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GROUP EMPOWERMENT CAPACITY AND CAPABILITY IN SCHOOLS OF NURSING

by

Mary Louanne Friend

Abstract of a Dissertation
Submitted to the Graduate School
of The University of Southern Mississippi
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy

December 2013

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ABSTRACT

GROUP EMPOWERMENT CAPACITