitment, job burnout, and turnover intention among licensed and unlicensed nursing personnel, and also demographic and personnel characteristics variables.

Question 2: What is the association between sanctification of work in a nontheistic view (SQ) and work-related outcomes such as job satisfaction, employee engagement, organizational commitment, job burnout, and turnover intention among licensed and unlicensed nursing personnel, and also adjusting for demographic and personnel characteristics variables?

Hypothesis 2: Sanctification of work in a nontheistic view (SQ) will be positively related to job satisfaction, employee engagement, and organizational commitment. In contrast, sanctification of work will be negatively related to job burnout and turnover intention.

Aim 3: Determine the relationship between sanctification of work in a theistic and nontheistic view and patient satisfaction as demonstrated by emotional support and attention to spiritual needs among nursing departments.

Question 3: What is the association between sanctification of work in a theistic and nontheistic view and patient satisfaction as demonstrated by emotional support and attention to spiritual needs among nursing departments?

Hypothesis 3: Sanctification of work in a theistic and nontheistic view will be positively related to patient satisfaction.

Methods

Sampling

This study used a consecutive sampling approach, considered as the best possible choice when the participants of the study are from a contained accessible population, hence reducing potential biases (Polit & Beck, 2012). The study personnel included licensed and unlicensed nursing personnel working at Adventist Health White Memorial (AHWM) in Los Angeles. AHWM-licensed nursing personnel were comprised of nurse leaders, clinical nurse educators, charge nurses and supervisors, primary care nurses, and nurses working in non-patient care areas, with a total number of 793. AHWM-unlicensed nursing personnel included 112 CNAs, 23 unit secretaries, 12 monitor technicians, 25 emergency medical technicians, 17 mental health workers, and 14 nursing administrative assistants. All licensed and unlicensed nursing-related personnel employed during the study period (April 10-24, 2018) at Adventist Health White Memorial met the inclusion criteria. No exclusion criteria existed, other than non-employees or non-nursing staff at this institution.

Setting

This study purposely selected Adventist Health White Memorial due to its organizational characteristics. AHWM is a 353-bed, not-for-profit, faith-based teaching hospital in the Los Angeles area, and one of the health ministries of the Adventist Health-West system. As a Seventh-day Adventist health ministry grounded in the beliefs, values, and health principles of the Seventh-day Adventist church, it is expected that each employee upholds the mission of living God's love by inspiring health, wholeness, and hope in all that they do. This setting also includes the tradition of deep respect and emphasis on whole-person health by caring for the mind, body and spiritual needs of every patient and every employee regardless of religious affiliation (Adventist Health White Memorial, 2019). This focus likely allows generalizability to other faith-based hospitals.

As a non-profit organization experiencing reduction in government funding, it is worthwhile to study how an attribute such as the sense that work is sanctified affects its nursing staff, and in the process, affects patient and organizational outcomes. That is, it is vital to understand staff attributes that, if fostered, might impact employees, customers, and hospital resources in beneficial ways. Indeed, non-profit organizations are known for their unique attributes as mission-driven, community and service-oriented, quality-focused, and integrating organization values in their daily operations (McMurray, Pirola-Merlo, Sarros, & Islam, 2010).

Recruitment

The study was approved by the Chief Nursing Officer (CNO), who was provided with the study results in order to enhance clinical operations and the recruitment and retention of the nursing workforce. Because the researcher is a nursing leader at the research site, several approaches were taken to win the trust and confidence of participants. First, the researcher met with the AHWM nursing leadership team, then the Shared Governance Council, which is made up of frontline nurses and nurse leaders from every nursing unit/department, and who focus on improvements in several key areas: clinical practice, nursing quality outcomes, rewards, evidenced-based practice and nursing research. Second, the researcher provided an overview of the study and personally invited potential respondents to complete the hard copy questionnaire during their regular staff meeting. Third, the announcement information for study participation included the purpose of the study, recruitment criteria, a brief overview of the procedure, assurances of protection of privacy and confidentiality, the benefits of participation, and the researcher's contact information. Fourth, printed and digital announcements were released prior to recruitment to improve staff awareness of the study and the criteria for participation. Fifth, an incentive of a $10 Target gift card was given to those who completed the survey. In addition, a recruitment email was distributed to all nursing-related staff who were absent from the staff meetings in which the study was introduced.

A sample size of 435 achieved 80% power to detect an R^2 of 0.02 attributed to one independent variable, using an F-Test with a significance level (alpha) of 0.05. The variables tested were adjusted for an additional 15 independent variable(s) with an R^2 of

0.10 and 20% non-response rate. Given the method for recruiting subjects, it was anticipated that few would decline to participate.

Protection of Human Subjects

Approval from the Loma Linda University Institutional Review Board Human Subjects Committee (IRBHSC) was obtained prior to data collection, along with approval from the AHWM Research Committee. The study was presented to the AHWM nursing leadership team to enhance participation of nursing staff during the survey period. The researcher described the purpose and procedure of the study, and time was provided for potential respondents to ask questions or express concerns about their participation. The researcher provided assurance that the data collected would be anonymous, kept confidential, and reported in aggregate. Likewise, staff were assured that their employment would not be affected, whether or not they participated in the study. The researcher also assured the potential respondents that they could decline during the process if they so desired. A waiver of signed consent was attached to the front of the questionnaire, informing participants that submission of their responses constituted consent. The consent took place on the day of a staff meeting at the AHWM campus for participants who voluntarily participated in the survey. Minimal risk for the respondents was anticipated to complete the survey.

Data Collection Procedure

A list of staff and unit meeting schedules were obtained from the nurse managers. On the day of a staff meeting, the researcher presented the purpose of the study and

reviewed the components of consent. The time spent completing the survey was part of the staff meeting time. Time was allotted for completion of the survey, which took most respondents an average of 15 minutes to complete. The researcher waited in the hallway outside the staff meeting room to respond to any queries or concerns the questions might generate for respondents.

Participants were advised to return completed questionnaires to either a neutral third party waiting near the staff meeting room (with the incentive gift), or to the Education and Training department coordinator (who could give out the incentive gift). This person also kept record of those who participated and received a gift card so that no redundant response could be submitted. Once collected, the completed surveys were stored in the researcher's office in a locked drawer only accessible to the researcher. After data were entered into the researcher's password-protected personal computer, the file also was password protected. The hard copies of questionnaires are stored and will be destroyed per university policy following completion of the study. However, data is kept for 3 years after completion of the study.

Results were shared with the division of nursing through staff meetings, Shared Governance meetings, and other meeting venues.

Measures of Concepts

Data were collected using standardized, psychometrically evaluated questionnaires. These included *The Duke University Religion Index (DUREL), Sanctification of Work Scale, Overall Job Satisfaction Scale, Employee Engagement Scale, Affective Commitment Scale (Organizational), abbreviated Maslach Burnout*

Inventory (a-MBI), Turnover Intention Scale, and *Demographics and Personnel Characteristics.* There are 82 items on the survey questionnaire. (Please see Appendix A for a complete copy of the questionnaire.) The Patient Satisfaction results were obtained from HCAHPS through NRC via the AHWM Organizational Performance Department.

The Duke University Religion (DUREL) Index

The Duke University Religion (DUREL) Index (Koenig & Bussing, 2010), is designed to measure three major dimensions of religiosity among individuals living in cultures dominated by Western religions (i.e., Christianity, Judaism, and Islam). It is a 5-item measure that assesses organizational religious activity (ORA), non-organizational religious activity (NORA), and intrinsic religiosity (IR). ORA focuses on public religious practices such as attending church or other religious gatherings, while NORA includes private religious practices such as devotion, prayer, scripture study, or meditation. IR refers to the impact of spiritual beliefs and values of the individual in daily living. The first two dimensions originated from the large National Institutes of Health studies in North Carolina, while the third dimension came from Dean Hoge's 10-item Intrinsic Religiosity Scale generated from a 20-item Intrinsic-Extrinsic scale by Allport and Ross (1967). These three scales cannot be summed. This instrument has been tested using cross-sectional and longitudinal studies around the world and translated into 10 languages.

The overall scale has excellent psychometric properties, with high test-retest reliability (intra-class correlation = 0.91), high internal consistence (Cronbach's alpha's = 0.78-0.91), and high convergent validity with other measures or religiosity (r's = 0.71-

0.86). Each dimension is measured individually: IR = three items, the other two, ORA and NORA, are each one item (Koenig & Bussing, 2010).

Sanctification of Work Scale

The *Sanctification of Work Scale* (Walker, et al., 2008) originated from the *Sanctification Scale* developed by Mahoney and associates for marriage research (1999). It has two subscales: the Manifestation of God (MOG) scale with 14 items, and the Perceived Sacred Qualities (SQ) scale, with 9 items (Mahoney, et al., 1999). Slight revisions were made to the MOG subscale and SQ subscale for use in the sanctification of work study. The 12-item MOG scale, also known as a theistic scale, measures the extent to which individuals perceive God as having significance in their work. MOG response options include 7-point Likert scales from 1 (*strongly disagree*) to 7 (*strongly agree*). The 10-item SQ scale, also called a nontheistic scale, assesses how much an individual's perception of work contains divine qualities. Divine qualities include adjectives such as holy, miraculous, inspiring, blessed, or eternal, but do not specifically refer to God or a Higher Being. The adjectives can be measured from 1 (*does not describe at all*) to 7 (*very closely describes*).

The sanctification scale has been used in sanctification studies specific to marriage, parenting, and sexuality (Hernandez, Mahoney, & Pargament, 2011; Walker et al., 2008). The internal consistency of the MOG scale ranges from 0.97-0.98 (Mahoney, Carels, et al., 2005; Mahoney, Pargament, et al., 2005; Walker, et al., 2008). The SQ scale's internal consistency remained 0.95 across these same studies.

Overall Job Satisfaction Scale

The Overall Job Satisfaction Scale originated from Brayfield-Roth in 1951, then was adapted by Judge, Locke, Durham and Kluger (1998), and applied by Duffy, Bott, Allan, Torrey, and Dik (2012). This instrument was used by Duffy and associates (2012) in their study of calling and job satisfaction among a wide array of occupational fields, including business, customer service, education, and accounting. The concept of living was measured as perceptions of career commitment and work meaning. The 5-item overall job satisfaction scale includes a 7-point Likert scale from 1 (*strongly disagree*) and 7 (*strongly agree*).

Psychometric properties reported by Judge, et al., (1998) include a reliability of 0.88 and discriminant validity of 0.89 from a sample of university employees from two countries. In 2012, Duffy conducted a job satisfaction study among adults of different ethnicities from a wide array of occupations. In that study, Duffy found internal consistency reliability of 0.88. In 2014, Duffy's longitudinal study on work well-being among 217 fulltime or part-time employed adults who completed three waves of testing, showed internal consistency reliability of 0.91, 0.92, and 0.92.

Employee Engagement Scale

The measure of employee engagement selected is grounded on *Kahn's Theory of Employee Engagement,* that identifies three conditions conducive to engagement, namely psychological meaningfulness, psychological safety, and psychological availability (May, et al., 2004). The psychological meaningfulness scale is a 6-item measure that assesses the degree of meaning that individuals discover in their work-related activities. The

second subscale, measuring psychological safety, is a 3-item scale that assesses the degree of freedom to perform one's job role without feeling threatened in the workplace. The third subscale, which quantifies psychological availability, is a 5-item measure that assesses the level of psychological presence at work (Spreitzer, 1995). The three subscales use a 5-point Likert format with 1 (*strongly disagree*) and 5 (*strongly agree*) as anchors.

The internal consistency for the psychological safety and psychological availability based from Kahn's study (1990) revealed a Cronbach's alpha of 0.71 and 0.85, respectively. Similarly, Spreitzer (1995) adapted the concept of psychological meaningfulness as one of the dimensions of the multifaceted concept of empowerment in her study of 393 managers from an industrial company. The Cronbach's alpha for psychological meaningfulness was 0.90.

Affective Commitment Scale (Organizational)

The development of the *Organizational Commitment Scale (OCS)* was based on Jackson's (1970) different stages of test construction principles (construct as a theoretical concept of varying degrees of abstraction or generalizability) and developed by Meyer and Allen in 1984 (McGee & Ford, 1987). The *Affective Commitment Scale (ACS)* is an 8-item measure that assesses the personal commitment by an individual to the organization as evidenced by feelings of attachment to the organization, and involvement in and identification with the organization. The OCS has three dimensions that include affective, continuance, and normative commitment. Each dimension measures commitment independently, with affective commitment as the attitudinal domain, and

continuance as the behavioral domain. These two dimensions were published by Meyer and Allen in 1984; the normative dimension was added in 1990. The responses use a 7-point Likert format with 1 (*strongly disagree*) to 7 (*strongly agree*) (Allen & Meyer, 1996).

The psychometric properties of ACS show a median alpha coefficient of 0.85 across studies (Allen & Meyer, 1996). Walker, et al.'s (2008) study on sanctification of work used the ACS and showed a Cronbach's alpha of 0.85. Allen and Meyer (1996) examined the construct validity of affective, continuance, and normative commitment scales as used in assessing organizational commitment, and found that the test-retest reliabilities in cross-sectional studies and one longitudinal study were within a median co-efficient of 0.85 and consistent with comparable measures such as the Organizational Commitment Questionnaire. McGee and Ford (1987) supported the finding that ACS differs from the Continuance Commitment Scale (CCS), which measures overt benefits such as rewards and recognition.

Abbreviated-Maslach Burnout Inventory (Job Burnout)

The Maslach Burnout Inventory (MBI) is designed to measure aspects of burnout syndrome. The original MBI scale was developed by Maslach and Jackson in 1981 with 22 items (Maslach & Jackson, 1981; Vanhuele, Rosseel, & Vlerick, 2007). The abbreviated version of the MBI (a-MBI) is a 9-item tool developed by McManus, Winder, and Gordon in 2002. The scale uses a 7-point Likert scale with response ranging from 0 (*never*) to 6 (*everyday*). The *abbreviated-MBI (a-MBI)* maintained the three subscales of emotional exhaustion (EE), depersonalization (DP), and personal

accomplishment (PA). The EE has four items, the DP has two, and the PA has three (McManus, et al., 2002).

The MBI has been used in different work settings. In Maslach and Jackson's (1981) initial study, the reliability coefficients for the subscales yielded 0.89 (frequency) and 0.74 (intensity) for EE, 0.77 (frequency) and 0.72 (intensity) for DP, and 0.74 (frequency) and 0.74 (intensity) for PA. In the 2002 study by McManus, et al., of 551 doctors, the causal association between burnout and stress revealed Cronbach's alpha of 0.85, 0.59, and 0.64, respectively. The factor analysis confirmed the presence of the three factors: emotional exhaustion, depersonalization, and personal accomplishment.

Turnover Intention Scale

The original 3-item *Turnover Intention Scale* from Mobley and associates (1979) was revised by Cohen (1999) into three subscales using the same items but replacing the term "organization" with "job" and "occupation." The term "organization" in this context means the individual's identification with their workplace (Blau & Boal, 1989); "job" is defined as the perceived value of work itself (Mobley, et al., 1979), and "occupation" is described as the profession itself (Cohen, 1999). The 9-item scale is measured with a 5-point range with 1 (*strongly agree*) and 5 (*strongly disagree*); the higher scores denoted weaker turnover intentions. A 1999 study by Cohen on turnover intention among Arab and Jewish nurses used the 9-item Turnover Intention Scale with three subscales, and reported Cronbach's alphas of 0.94, 0.89, and 0.92, respectively.

HCAHPS Survey (Patient Satisfaction Survey)

The *HCAHPS Survey* is a 32-item, standardized survey instrument that has been in use since 2006. The HCAHPS measures patients' perceptions of their hospital experience, including patient satisfaction. This survey provides the public with comparable information on hospital quality, identifies hospital incentives for quality of care, and serves as an instrument in enhancing accountability and transparency of hospitals on the quality of care provided to patients. AHWM's participation in the CMS Hospital Value-Based Purchasing (Hospital VBP) program, which rewards acute care hospitals for the quality of care they provide to Medicare patients, identified eight HCAHPS measures, called dimensions. . The six HCAHPS composites include Communication with Nurses, Communication with Doctors, Staff Responsiveness, Pain Management, Communication about Medicines, and Discharge Information, along with one composite that combines Cleanliness and Quietness items. The last dimension is a global item, the Overall Rating of the Hospital (HCAHPS Fact Sheet, 2017). Two supplemental questions were added by AHWM to assess spiritual care: the first item focuses on satisfaction with attention to spiritual needs, and the second item measures staff members' demonstration of emotional support. The data for supplemental questions were obtained from the AHWM's Organizational Performance Department.

Adventist Health-White Memorial partnered with a survey vendor, the National Research Corporation (NRC), to conduct the HCAHPS survey with a random sample of adult inpatients between 48 hours and 6 weeks after discharge. Eligible participants are patients admitted in the medical, surgical, and maternity care service lines. Data collection was done through mail, telephone, mail with telephone follow-up, or

interactive voice recognition (IVR). Similarly, for patients in the Emergency Department (ED), a survey was also provided in the outpatient setting. The questionnaire came in English, Spanish, Chinese, Russian, Vietnamese, and Portuguese versions. The NRC provides real-time reports every month and annually; the results from these reports identify areas for organizational change and improvement, and an opportunity to understand the patient experience with greater depth and clarity (HCAHPS QA Guideline, Version 12, March, 2017).

The HCAHPS Survey evolved through a rigorous research process that included instrument development, pilot testing, psychometric analyses and numerous small-scaled field tests until it was launched in October 2006 with the support from National Quality Forum and Centers for Medicare and Medicaid Services (CMS). In March 2008, the first public reporting was published and used as a national database for hospital comparison (HCAHPS Fact Sheet).

Demographics and Personnel Characteristics

The characteristics of the participants and other demographics information were assessed. This section of the survey included items assessing gender, age, marital status, ethnicity, job role, work shift, highest healthcare-related education, religious affiliation, work department, years in nursing, and years of service in the organization. These were developed by the researcher. The religious affiliation was initially classified into 10 groups (Agnostic/Atheist, Catholic, Non-denominational, Protestant, Seventh-day Adventist, Jewish, Muslim, None, Secularist/Humanist, and Other (Table 2). However, this variable was further categorized into seven groups to combine low frequency

religious affiliation such as Jewish, Antiochian Orthodox, Muslim, Secularist/Humanist, Buddhist, Free Thinker/Free Thought, and Episcopalian as “other groups.”

Analysis Plan

Data Preparation and Management Plan

Upon obtaining the questionnaires from participants, completeness of the survey was checked by the researcher at the point of survey location for missing data or error prior to data entry. Each case was numbered, and an electric data file and codebook was created as a reference for data. Missing data were not ignored. Data were entered into a Microsoft Access database and then analyzed using Statistical Analysis System, version 9.3 (SAS; SAS Institute Inc., Cary, NC).

Analysis Plan

Descriptive statistics, including measures of central tendency and frequency, initially were used to analyze all variables and clean the dataset. Cronbach's alpha was used to assess the internal reliability of the items for the DUREL intrinsic religiosity subscale, Overall Job Satisfaction, Employee Engagement, Affective Commitment, Maslach Burnout Inventory, and Turnover Intention scale variables.

A robust linear regression was then used to explore the relationships between dependent variables and independent variables (Table 1). Prior to running the regression analyses, assumptions of normality were checked; residuals were found to be normally and randomly distributed with no outliers (see Appendix B, Figures 1 & 2). Alpha was set at 0.05 significance level. Various models were computed. Initially, models with only

demographic variables were run (i.e., Models 1 and 2); next, adjusting for these demographic variables, a model that included all the major study variables was run (i.e., Model 3).

Table 1. *Statistical Method for Each Research Question*

Research Questions	Measures	Statistical Procedures
1. What is the association between sanctification of work in a theistic view (MOG) and work-related outcomes such as job satisfaction, employee engagement, organizational commitment, job burnout, and turnover intention among licensed and unlicensed nursing personnel, and also demographic and personnel characteristics variables?	Sanctification of Work Scale – MOG subscale, DUREL Index, Overall Job Satisfaction, Employee Engagement Scale, Affective Commitment Scale, Maslach Burnout Inventory, Turnover Intention Scale, Demographic and Personnel Characteristics	Robust Linear Regression, Model 3
2. What is the association between sanctification of work in a nontheistic view (SQ) and work-related outcomes such as job satisfaction, employee engagement, organizational	Sanctification of Work Scale – SQ subscale, DUREL Index, Overall Job Satisfaction, Employee Engagement Scale, Affective Commitment Scale, Maslach Burnout Inventory,	Robust Linear Regression, Model 3

commitment, job burnout, and turnover intention among licensed and unlicensed nursing personnel, and also demographic and personnel characteristics variables?	Turnover Intention Scale, Demographic and Personnel Characteristics	
3. What is the association between sanctification of work in a theistic and nontheistic view and patient satisfaction as demonstrated by emotional support and attention to spiritual needs among nursing departments?	Sanctification of Work Scale – MOG subscale, Sanctification of Work Scale – SQ subscale, NRC Data-HCAHPS Survey, Demographics and Personnel Characteristics	Robust Linear Regression, Model 2

Chapter Summary

In this chapter, the details of the methodology for a study intended to measure associations of sanctification of work among nursing staff and various work-related and patient outcomes were presented. A quantitative research design was introduced that was reflective of a post-positivist philosophy, as well as assumptions emanating from the sanctification theory that is pertinent to this study. The research aims, questions, and hypotheses that guide the study were then presented. The sampling method, data collection procedure, the measures of the concepts, and analysis plan were discussed.

CHAPTER FOUR

FINDINGS

Introduction

The purpose of this study was to measure associations between the sanctification of work and work-related outcomes among nursing personnel, and satisfaction with care among patients. Data collection was conducted from April 10-24, 2018. Data were analyzed using Statistical Analysis System (SAS) software. The findings are presented as follows: (a) setting and sample, (b) reliability of the measures, (c) descriptive data analysis of the variables under study, and (d) findings addressing the research questions.

Setting and Sample

Setting

Participants were recruited from a non-profit, faith-based teaching hospital in the urban setting of Los Angeles, California. The study site was a hospital that mainly cares for the underserved community of East Los Angeles and its neighboring cities. According to its motto, it integrates the mission of "living God's love by inspiring health, wholeness, and hope" not only for the community it serves, but to anyone it touches. The hospital is grounded in the principles of whole person care, in which spiritual care is valued and expected for patients and staff alike.

Sample

The sample consisted of 463 licensed and unlicensed nursing personnel who agreed to participate in this study. Demographic characteristics of nursing personnel are

presented in Table 2. The mean age was 42.04 (*SD* = 12.54) years, with an age range from 22 to 73 years. Most were female (*n* = 368, 81.42%), worked the day shift (*n* = 291, 64.38%), were bedside nurses (*n* = 289, 63.94%), BSN-prepared (*n* = 226, 60%), and Roman Catholic (*n* = 270, 59.73%). The two most frequent ethnicity categories were Hispanic (*n* = 204, 45.13%) and Asian (*n* = 191, 42.26%). Almost half of the respondents were in their current profession for more than 10 years (*n* = 211, 46.68%), while most participants worked at the study site either less than 5 years (*n* = 194, 42.92%) or more than 10 years (*n* = 158, 34.96%).

Table 2. *Demographic and Work-related Characteristics of Study Participants (N = 463)*

Variable		*n (%)*
Gender	Male	84 (18.58)
	Female	368 (81.42)
Ethnicity	Asian	191 (42.26)
	Hispanic	204 (45.13)
	Others	75 (12.61)
Current Role	ED RN/EMT	29 (6.42)
	Bedside Nurse/Charge Nurse	289 (63.94)
	Support Staff (i.e. CNA, MHW, surgical tech)	75 (16.59)
	Other (e.g., nurse manager, nurse director, nurse educator, case manager, coordinator)	59 (13.05)
Highest Healthcare-related Education	LVN/ADN	112 (24.78)
	BSN	226 (50)

	MSN/Doctoral	29 (6.42)
	Other (i.e. surgical tech certificate, high school graduate)	85 (18.81)
Religious Affiliation	Agnostic/Atheist	12 (2.6)
	Christian/Catholic/Orthodox	277 (59.8)
	Christian/Non-denominational	54 (11.7)
	Christian/Protestant/Episcopalian	40 (8.6)
	Christian/Seventh-day Adventist	41 (8.9)
	Jewish	3 (0.6)
	Muslim	1 (0.22)
	None	29 (6.3)
	Secularist/Humanist	2 (0.9)
	Buddhist	4 (0.9)
Years Worked in Current Profession	< 5 years	142 (31.42)
	5 - 10 years	99 (21.9)
	> 10 years	211 (46.68)
Work Shift	Day	291 (64.38)
	Evening**	9 (1.99)
	Night	125 (27.65)
	Variable	19 (4.2)
	Office Hours	8 (1.77)
Years Worked in AHWM	< 5 years	194 (42.92)
	5 – 10 years	100 (22.12)

	> 10 years	158 (34.96)
Unit/Department*	Medical Surgical/Cancer Center/Continuum of Care	99 (21.9)
	Women and Children Services	61 (13.5)
	Behavioral Health/ Intensive Care Unit/Emergency Department	70 (15.49)
	Telemetry/Resource Pool/Staffing Office	115 (25.44)
	Perioperative Services/Cath Lab	67 (14.82)
	Others (i.e. Nursing Administration, Education & Training)	40 (8.85)

*Clustered along service lines of the organization (e.g., most resource pool staff are assigned to work in telemetry).
**Evening shift –is usually the middle shift, in between the typical day shift.

Reliability of the Measures

This study aimed to determine the relationship between sanctification of work and work-related outcomes, and the relationship between sanctification of work and patient satisfaction. Influencing factors of age, gender, ethnicity, education, religious affiliation, work shift, years in current profession, and years of service to the organization were controlled accordingly. The tools used in the study included (a) The Duke University Religion Index (DUREL); (b) Sanctification of Work Scale; (c) Overall Job Satisfaction Scale; (d) Employee Engagement Scale; (e) Affective Commitment Scale; (f) abbreviated Maslach Burnout Index (a-MBI); and (g) Turnover Intention Scale. Reliability of the measures are presented in Table 3. Previous psychometric evaluation of these tools demonstrated acceptable reliability and validity; therefore, in this study they were tested

only for internal reliability. Cronbach's alpha was used to assess the internal reliability of the different scales.

Internal reliability of most of the tools, assessed using Cronbach's alpha, met the criteria of above 0.80 for the whole scale and 0.70 for the subscale. In the DUREL Index, only the Intrinsic Religiosity (IR) subscale had a Cronbach's alpha, since it met the criteria of at least three items. The 12-item Manifestation of God (MOG) and 10-item Sacred Qualities (SQ), subscales of the Sanctification of Work Scale, revealed Cronbach's α of 0.98 (for MOG) and 0.95 (for SQ), respectively. The Overall Job Satisfaction Scale had a modest Cronbach's α of 0.70 and was considered acceptable, while the Psychological Conditions scale (employee engagement) showed 0.84. The Cronbach's α for Affective Commitment scale, a-MBI, and Turnover Scale were 0.78, 0.79, and 0.95, respectively.

Table 3. *Internal Reliability of Measures*

Scale Name	Number of Items	Cronbach's alpha
Duke University Religion Index (DUREL) Index: Organizational Religious Activity (ORA) subscale	1	N/A
Duke University Religion Index (DUREL) Index: Non-organizational Religious Activity (NORA subscale	1	N/A
Duke University Religion Index (DUREL) Index: Intrinsic Religiosity (IR) subscale	3	0.88
Sanctification of Work Scale: Manifestation of God (MOG) subscale	12	0.98
Sanctification of Work Scale: Sacred Qualities (SQ) subscale	10	0.95
Overall Job Satisfaction	5	0.70
Employee Engagement Scale: Psychological Conditions Scale	14	0.84
Affective Commitment Scale	8	0.78
abbreviated Maslach Burnout Index (a-MBI)	9	0.79
Turnover Intention Scale	9	0.95

Note: N/A = not applicable

Descriptive Data Analysis of the Study Variables

Characteristics of the Measures

Descriptive statistics indicated measurement of each major concept is presented in Table 4; the mean ± standard deviation, median, range, and total scale for these quantitative variables provide numeric description of the variables.

Descriptive Statistics for Major Concepts

The Duke University Religion (DUREL) Index

The religiosity of the participants was measured by the DUREL Index, which consists of three subscales. The first subscale, Organizational Religious Activity (ORA), has one item and the responses can range from 1 (*never*) to 6 (*more than once a week*); it is averaged by the item score. The higher the score, the more frequently the participants attend church or other religious meetings. The second subscale known as the Non-Organizational Religious Activity (NORA) consists of one item, with response options ranging from 1 (*rarely or never*) to 6 (*more than once a day*) and it is averaged by the item score. The higher the score, the more frequently nursing personnel spent time in private religious activities. The last subscale, Intrinsic Religiosity (IR), includes three items with response options ranging from 1 (*definitely not true*) to 5 (*definitely true*). Item responses are summed. The higher the score, the more participants have integrated spirituality throughout their lives, potentially ranging from 1-6See Table 4 and Appendix C, Table 1

Sanctification of Work Scale

Sanctification of work of nursing personnel was measured by the Sanctification of Work scale. The two major subscales of Manifestation of God and Sacred Qualities were used for analyses.

Manifestation of God (MOG) subscale

The item scores of the 12-item MOG subscale ranged from 1 (*strongly disagree*) to 7 (*strongly agree*), with responses ranging from 12-84. The overall score for each scale was calculated by taking the average of all items of that scale. The higher the scale score, the higher the perception of sanctified work. The item average of 5.72 (*SD* = 1.57; *Mdn* = 6.08, with a possible range of 1-7 for each item) was obtained from this study sample; scores ranged, however, between 1 and 7. The scale total was 68.63. See Table 4.

The 12 MOG item means and *SDs* obtained (Appendix C, Table 2) were similar. The highest means were for the items of *God played a role in the development of my job* (*M* = 5.94, *SD* = 1.60) and *God is present in my work* (*M* = 6.11; *SD* = 1.49). Although the lowest mean score was for the item, *Actions surrounding my job follow the Holy Writings of my faith and/or religion* (*M* = 5.48; *SD* = 1.66), it still indicated that these respondents experienced a fairly high sense of sanctification of work.

Sacred Qualities (SQ) subscale

The 10-item SQ subscale response options range from 1 (*very closely describes*) to 7 (*very unclosely describes*), and the scale score is calculated by averaging all item scores. The lower the score, the higher the perception of sanctified work. In this sample, the observed items averaged 2.52 (*SD* = 1.16; *Mdn* = 2.30; range 1 – 7), indicating fairly

high and unfluctuating SQ. The responses potentially ranged from 10-70. (See Table 4 and Appendix C, Table 3.) This finding strongly indicated that the nursing personnel viewed work as sanctified.

Overall Job Satisfaction Scale

The response options for the five items of the Overall Job Satisfaction scale range from 1 *(strongly disagree*) to 7 (*strongly agree*), and the scale score is the average of all the item scores. The higher the score, the more satisfied the nursing personnel was with their work. Responses to this scale ranged from 5-35. The item mean observed in this sample was 5.36 (*SD* = 1.07; *Mdn* = 5.60; range = 2–7). See Table 4.

The item means and *SD*s of this scale (Appendix C, Table 4) were similar. The highest ranked item *I find real enjoyment in my work (SD* = 1.27; *Mdn* = 5.84) indicated the level to which participants perceived their work as fulfilling and satisfying.

Employee Engagement Scale

Employee engagement was measured by a 14-item scale assessing the psychological conditions of meaningfulness, safety, and availability that are conducive to engagement. The item response options range from 1 (*strongly disagree*) to 5 (*strongly agree*), and the scale score is the average of all the item scores (Appendix C, Table 5). Higher scores indicated that respondents' were more likely to see their work as meaningful, have a lower feeling of threat in the workplace, and a greater sense of a healthy psychological presence at work. The responses ranged from 14-70. The observed item average scores were between 2.07 and 5 (*M* = 4.31, *Mdn* = 4.43; *SD* = 0.47),

indicating strong agreement that participants were engaged at the study site. See Table 4. The highest ranked item, *the work I do on this job is very important to me*, produced a mean score of 4.67 (*SD* = 0.59). This verifies the overall score that demonstrated these nursing study participants were very engaged at work.

Affective Commitment Scale (Organizational)

Respondents' organizational commitment was measured by an 8-item Affective Commitment Scale, which produces scores ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The scale score is calculated by summing the item scores; the higher the score, the greater the perception of organizational commitment. The actual score was between 1 and 7 (*M* = 5.14*; Mdn = 5.25; SD* = 1.03). The responses ranged from 8-56. The descriptive statistics for these items are presented in Table 4 and Appendix C, Table 6. Responses to each item were similar, with an average item score of 5.14 (*SD* = 1.03, with a potential range of 1 - 7). These findings depict the level to which nursing participants in this study were personally committed to the organization through feelings of attachment to the organization, involvement in, and identification with the organization.

Abbreviated-Maslach Burnout Inventory (Job Burnout)

Job burnout was measured by Maslach's 9-item abbreviated Burnout Inventory; its item response options range from 0 (*never*) to 6 (*daily*), and the scale total score is the average of all the item scores. The higher the score, the more frequently the nursing personnel perceived burnout at work. The responses ranged from 9-63. The average item

score ranged from 0.33 to 5.00 (*M* = 1.71*; Mdn* = 1.56; *SD = 0.88*). (See Table 4.) Item means and *SDs* of this scale are presented in Appendix C, Table 7. Findings indicate that, overall, these respondents experienced little burnout. The item *I feel emotionally drained from my work,* had the highest score, with a mean of 2.86 (*SD* = 1.52), suggesting a low level of burnout.

Turnover Intention Scale

Item scores of the 9-item Turnover Scale can range from 1 (*strongly disagree*) to 5 (*strongly agree*); the scale total score is averaged of its item scores. The lower the scale score, the lower the intention to leave. The observed score on an item was between 1 and 5 (*M* = 1.82*; Mdn* = 1.67; *SD* = 0.84). See Table 4. The responses ranged from 9-45. Thus, dedication and loyalty to the organization, job, and occupation or profession were strongly felt in this sample.

The item means and *SD*s of this scale (Appendix C, Table 8) indicated that turnover intention among respondents was fairly low and consistent (*SD* = 0.84). The items with the highest means included, *I think a lot about leaving the organization* (*M* = 2.11; *SD* = 1.07), and *I am actively searching for an alternative to the organization* (*M* = 2.00; *SD* = 1.04). However, the lowest means were for items describing the thought of leaving their occupation or profession (*M* = 1.67; *SD* = 0.96) and the urgency of leaving their occupation or profession (*M* = 1.62; *SD* = 0.91). Thus, these nursing study participants were not thinking of leaving the organization, their occupation, or profession.

HCAHPS Survey (Patient Satisfaction Survey)

Data from two supplemental questions added by the study site organization to a standardized patient satisfaction measure (i.e. Hospital Consumer Assessment of Healthcare Providers and Systems) were used to measure how study variables were associated with patient satisfaction. These items asked discharged patients about the quality of the emotional and spiritual care they received while hospitalized. For patients receiving care in an outpatient setting, only the emotional support item was used. Response options to both items ranged from 1 (*never*) to 4 (*always*). The data were obtained from the National Research Corporation (NRC) through the study site's Organizational Performance Department. Thus, only the percentile ranking for each department was obtainable (not individual patient data).

Table 4. *Characteristics of Major Concepts: Measures of Central Tendency (N = 463)*

	Range of Responses		*Median for Item Means*	*Mean of Item Means (SD)*	*Scale Total (SD)*
	Number of items (number response options)	Observed range of responses			
DUREL: Organizational Religious Activity (ORA)	1 (6)	1 - 6	4.00	3.65 (1.42)	3.65 (1.42)
DUREL: Non-organizational Religious Activity (NORA)	1 (6)	1 - 6	3.00	3.22 (1.79)	3.22 (1.79)
DUREL: Intrinsic Religiosity (IR)	3 (5)	1 - 5	4.33	4.16 (0.98)	12.49 (2.95)
Sanctification of Work: MOG	12 (7)	1 - 7	6.08	5.72 (1.47)	68.63 (17.59)
Sanctification of Work: SQ	10 (7)	1 - 7	2.30	2.52 (1.16)	25.22 (11.65)
Overall Job Satisfaction	5 (7)	2 - 7	5.60	5.36 (1.07)	26.82 (5.33)
Employee Engagement	14 (5)	2.1 - 5	4.43	4.31 (0.47)	60.37 (6.60)
Affective Commitment	8 (7)	1 - 7	5.25	5.14 (1.03)	41.12 (8.28)
Job Burnout	9 (7)	0.3 - 5	1.56	1.71 (0.88)	15.36 (7.93)
Turnover Intention	9 (5)	1 - 5	1.67	1.82 (0.84)	16.38 (7.55)

Note: *SD* = standard deviation

Inferential Analysis of the Study Variables

Findings Addressing the Research Questions

Associations Between Sanctification of Work: Manifestation of God and Other Study Variables

Associations were first explored between sanctification of work (using the Manifestation of God subscale) and work-related outcomes, demographics, and other respondent characteristics. Work-related outcomes such as employee engagement (p = <0.001), and affective commitment (p = 0.005) were positively correlated with sanctification of work (see Table 5). That is, respondents who reported feeling more engaged and committed at work were more likely to perceive God as having significance on their work. On the other hand, regression modeling showed that for each 1 unit decrease in job satisfaction, the perception of work as sanctified decreased by 0.12 units (p = 0.008).

The three indicators of religiosity measured by the DUREL Index were all positively associated with MOG (see Table 5). That is, for every 1-unit increase in organized religiosity (e.g., frequency of attendance religious services), it showed a 0.24 unit increase in MOG (95% CI = 0.18, 0.29; p<0.001). Non-organizational religiosity (i.e., private devotional experience), although significantly predictive, was less influential on MOG (B=0.15; 95% CI 0.11, 0.20; p<0.001). Intrinsic religiosity, or the pervasiveness of one's faith in one's life, was substantially predictive; for every 1-unit increase, MOG increased 0.78 units (95% CI = 0.69, 0.86; p<0.001).

Demographic and other respondent characteristics likewise showed associations with sanctification of work. On average, females (p = 0.001) scored 0.29 points higher

than males on their perception of the divine significance in their work. Respondents with no religious affiliation (p = <0.001) were 1.41 points lower than Catholics for sanctification of work specific to the MOG subscale, whereas agnostic/atheist respondents (p = <0.001) were 2.40 points lower than Catholics. Compared to Catholics, those categorized as "Other" religious affiliations were 0.43 points lower in their perception of divine significance in their work (p = 0.029). Table 5 presents the beta estimates, confidence intervals, and p-values.

For the model presented in Table 5, 72% of the variability in MOG was explained by the study variables. Thus, 28% of the variability in MOG remained unexplained. The explanatory value of each independent variable is as follows: DUREL: Organizational Religious Activity (B = 0.24, 95% CI = 0.18, 0.29, p value <0.001); DUREL: Non-Organizational Religious Activity (B = 0.15, 95% CI = 0.11, 0.20, p value = <0.001); DUREL: Intrinsic Religiosity (B = 0.78, 95% CI = 0.69, 0.86, p value = <0.001); Job Satisfaction (B = -0.12, 95% CI = -0.21, -0.03, p value = 0.008); Employee Engagement (B = 0.46, 95% CI = 0.28, 0.64, p value = <0.001), Affective Commitment (B = 0.12, 95% CI = 0.04, 0.21, p value = 0.005); female (vs. male) (B = 0.29, 95% CI = 0.12, 0.46, p value = 0.001); Agnostic/Atheist (vs. Catholic) (B = -2.40, 95% CI = -2.93, -1.87, p value = <0.001); having no religious affiliation (vs. Catholic) (B = -1.41, 95% CI = -1.76, -1.06, p value = <0.001), and other religious affiliations (i.e., Anthiocian Orthodox, Buddhism, Episcopalian, Free Thinker/Thought, Spiritual) rather than Catholic (B = -0.43, 95% CI = -0.80, -0.06, p value = 0.022).

Variables not found to be associated with sanctification of work measured using the MOG subscale were job burnout, turnover intention, age, ethnicity, current job role,

education, unit/department, years in current profession, years worked at the study site, specific religious affiliations, and work shift.

Table 5. *Robust Linear Regression Report on Variables Associated with Sanctification of Work – Manifestation of God (MOG) (N= 451)*

Variables Associated with Sanctification of Work – Manifestation of God (MOG)	B	95% Confidence Interval Limits	P-value
DUREL: Organizational Religious Activity (ORA)	0.24	0.18, 0.29	<0.001
DUREL: Non-organizational Religious Activity (NORA)	0.15	0.11, 0.20	<0.001
DUREL: Intrinsic Religiosity (IR)	0.78	0.69, 0.86	<0.001
Job Satisfaction	-0.12	-0.21, -0.03	0.008
Employee Engagement	0.46	0.28, 0.64	<0.001
Affective Commitment	0.12	0.04, 0.21	0.005
Female (vs. male)	0.29	0.12, 0.46	0.001
Agnostic/Atheist (vs. Catholic)	-2.40	-2.93, -1.87	<0.001
No Religious Affiliation (vs. Catholic)	-1.41	-1.76, -1.06	<0.001
Other Religious Affiliation: Anthiocian Orthodox, Buddhism, Episcopalian, Free Thinker/Thought, Spiritual	-0.43	-0.80, -0.06	0.022
Job Burnout	0.02	-0.08, 0.12	0.726
Turnover Intention	-0.03	-0.14, 0.07	0.552
Age	0.004	-0.004, 0.01	0.311
Ethnicity: Asian (vs. Hispanic)	0.08	-0.08, 0.24	0.310
Ethnicity: Others (vs. Hispanic)	-0.09	-0.32, 0.14	0.428
Years in Current Profession: 5-10 years (vs. <5 years)	-0.06	-0.28, 0.15	0.552
Years in Current Profession: >10 years (vs. <5 years)	-0.13	-0.38, 0.12	0.316

Years in AHWM: 5-10 years (vs. <5 years)	-0.07	-0.28, 0.13	0.479
Years in AHWM: >10 years (vs. <5 years)	-0.10	-0.24, 0.22	0.931
Work Shift: Night (vs. day shift)	0.14	-0.01, 0.29	0.067
Work Shift: Office Hours (vs. day shift)	0.08	-0.44, 0.61	0.752
Work Shift: Evening (vs. day shift)	-0.37	-0.83, 0.10	0.119
Work Shift: Variable (vs. day shift)	0.19	-0.16, 0.53	0.288
Education: LVN/ADN (vs. BSN)	-0.08	-0.24, 0.09	0.376
Education: MS/PhD (vs. BSN)	-0.14	-0.46, 0.18	0.397
Education: Other (vs. BSN)	-0.15	-0.45, 0.14	0.309
Current Role: ED RN/EMT (vs. bedside RN)	-0.09	-0.37, 0.19	0.528
Current Role: Other (vs. bedside RN)	-0.11	-0.37, 0.15	0.417
Current Role: Support Staff (vs. bedside RN)	0.27	-0.02, 0.56	0.069
Religious Affiliation: Christian/Non-denominational (vs. Catholic)	-0.01	-0.21, 0.20	0.964
Religious Affiliation: Christian/Protestant (vs. Catholic)	-0.08	-0.32, 0.17	0.534
Religious Affiliation: Christian/Seventh-day Adventist (vs. Catholic)	-0.07	-0.30, 0.16	0.574

Associations Between Sanctification of Work: Sacred Qualities (SQ) and Other Study Variables

The above steps were repeated to analyze how study variables predicted sanctification of work as manifested in the sacred qualities (SQ) subscale. Given its item response options, note that the lower the SQ score, the higher the respondent perceived work containing sacred qualities. Nursing personnel who are engaged ($p = 0.003$) and committed ($p = 0.002$) perceived their work as having sacred qualities using descriptors such as holy, inspiring, blessed, awesome, heavenly, spiritual, religious, mysterious,

miraculous, and sacred. The three major dimensions of religiosity, organizational religious activity (ORA), non-organizational religious activity (NORA), and intrinsic religiosity (IR), were positively associated with the perception of sacred qualities of work (all with *p* values <0.001). Furthermore, older individuals (*p* = 0.037), were less likely to perceive work as having sacred qualities. Females (*p* = 0.033) tended to perceive work as more sanctified than males; those who worked variable shifts (*p* = 0.002) perceived work as more sanctified than those working day shift (the reference category). Protestants (*p* = 0.001), Seventh-day Adventists (*p* = 0.009), and those without religious affiliation (i.e., "Nones") (*p*= <0.001) scored higher than Catholics, indicating that Protestant, SDA and non-religious respondents perceived work as having fewer sacred qualities than did Catholics. In summary, the nontheistic scale refers only to the perception of work as having sacred qualities and not specifically to manifestations of God. Table 6 summarizes the beta estimates, confidence estimates, and *p* values.

For the model presented in Table 6, 38% of the variability in sacred quality was explained by the following variables: DUREL: Organizational Religious Activity (B = -0.18, 95% CI = -0.25, -0.12, *p* value = <0.001); DUREL: Non-organizational Religious Activity (B = -0.09, 95% CI = -0.14, -0.04, *p* value = <0.001); DUREL: Intrinsic Religiosity (B = -0.30, 95% CI = -0.40, -0.19, *p* value = <0.001); Employee Engagement (B = -0.36, 95% CI = -0.59, -0.12, *p* value = 0.003); Affective Commitment (B = -0.17, 95% CI = -0.28, -0.06, *p* value = 0.002); Age (B = 0.01, 95% CI = 0.00, 0.02, *p* value = 0.037); Female (vs. male) (B = -0.24, 95% CI = -0.45, -0.02, *p* value = 0.033); and working a variable work shift (vs. day shift) (B = -0.62, 95% CI = -1.02, -0.22, *p* value = 0.002). Also, Christian/Protestants (vs. Catholics) (B = 0.41, 95% CI = 0.10, 0.72, *p*

value = 0.001); Christian/Seventh-day Adventists (vs. Catholics) (B = 0.40, 95% CI = 0.10, 0.70, *p* value = 0.009), and having no religious affiliation (vs. Catholics) (B = 0.84, 95% CI = 0.43, 1.25, *p* value = <.0001) also were significantly associated with sacred quality. Thus, in this model explaining contributors to sacred quality of work, 62% of the variability remained unexplained.

Variables that showed no association with sanctification of work specific to sacred qualities were the following: job satisfaction, job burnout, turnover intention, ethnicity, years in current profession, years worked at the study site, day/night/office work shifts, current job role, specific religious affiliations, and education.

Table 6. *Robust Linear Regression Report on Variables Associated with Sanctification of Work – Sacred Qualities (SQ) (N= 449)*

Variables Associated with Sanctification of Work – Sacred Qualities (SQ)	B	95% Confidence Interval Limits	P-value
DUREL: Organizational Religious Activity (ORA)	-0.18	-0.25, -0.12	<0.001
DUREL: Non-organizational Religious Activity (NORA)	-0.09	-0.14, -0.04	<0.001
DUREL: Intrinsic Religiosity (IR)	-0.30	-0.40, -0.19	<0.001
Employee Engagement	-0.36	-0.59, -0.12	0.003
Affective Commitment	-0.17	-0.28, -0.06	0.002
Age	0.01	0.00, 0.02	0.037
Female (vs. male)	-0.24	-0.45, -0.02	0.033
Work Shift: Variable Work Shift (vs. day shift)	-0.62	-1.02, -0.22	0.002
Religious Affiliation: Christian/Protestant (vs. Catholic)	0.41	0.10, 0.72	0.001
Religious Affiliation: Christian/Seventh-day Adventist (vs. Catholic)	0.40	0.10, 0.70	0.009
Religious Affiliation: No Religious	0.84	0.43, 1.25	<.0001

Affiliation (vs. Catholic)			
Job Satisfaction	-0.06	-0.17, 0.06	0.321
Job Burnout	-0.01	-0.14, 0.12	0.831
Turnover Intention	0.09	-0.04, 0.23	0.178
Ethnicity: Asian (vs. Hispanic)	0.14	-0.06, 0.33	0.181
Ethnicity: Others (vs Hispanic)	0.22	-0.50, 0.06	0.130
Current Profession: 5-10 years (vs. <5 years)	0.02	-0.25, 0.29	0.874
Current Profession: >10 years (vs. <5 years)	0.22	-0.54, 0.09	0.156
Years in AHWM: 5-10 years (vs. <5 years)	-0.05	-0.31, 0.21	0.693
Years in AHWM: >10 years (vs. <5 years)	0.03	-0.26, 0.32	0.843
Work Shift: Night (vs. day shift)	-0.09	-0.28, 0.10	0.356
Work Shift Office hours (vs. day shift)	-0.35	-1.02, 0.32	0.310
Work Shift Swing (vs. day shift)	-0.15	-0.76, 0.46	0.625
Education: LVN/ADN (vs. BSN)	0.09	-0.12, 0.30	0.412
Education: MS/PhD (vs. BSN)	0.19	-0.21, 0.59	0.358
Education: Other (vs. BSN)	0.09	-0.28, 0.55	0.629
Religious Affiliation: Agnostic/Atheist (vs. Catholic)	0.28	-0.34, 0.89	0.380
Religious Affiliation: Christian/Non-Denominational (vs. Catholic)	0.08	-0.18, 0.35	0.538
Religious Affiliation: Other (vs. Catholic)	0.12	-0.32, 0.57	0.586
Current Role: ED RN/EMT (vs. bedside RN)	0.03	-0.33, 0.38	0.879
Current Role: Other (vs. bedside RN)	0.15	-0.17, 0.48	0.356
Current Role: Support staff (vs. bedside RN)	-0.03	-0.39, 0.34	0.884

Association Between Sanctification of Work and Patient Satisfaction

The HCAHPS allows measurement of patient satisfaction; in addition, the study site included two items that measured emotional support and attention to spiritual needs by nursing personnel. The patient satisfaction scores were provided by the NRC to the Organizational Performance department at the study site. These HCAHPS patient satisfaction scores are generated in aggregate by unit or department. Table 7 provides the HCAHPS scores on emotional support and attention to spiritual needs for the available units. Given that only unit level and not individual level HCAHPS scores are available, the association between emotional support/attention to spiritual needs with sanctification of work (i.e. MOG and SQ) cannot be determined, as HCAPHS scores and unit types are completely confounded.

Table 7. *HCAHPS Scores on Emotional Support and Attention to Spiritual Needs by Unit*

Unit	Emotional Support	Attention to Spiritual Needs
2 South Medical Surgical	65.8	90.9
3 South Medical Surgical	78.4	89.9
4 North Medical Surgical	69.1	89.2
5 North Telemetry	68.3	85.1
6 North Telemetry	68.9	85.2
6 South Telemetry	74.3	82.4

Perinatal Care (Neonatal Intensive Care Unit, Pediatrics, Pediatric Intensive Care Unit, Labor & Delivery, and Maternity Unit)	64.9	94.5
Emergency Department	59.6	N/A

Summary of Findings

The above analyses examined how work-related outcomes and patient satisfaction were associated with sanctification of work (measured both by MOG and SQ), among nursing personnel. The findings showed that engagement and commitment at work and religiosity independently explained the perception of work as sanctified, whether measuring sanctification of work from a theistic (per MOG) or nontheistic view (per SQ). When examining associations by religious affiliation, it was found that respondents without religious affiliation viewed work as less sanctified (per both MOG and SQ) than Catholics. Females viewed work as more sanctified than males per MOG and SQ views. On the nontheistic view, the older respondents were less likely to see work as having sacred qualities. Protestant respondents (including Seventh-day Adventists) also perceived work having fewer sacred qualities. Given the aggregated nature of the institution-owned data obtained, it was impossible to determine if sanctification of work and patient satisfaction, particularly emotional support and attention to spiritual needs, were associated.). Lastly, 72% of the variance in sanctification of work, particularly as measured by the MOG subscale, was explained by the work-related outcomes of engagement, commitment, and satisfaction, as well as religiosity, and also demographic

and personnel characteristics including gender, and specific religious affiliation. Meanwhile, 38% of the variance in SQ was explained by the work-related outcomes of engagement and commitment, as well as by religiosity and demographic and personnel characteristics such as age, gender, variable shift, and specific religious affiliations.

Chapter Summary

This chapter described the findings of the analysis of data from a sample of 463 licensed and unlicensed nursing personnel from a non-profit, faith-based, teaching hospital in an urban California city. Numerous independent variables were observed to be associated with the sanctification of work, whether measured theistically (MOG) or non-theistically (SQ). These findings will be discussed in Chapter 5.

CHAPTER FIVE

DISCUSSION

Introduction

This study explored the association between the independent variables of work-related outcomes such as job satisfaction, employee engagement, organizational commitment, job burnout, and turnover intention, as well as patient satisfaction, and the dependent variable of sanctification of work. The findings were based on data collected from a sample of 463 licensed and unlicensed nursing personnel from a non-profit, faith-based teaching hospital in the urban setting of Los Angeles, California. The following discussion is organized into five sections: (a) demographics and work-related characteristics of nursing personnel; (b) interpretations and discussions of the findings by the research questions initially posed; (c) implications of the research findings; (d) limitations and recommendations, and (e) conclusion.

Demographics and Work-related Characteristics of Nursing Personnel

Studies on sanctification of work have explored the phenomenon among different work groups such as working mothers (Hall, et al., 2012), educators and school administrators (Carroll, et al., 2014), and service industry employees such as those in sales, library, and business operations (Walker, et al., 2008). However, no studies have been conducted on sanctification of work in the nursing profession; thus, no comparison of findings from previous studies is possible. Furthermore, nursing studies about work-related outcomes generally neglect to include unlicensed nursing personnel such as Certified Nurse Assistants, unit secretaries, monitor technicians, and emergency medical technicians.

The demographics of Registered Nurses for the state of California were found to be similar to the participants of the present study. For example, in California, RNs are predominantly female (88% in 2016), although the number of male nurses significantly increased from 5% in 1990 to 12% in 2016. In this study, 81% were female. The average age of California nurses is 45 years (Spetz, Chu, Jura, & Miller, 2017); the average age of the study respondents was 42 years. The patient population at the study site serves a specific catchment area, a five-mile radius around the hospital including the Northeast and East LA Health Districts. Although the area is composed of 90% Hispanics (Adventist Health White Memorial, 2019) and the majority of the hospital's workforce is Hispanic, this sample was composed of only 45% Hispanic nursing personnel. In particular, the Los Angeles region is one of the most diverse regions in the U.S., with a high proportion of Hispanic/Latino and Filipino RNs (Spetz, Chu, Jura, & Miller, 2017). This ethnic makeup may, in part, explain why 60% of respondents identified as Roman Catholic, compared to less than 40% in nursing studies such as Mamier and Taylor (2015); 38% in Taylor, Armenta, and Highfield (1995), or 20% in Taylor, et al. (2009).

Four percent of respondents worked variable shifts: day or night, mid-shift or weekends, depending on the needs of the unit. According to Dehler and Welsh (2010), there is a paradigm shift in the science of organizational structure – from the industrial workplace of yesterday, to a service-oriented workplace, and now to the new workplace of experience-based work lives. In the industrial age, work was tedious and operated from a hierarchical structure, with employees taking orders and following rigid work schedules. However, the nature of work in the new economy has changed the relationship between workers and organizations, with skilled individuals having more self-

determination and agency in the workplace, including the option of working variable shifts to better align with career goals and personal responsibilities. This new agency of workers becomes a source of meaning, enjoyment, satisfaction, and fulfillment, and may help explain why nursing personnel working variable shifts perceived work as having more sacred qualities. Because this is a new finding from previous sanctification of work studies, no data links this variable to sanctification of work.

In this study, there was no evidence of a relationship between length of employment and sanctification of work. Nearly half (43%) of the respondents had worked at the study site for less than 5 years, 22% had been at the study site for 5 to 10 years, and 35% of the sample had worked in the organization for more than 10 years (i.e., 11-40 years). These findings differ from those of other studies. For example, Kelarijani and colleagues (2014) found that length of service was positively related to organizational commitment among nurses in Tehran. Vagharseyyedin's (2016) integrative review of 33 studies found that the nurses' years of service was negatively associated with organizational commitment. In addition, the longer the nurse is in the job and in the profession, the lower the intention to leave (Nei, et al., 2015).

The working environment of the study respondents included medical-surgical units, telemetry units, critical care units, perioperative units, women's and children's services, emergency department, nursing administration, and other nursing-related departments, each with its unique culture and characteristics. With no previous studies related to sanctification of work in nursing, no comparisons can be made; it is known, however, that work setting does impact job burnout. For example, Canadas-De la Fuente, et al. (2015) found that nurses working in women's and children's services had lower

levels of burnout compared to nurses in other direct patient care areas. In addition, nurses with managerial positions had lower levels of the depersonalization dimension of burnout compared to direct patient care providers. However, no association between work unit or department and sanctification of work was found.

In summary, this sample population represented not only the nursing population but also the unlicensed nursing personnel that can be neglected as a sample study group. The demographics of licensed nursing personnel, such as gender, age, and highest health-care related education, were similar to those of the general population of nurses in California. Work-related characteristics, like years of service and work unit, are factors known to be associated with organizational commitment and burnout in nursing. In this study, these factors were observed to explain sanctification of work, as was the newly explored variable of shift worked.

Answering the Research Questions

Research question 1 asked: What is the association between sanctification of work in a theistic view, also known as Manifestation of God (MOG), and the work-related outcomes of job satisfaction, employee engagement, organizational commitment, job burnout, and turnover intention among licensed and unlicensed nursing personnel, and also demographic and personnel characteristics variables?

Association Between Sanctification of Work in a Theistic View – Manifestation of (MOG) and Work-related Outcomes, and Demographic and Personnel Characteristics

Descriptive Analysis of Sanctification of Work, MOG Subscale

In this study, MOG had a high average score of 68.63 on a scale of 1-7, with 1 *as strongly disagree* and 7 as *strongly agree*. The MOG mean from Walker et al's 2008 study of full-time workers in a wide variety of professional occupations was 56.50, whereas Carroll et al.'s study (2014) of employees in a Catholic education system was 64.30. The higher MOG result of this study may be due to predominantly Christian respondents.

Inferential Analysis of Sanctification of Work (MOG Subscale) and Work-related Outcomes, Demographic, and Personnel Characteristics

The results indicated that sanctification of work (conceptualized as MOG) was positively associated with religiosity in terms of the three dimensions measured by the DUREL Index, namely: organizational religious activity (ORA), non-organizational religious activity (NORA), and intrinsic religiosity (IR). MOG was also independently explained by employee engagement, affective commitment, and female gender. This simply means that nurses who were female, religious, and engaged and committed at work were associated with sanctification of work, while nursing personnel who were less satisfied at work for less likely to see their work as sanctified. Agnostic or atheist respondents, and those categorized as "other religious affiliations" due to low frequency

such as Orthodox, Buddhist, Episcopalian, Free Thinker/Thought, or Spiritual had no association with MOG. Given the inherent nature of the phenomenon of sanctification of work, it is no surprise that various indicators of religiosity were significantly associated with MOG.

Similarly, Walker and associates 2008 study of 103 full-time employees in a variety of professional occupations demonstrated that MOG was positively related to job satisfaction and organizational commitment. A 2014 qualitative study among 85 nurses from surgical, medical, and critical wards of a large hospital in Iran found that job satisfaction among RNs was found to be associated with spirituality, or the strengthening of one's religious faith, renewing of energy, and sense of reward from God for helping the sick (Atefi, Abdullah, Wong, & Mazlom, 2014). Furthermore, Atefi, et al.'s study found that nurse job satisfaction was also linked to clinical autonomy. This is relevant to the present findings given that clinical autonomy (or having control over one's work) is one of the conditions promoting employee engagement (Kahn, 1990).

Conversely, turnover intention and job burnout findings suggested that these work-related outcomes were not associated with sanctification of work (measured as MOG). That is, thoughts of leaving the organization or profession (p=value=0.552) and feeling burned out at work (p-value=0.726) were not found. This finding is corroborated by the results of Brewer et al.'s study (2015), in which nurses' organizational commitment had a significant positive direct effect on turnover intention. These findings also may be due to the respondents' high perception of work as sanctified (M=5.72); that is, work pressures and hassles are manageable, and delivery of patient care is rewarding when one views nursing as sacred work. On the other hand, Maslach and Jackson (1981)

described burnout as associated with the belief that one's work is not meaningful or worthwhile. Since the study participants perceived their work as sanctified, perception of burnout (p-value=0.726) was not felt or perceived. These results could explain why both turnover intention (p-value=0.552) and job burnout were not found to be significant.

In summary, the respondents in the present study who perceived their work as sanctified from a theistic view were more engaged and committed to their work. To put this in other language, it might be said that nurses who participated in and felt attached to their employing organization's activities were likely to be those who ascribed sacred meaning and values to their work.

Association Between Sanctification of Work in a Nontheistic View – Sacred Qualities (SQ) and Work-related Outcomes, and Demographic, and Personnel Characteristics

The second research question asked: What is the association between sanctification of work in a nontheistic view (SQ) and work-related outcomes such as job satisfaction, employee engagement, organizational commitment, job burnout, and turnover intention among licensed and unlicensed nursing personnel, and also demographic and personnel characteristics?

Descriptive Analysis of Sanctification of Work, SQ Subscale

The nontheistic view of sanctification of work (as measured by the SQ subscale), had a mean score of 25.21; the average item score for the 10-item scale was 2.3

(response options ranged from 1-7); the lower SQ scores showed that more respondents perceived their work as possessing sacred qualities without using "God language." Sacred qualities include holy, inspiring, blessed, awesome, heavenly, spiritual, religious, mysterious, miraculous, and sacred. The SQ average score from Walker et al.'s 2008 study of full-time workers in a wide variety of professional occupations was 37.50, while Carroll et al.'s 2014 study among employees of a Catholic education system was 50.14. In this study, the high perception of sanctified work as imbued with sacred qualities may be due to the diverse religious affiliations of the respondents, and also some respondents' perception of the nursing profession as a calling and a ministry. Furthermore, working in a faith-based organization rooted in the ministry of healing may have promoted a sense of Christian service to the people they serve. In this study, the mean score of SQ subscale was higher compared to the previous sanctification of work studies done among other professionals.

Inferential Analysis of Sanctification of Work (SQ Subscale) and Work-related Outcomes, and Demographic, and Personnel Characteristics

Sanctification of work in a non-theistic view was found to be either positively or negatively related to work outcomes, demographic and nursing characteristics. SQ was positively associated with work-related outcomes of employee engagement (p-value=0.003) and organizational commitment (p-value=0.002), along with demographic and nursing characteristics such as female gender (p-value=0.033) and variable work shifts (p-value=0.002). All three aspects of religiosity (i.e., ORA, NORA, and IR) were positively associated with SQ. Thus, respondents who perceived work as having sacred

qualities were more spiritual and religious, engaged, and committed at work. In addition, female respondents (p-value=0.033) and those with variable work shifts (p-value=0.002) were more likely to perceive their work as having sacred qualities compared to males, and those who worked solely during office hours, day, night, or evening shifts. Also, older nurses (p-value=0.037) were less likely to perceive their work as sanctified. In addition, respondents who were not Catholic (such as Protestants, Seventh-day Adventists, or those without religious affiliations) were less likely to perceive their work as sanctified.

In a previous study, the SQ subscale was positively associated with job satisfaction, organizational commitment, and lower intention to leave (Walker, et al., 2008). SQ was observed to be a better predictor of job satisfaction, turnover intention, and organizational commitment than the MOG subscale (Carroll, et al., 2014).

The regression models computed in this study revealed that job satisfaction, employee engagement, organizational commitment, religiosity (DUREL Index), demographics (including gender, age, and religious affiliation), and personnel characteristics such as variable shift, independently explained sacredness of work, whether it was measured with a theistic or non-theistic framing. Although a few studies exploring this phenomenon have obtained similar results, it is helpful to consider factors that could explain why this sample of nursing personnel produced these findings. Is it because the nursing profession is considered a calling or a ministry? Do nurses consider it an obligation or duty to perceive work as more sanctified compared to other professions? Does the Florence Nightingale pledge to practice the profession as calling to serve humanity still valued? These may be possible explanations. Likewise, previous

research done by Chatters, Taylor, Bullard, and Jackson (2008) documented how women typically self-report higher spirituality and religiosity than do men. Moreover, the finding that Roman Catholics reported more sanctification of work than did participants of other religions may reflect the Catholic Church's centuries old tradition of social service and compassion for the vulnerable and ill.

Association Between Sanctification of Work in a Theistic – Manifestation of God (MOG) and Nontheistic View – Sacred Qualities (SQ) and Patient Satisfaction

Research question three: What is the association between sanctification of work in a theistic and nontheistic view, and patient satisfaction among nursing departments, as demonstrated by emotional support and attention to spiritual needs?

Patient satisfaction mainly focused on two survey items namely: emotional support and attention to spiritual needs by nursing personnel. The patient satisfaction scores were generated from the HCAHPS scores by unit or department. Due to the nature of the aggregated HCAHPS survey data, the association between sanctification of work and patient satisfaction specific to emotional support and attention to spiritual needs was not explored.

Summary

In summary, with this sample of nursing personnel, work and demographic factors explained substantial amounts of the variance in sanctification ascribed to work. However, MOG, had a higher variability of 72%, compared to SQ with 38% variability, indicating that MOG study variables were more illustrative of the factors contributing to

MOG than the variables that contributed to SQ. The two work-related outcomes of employee engagement and organizational commitments were positively associated with both the MOG and SQ subscales, while job satisfaction was negatively associated with the MOG subscale. All aspects of religiosity measured by the DUREL Index were positively associated with both the MOG and SQ subscales. Neither turnover intention nor job burnout showed an association with the MOG or SQ subscales.

The findings in this study are instructive for future nursing strategies in education, research, and practice. That said, the results may have been influenced by many factors. Working in a faith-based, non-profit organization has a great impact in the work life of the employees. Bielefeld and Cleveland (2013) described faith-based organizations as workplaces with religious identity and traditions, which influence workers to view their work as a service to others. Workers also may feel a strong bond as members of a faith community, which enhances positive work outcomes. Employee engagement and organizational commitment are positive work outcomes that may result from a well-managed, faith-based organization that identifies with its mission.

Implications of the Research Findings

Implications for Theory and Practice

Findings from this study supported the relevance of sanctification theory, particularly since it was applied for the first time to the nursing profession. The value and effectiveness of sanctification theory explored a new facet of spirituality in nursing, and how spirituality in the profession relates to outcomes such as employee engagement and organizational commitment. The findings also show how sanctification of work can

be a useful concept for nurses. Sanctification of work, both in theistic and nontheistic views, can be used to measure one aspect of the abstract concept of spirituality -- one's own perception of the sacredness of work. The theory of sanctification of work, as well as the measures of manifestation of God (MOG) and perceived sacred qualities (SQ) provide framing and methods for studying sacred matters from a social scientific rather than a theological perspective (Pargament & Mahoney, 2005). This study has introduced the phenomenon of sanctification of work into nursing and demonstrated that it is significantly associated with work-related characteristics and outcomes among nursing personnel. This study is beneficial to nursing because it shows that sanctification of work is known to be associated with some nurse characteristics and work outcomes.

For nursing practice, findings confirmed that several work outcomes influence the sanctification a nurse ascribes to work. Finding the relationship between employee engagement, organizational commitment, and nursing personnel's perceptions about the sacred meaningfulness of work suggests that this new concept of sanctification may have implications for practice. It is possible that the sanctification of work may allow clinicians to respond with resilience to the intense demands of working in the healthcare sector. The philosopher Friedrich Neitzche once wrote, "He who has a why to live can bear almost any how." These findings infer that when a nurse believes their work is a response to, or a means of sharing, God's love, then one is also more committed and engaged in that work.

These results suggest salient implications for nurse administrators and educators. Sanctification of work was positively associated with employee engagement and organizational commitment, and these are qualities that any healthcare organization

would encourage. To introduce sanctification of work among nursing personnel, strategies can be developed to promote healthy working environments. A sense of the sacredness of work can be integrated into an organization's philosophy of care, and, ideally, modeled by nursing leadership and communicated to all nursing staff. To ensure new nursing employees have a minimum level of SoW, a screening tool for hiring nursing personnel can include a section with sanctification of work questions. The MOG subscale, which was found to be the more sensitive indicator, would likely be the best tool to use for such screening. Potential dissatisfied, unengaged and uncommitted nursing staff can be identified early if there is a program allowing periodic evaluation of sanctification of work.

Implications for educators in schools of nursing and in clinical settings may include adding the concept of sanctification of work in fundamental nursing topics or into new hire orientation or ongoing education. Evaluating the effectiveness of teaching this concept can be accomplished by a pre- and post-teaching survey to measure learners' perception of nursing work. In addition, since female nurses were more likely to see their work as sacred, educators should find ways for male students and personnel to voice opinions and ask focused questions related to sanctification of work. An annual spiritual retreat for employees led by the spiritual care or chaplaincy service could include activities such as guided journal writing about one's professional journey (e.g., it could be labelled, "Called to Serve").

Implications for Research

This study contributed knowledge about the association of sanctification of work with work-related outcomes, demographics, and personnel characteristics. The sanctification of work scale, comprised of two subscales, MOG and SQ, was used for the first time to measure SoW among licensed and unlicensed nursing personnel. These scales were easy to administer and found to possess internal reliability in this nursing personnel sample. Although data collected with these scales were skewed, this may have been due to the religious context of the sample rather than the design of the scales.

This current study added to the body of knowledge about the positive association of employee engagement and religiosity with sanctification of work. Further research that may prove especially fruitful might be to investigate whether sanctification of work has some effect on what Kaur, Sambasivan, and Kumar (2013) defined as the spiritual intelligence and caring behaviors of nurses. This caring behavior is influenced by physiological, psychological, sociocultural, developmental, and spiritual factors. In turn, the question can be asked as to whether the SoW of nurses contributes to patient's satisfaction, well-being, and subsequently, to the performance of healthcare organizations.

Other lessons learned from this study can be applied to future research. In addition, due to the busy nature of acute care settings, collecting data during staff meetings could be an efficient approach. Likewise, data collection is easier with leadership support and buy-in. Furthermore, using a national database such as HCAHPS in the study needs careful review to determine whether these data would answer research questions through the proposed data analysis.

Additional questions are proposed for future research: First, the concept of sanctification of work can be introduced to the School of Nursing and clinical practice settings. An experimental design could be used to determine the effectiveness of an intervention on change of perception. For example, a pre- and post-test designed study could evaluate the effectiveness of a workshop about integrating sanctification of work into daily nursing practice.

Second, because the sanctification of work concept is new to nursing, perspectives from the licensed and unlicensed nursing personnel could help identify strategies they use to create a sense of sanctification for work. A qualitative research design through semi-structured interviews would be ideal to gather this type of data. Personal experiences and stories of the respondents could be heard and captured through this method.

Third, through qualitative and quantitative research, a sanctification of work recruitment tool could be developed to help screen for candidates with a high sense of SoW or intrinsic religiosity—given its predictiveness for high SoW. Understandably, the ethical and legal issues surrounding the use of such a recruitment tool would need to be addressed.

Limitations and Recommendations

Several study limitations should be considered. This study sample was delimited specifically to licensed and unlicensed nursing personnel in one faith-based, non-profit teaching hospital setting; therefore, it provided insight into the sanctification of work and

contributing factors only for this group. Future research could benefit from multi-site designs and sample sites with more non-religious or non-Christian personnel.

A cause and effect relationship could not be derived due to the cross-sectional, correlational design. A longitudinal design would allow researchers to observe the dynamic changes among the variables in sanctification of work, work-related outcomes and personnel characteristics, and patient satisfaction specific to spiritual care. In that way, the associations of the variables could be examined to see whether they are significant predictors over time.

In addition, the respondents might have liked to explain their perspectives on the questionnaire, but this was not possible. A mixed method design could allow for qualitative exploration of nurses' subjective perspectives.

Measuring the association between patient satisfaction and the sanctification of work among nursing personnel proved impossible in this study. Future research should collect data directly from patients, possibly linked with the nurses who cared for them. Patient data and nursing personnel data would need to be collected in the same time period.

Another possible limitation is the method of combining the religious affiliations into categories for the multivariate analyses. It may be that grouping Christian Orthodox with Christian Catholic, Episcopalian with Christian/Protestant, and no religion with agnostic/atheist would have been more appropriate, given the cultural and theological similarities.

In summary, future studies may consider longitudinal or comparative designs with even larger sample sizes, as well as mixed method designs to better understand the

participants' responses. Also, choosing a psychometrically tested and evaluated tool to measure patient satisfaction with spiritual is recommended. These adjustments might help achieve more reliable findings among the variables under study and enhance understanding of these associations at different time points.

Conclusion

Spirituality in nursing has been researched and studied for decades. Addressing spirituality is recognized now as an important aspect of nursing care. Sanctification of work is a new construct related to spirituality that this study has applied to nursing. The findings of this quantitative, descriptive, cross-sectional, correlational study provide isolated yet strong evidence that the sanctification of work among nurses is associated with the critical and continually pursued outcomes of job satisfaction, employee engagement, and organizational commitment. Therefore, future research and evidence-based practice on sanctification of work are warranted.

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APPENDIX A

SURVEY QUESTIONNAIRE

Impact of Nurses' Sanctification of Work on Work-related Outcomes and Patient Satisfaction

The following questions ask about your religiosity. Feel free to replace the term "God" to your own preference (i.e., "Yahweh", "Higher Power", "Allah", "Buddha", etc.) when answering the questions. Please **circle the number** that best describes your religiosity.

Items	Never	Once a year or less	A Few Times a Year	A Few Times a Month	Once a Week	More Than Once a Week
How often do you attend church or other religious meetings?	1	2	3	4	5	6

Items	Rarely or Never	A Few times a Month	Once a Week	Two or More Times a Week	Daily	More Than Once a Day
How often do you spend time in private religious activities, such as prayer, meditation or Bible Study	1	2	3	4	5	6

Items	Definitely Not True	Tends Not to be True	Unsure	Tends to be True	Definitely True
1. In my life, I experience the presence of the Divine (i.e. God)	1	2	3	4	5
2. My religious beliefs are what really lie behind my whole approach to life	1	2	3	4	5
3. I try hard to carry my religion over into all other dealings in life	1	2	3	4	5

This survey measures the extent, to which you perceive a higher power as having significance on your work. The following statements use the term "God", however, feel free to replace the term "God" to your own word such as "Higher Power", "Yahweh", "Allah", "Buddha", etc. when answering them.

Please indicate the degree to which you agree or disagree with each of the following statements. **Circle the best answer.**

1= strongly disagree
2= moderately disagree
3= slightly disagree
4= neutral
5= slightly agree
6= moderately agree
7= strongly agree

Items	Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree
1. God played a role in the development of my job.	1	2	3	4	5	6	7
2. God is present in my work.	1	2	3	4	5	6	7
3. My job is a reflection of God's will.	1	2	3	4	5	6	7
4. My job is an expression of my spirituality or religiousness.	1	2	3	4	5	6	7
5. My job is consistent with my spiritual or religious identity.	1	2	3	4	5	6	7
6. I experience God through my job.	1	2	3	4	5	6	7
7. My job reflects my image of what God wants for me.	1	2	3	4	5	6	7
8. My job is influenced by God's actions in my life.	1	2	3	4	5	6	7
9. My job represents the holy work of God.	1	2	3	4	5	6	7
10. My job represents God's presence in my life.	1	2	3	4	5	6	7
11. My actions surrounding my job follow the Holy writings and what they teach.	1	2	3	4	5	6	7
12. My actions surrounding my job follow the teachings of my faith and/or religion.	1	2	3	4	5	6	7

This survey asks for your reviews about the sacred qualities of your work. Please rate whether your job is more closely described by the adjective on the left or on the right by **placing a check mark (√)** on the appropriate box. If you are unsure about how to answer a question, please give the best answer you can.

Items	Very Closely Describes	Closely Describes	Slightly Describes	Neutral	Slightly Describes	Closely Describes	Very Closely Describes	Items
								
1. Holy								1. Unholy
2. Inspiring								2. Uninspiring
3. Blessed								3. Cursed
4. Awesome								4. Unimpressive
5. Heavenly								5. Earthly
6. Spiritual								6. Worldly
7. Religious								7. Nonreligious
8. Mysterious								8. Routine
9. Miraculous								9. Ordinary
10. Sacred								10. Secular

Read the following items which assess your overall job satisfaction. Please indicate the level of agreement on the following statements regarding your work. **Circle the number.**

1= strongly disagree
2= moderately disagree
3= slightly disagree
4= neutral
5= slightly agree
6= moderately agree
7= strongly agree

Items	Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree
1. I feel fairly well satisfied with my present job.	1	2	3	4	5	6	7
2. Most days, I am enthusiastic about my work.	1	2	3	4	5	6	7
3. Each day of work seems like it will never end.	1	2	3	4	5	6	7
4. I find real enjoyment in my work.	1	2	3	4	5	6	7
5. I consider my job rather unpleasant.	1	2	3	4	5	6	7

Recall your experience and indicate the level of agreement on the following statements regarding your work. **Circle the number.**

1=strongly disagree
2=disagree
3=neutral
4=agree
5=strongly agree

Items	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. The work I do on this job is very important to me.	1	2	3	4	5
2. My job activities are personally meaningful to me.	1	2	3	4	5
3. The work I do on this job is worthwhile.	1	2	3	4	5
4. My job activities are significant to me.	1	2	3	4	5
5. The work I do on this job is meaningful to me.	1	2	3	4	5
6. I feel that the work I do on my job is valuable.	1	2	3	4	5
7. I'm not afraid to be myself at work.	1	2	3	4	5
8. I am afraid to express my opinions at work.	1	2	3	4	5
9. There is a threatening environment at work.	1	2	3	4	5

10. I am confident in my ability to handle competing demands at work.	1	2	3	4	5
11. I am confident in my ability to deal with problems that come up at work.	1	2	3	4	5
12. I am confident in my ability to think clearly at work.	1	2	3	4	5
13. I am confident in my ability to display the appropriate emotions at work.	1	2	3	4	5
14. I am confident that I can handle the physical demands at work.	1	2	3	4	5

The following is a list of statements about your personal commitment to the organization where you work. **Circle the number** that best describes your view.

1= strongly disagree
2= moderately disagree
3= slightly disagree
4= neutral
5= slightly agree
6= moderately agree
7= strongly agree

Items	Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree
1. I do not feel a strong sense of belonging to my organization.	1	2	3	4	5	6	7
2. I do not feel "emotionally attached" to this organization.	1	2	3	4	5	6	7
3. This organization has a great deal of personal meaning for me.	1	2	3	4	5	6	7
4. I do not feel like "part of the family" at this organization.	1	2	3	4	5	6	7
5. I would be very happy to spend the rest of my career with this	1	2	3	4	5	6	7

organization.							
6. I enjoy discussing my organization with people outside it.	1	2	3	4	5	6	7
7. I really feel as if this organization's problems are my own.	1	2	3	4	5	6	7
8. I think I could easily become as attached to another organization as I am to this one.	1	2	3	4	5	6	7

These next questions ask about the unique qualities that you bring to work. **Circle the number** that best describes you.

0= never
1= almost never (a few times a year or less)
2= rarely (once a month)
3= sometimes (a few times a month)
4= often (once a week)
5= very often (a few times a week)
6= always (every day)

Items	Never	Almost Never (a few times a year or less)	Rarely (once a month)	Some-times (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
1. I feel emotionally drained from my work.	0	1	2	3	4	5	6
2. I feel fatigued when I get up in the morning and have to face another day on the job.	0	1	2	3	4	5	6
3. Working with people all day is really a strain for me.	0	1	2	3	4	5	6
4. I've become more uncaring towards people since I took this job.	0	1	2	3	4	5	6
5. I feel I treat some patients as if they were impersonal objects.	0	1	2	3	4	5	6

6. I don't really care what happens to some patients.	0	1	2	3	4	5	6
7. I deal very effectively with the problems of my patients.	0	1	2	3	4	5	6
8. I feel I'm positively influencing other people's lives through my work	0	1	2	3	4	5	6
9. I feel delighted after working closely with my patients.	0	1	2	3	4	5	6

The next questions ask about your dedication and loyalty to the organization, job, and occupation or profession. **Circle the number** to indicate the level of agreement to the following statements.

1= strongly disagree
2= disagree
3= neutral
4= agree
5= strongly agree

Items	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. I think a lot about leaving the organization.	1	2	3	4	5
2. I am actively searching for an alternative to the organization.	1	2	3	4	5
3. As soon as possible, I will leave the organization.	1	2	3	4	5
4. I think a lot about leaving the job.	1	2	3	4	5
5. I am actively searching for an alternative to the job.	1	2	3	4	5
6. As soon as possible, I will leave the job.	1	2	3	4	5
7. I think a lot about leaving my occupation.	1	2	3	4	5
8. I am actively searching for an alternative to my occupation.	1	2	3	4	5
9. As soon as possible, I will leave my occupation.	1	2	3	4	5

Demographic Questions

Please **put a check mark (√)** on the appropriate box that best describes you or **write the number or word** on the line.

1. You are: □ Male □ Female □ Other: _____

2. What is your age? _____ years old

3. What is your ethnicity?

□ Asian American
□ Black and/or African American
□ Hispanic/Latino
□ Native Hawaiian/other Pacific Islander
□ White and/or Euro-American
□ If 2 or more, which ethnicity do you identify most? _____
□ other (specify): _____

4. What is your current role in the White Memorial Medical Center?

□ Administrative Assistant
□ Charge Nurse/Nurse Lead
□ CNA (Certified Nursing Assistant)/Patient Aide
□ Educator (Clinical Education/Clinical Information System)
□ EMT (Emergency Medical Technician)
□ MHW (Mental Health Worker)
□ Monitor Technician
□ Nurse Director/Director
□ Nurse Manager
□ Staff LVN
□ Staff RN
□ Unit Secretary
□ Other (specify): _____

5. What is the highest healthcare-related education that you have?

□ Vocational-nursing
□ Associate degree-nursing
□ Bachelor's degree-nursing
□ Master's degree-nursing
□ Doctoral degree-nursing practice (DNP)
□ Doctoral degree-nursing (PhD)
□ Other (specify): _____

6. What is your religious affiliation?

□ Agnostic/Atheist
□ Christian/Catholic
□ Christian/Non-denominational
□ Christian/Protestant
□ Christian/Seventh-day Adventist
□ Jewish
□ Muslim
□ None
□ Secularist/Humanist
□ Other (specify): _____

7. What unit/department do you work?

□ 1E Rehab
□ 2S MS
□ 2E Peds
□ 2E PICU
□ 3S MS
□ 3E SNF
□ 4N MS Ortho
□ 4S Maternity
□ 4S Behavioral Med (A/B)
□ 5N Tele
□ 5S ICU
□ 6N Tele
□ 6S Tele
□ Antepartum
□ Cath Lab/EP Lab
□ Education & Training
□ Emergency Department
□ GI Lab
□ Labor & Delivery (L&D)
□ Los Angeles Ambulatory Services Center (LASC)
□ Neonatal Intensive Care Unit (NICU)
□ Nursing Administration
□ Operating Room (OR)
□ Patient Intake
□ Post-Anesthesia Care Unit (PACU)
□ Resource Pool
□ Same Day Surgery (SDS)
□ Other (specify): _____

8. For how many years have you worked in your current profession: _____ years

9. Work shift: □ Day □ Swing □ Night □ Variable □ Office hours

10. For how many years have you worked in White Memorial? _____ years

You may not realize how much I appreciated your support….

Please return completed questionnaire at the staff meeting location in E&T coordinator's office.

A token of appreciation awaits you

and is ready for pick up☺!

APPENDIX B

DIAGNOSTIC OUTCOMES ON MOG AND SQ

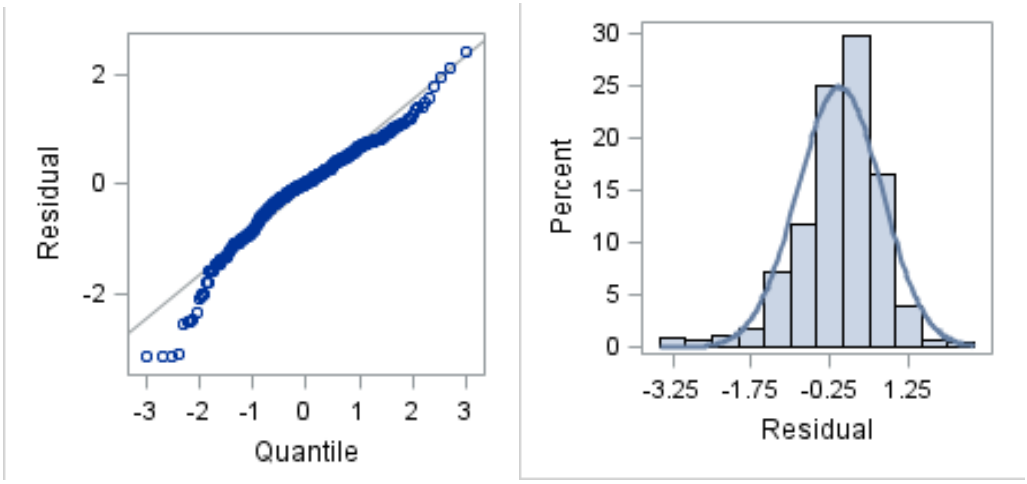

Figure 1 Diagnostics Outcome = Manifestation of God (MOG)

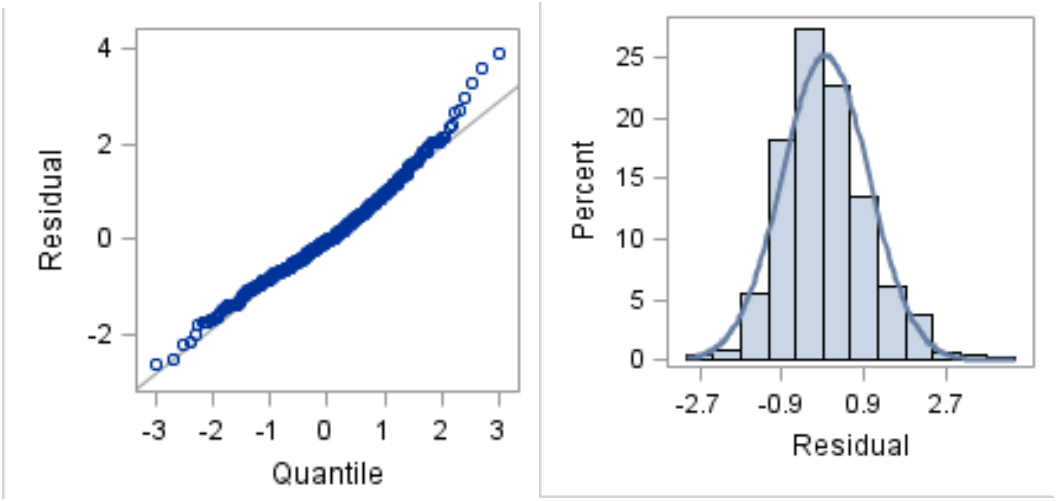

Figure 2 Diagnostics Outcome = Sacred Qualities (SQ)

APPENDIX C

ITEM STATISTICS ON EACH MEASURE

Item Statistics on DUREL Index			
	Mean	Std. Deviation	N
How often do you attend church or other religious meetings?	3.65	1.422	463
How often do you spend time in private religious activities, such as prayer, meditation or Bible Study?	3.22	1.793	463
In my life, I experience the presence of the Divine (i.e. God)	4.39	0.981	463
My religious beliefs are what really lie behind my whole approach to life	4.10	1.139	463
I try hard to carry my religion over into all other dealings in life	4.00	1.169	463

Table 1 Item Statistics on DUREL Index

Item Statistics on MOG Subscale			
	Mean	Std. Deviation	N
God played a role in the development of my job.	5.937	1.6030	463
God is present in my work.	6.106	1.4944	463
My job is a reflection of God's will.	5.892	1.5904	463
My job is an expression of my spirituality or religiousness.	5.594	1.6221	463
My job is consistent with my spiritual or religious identity.	5.624	1.6067	463
I experience God through my job.	5.747	1.6072	463
My job reflects my image of what God wants for me.	5.689	1.6111	463
My job is influenced by God's actions in my life.	5.626	1.6803	463
My job represents the holy work of God.	5.635	1.6378	463
My job represents God's presence in my life	5.667	1.6255	463
My actions surrounding my job follow the Holy writings and what they teach.	5.477	1.6564	463
My actions surrounding my job follow the teachings of my faith and/or religion	5.631	1.5926	463

Table 2 Item Statistics on MOG Subscale

Item Statistics on SQ Subscale			
	Mean	Std. Deviation	N
Holy	2.67	1.345	462
Inspiring	2.15	1.345	462
Blessed	2.06	1.328	462
Awesome	2.24	1.330	462
Heavenly	2.74	1.502	462
Spiritual	2.42	1.424	462
Religious	2.56	1.379	462
Mysterious	3.06	1.461	462
Miraculous	2.65	1.450	462
Sacred	2.66	1.417	462

Table 3 Item Statistics on SQ Subscale

Item Statistics on Job Satisfaction

	Mean	Std. Deviation	N
I feel fairly well satisfied with my present job.	5.6803	1.53367	463
Most days, I am enthusiastic about my work.	5.7127	1.40715	463
I find real enjoyment in my work.	5.8380	1.26803	463
Each day of work seems like it will never end. (reverse)	4.0972	1.88789	463
I consider my job rather unpleasant. (reverse)	5.4924	1.76285	463

Table 4 Item Statistics on Job Satisfaction

Item Statistics on Engagement Scale

	Mean	Std. Deviation	N
The work I do on this job is very important to me.	4.6667	0.59402	462
My job activities are personally meaningful to me.	4.5065	0.69000	462
The work I do on this job is worthwhile.	4.5390	0.66326	462
My job activities are significant to me	4.4957	0.66439	462
The work I do on this job is meaningful to me	4.5671	0.64438	462
I feel that the work I do on my job is valuable.	4.5909	0.66470	462
I'm not afraid to be myself at work.	4.3203	0.88441	462
I am afraid to express my opinions at work	2.6537	1.30790	462
I am confident in my ability to handle competing demands at work.	4.2576	0.80985	462
I am confident in my ability to deal with problems that come up at work.	4.2771	0.76322	462
I am confident in my ability to think clearly at work.	4.3766	0.70398	462
I am confident in my ability to display the appropriate emotions at work.	4.2468	0.79841	462
I am confident that I can handle the physical demands at work.	4.4113	0.73325	462
There is a threatening environment at work. (reverse)	3.7749	1.23453	462

Table 5 Item Statistics on Engagement Scale

Item Statistics on Affective Commitment

	Mean	Std. Deviation	N
I do not feel a strong sense of belonging to my organization. (reverse)	5.4557	1.71878	463
I do not feel "emotionally attached" to this organization. (reverse)	5.4622	1.69356	463
I do not feel like "part of the family" at this organization. (reverse)	5.5421	1.72261	463
This organization has a great deal of personal meaning for me.	5.5356	1.44237	463
I would be very happy to spend the rest of my career with this organization.	5.3564	1.61178	463
I enjoy discussing my organization with people outside it.	5.3672	1.55113	463
I really feel as if this organization's problems are my own.	4.2160	1.71219	463
I think I could easily become as attached to another organization as I am to this one. (reverse)	4.1836	1.67060	463

Table 6 Item Statistics on Affective Commitment

Item Statistics on Job Burnout			
	Mean	Std. Deviation	N
I deal very effectively with the problems of my patients. (reverse)	2.5216	1.75710	462
I feel I'm positively influencing other people's lives through my work. (reverse)	2.1623	1.39788	462
I feel delighted after working closely with my patients. (reverse)	2.0779	1.38256	462
I feel emotionally drained from my work	2.8615	1.52573	462
I feel fatigued when I get up in the morning and have to face another day on the job	2.5368	1.60994	462
Working with people all day is really a strain for me.	1.4221	1.48798	462
I've become more uncaring towards people since I took this job.	0.8355	1.37336	462
I feel I treat some patients as if they were impersonal objects.	0.6255	1.26887	462
I don't really care what happens to some patients.	0.3442	0.96611	462

Table 7 Item Statistics on Job Burnout

Item Statistics on Turnover Intention			
	Mean	Std. Deviation	N
I think a lot about leaving the organization	2.11	1.072	463
I am actively searching for an alternative to the organization.	2.00	1.041	463
As soon as possible, I will leave the organization.	1.81	0.919	463
I think a lot about leaving the job.	1.89	1.026	463
I am actively searching for an alternative to the job.	1.86	1.025	463
As soon as possible, I will leave the job.	1.74	0.934	463
I think a lot about leaving my occupation.	1.67	0.957	463
I am actively searching for an alternative to my occupation.	1.70	0.964	463
As soon as possible, I will leave my occupation	1.62	0.914	463

Table 8 Item Statistics on Turnover Intention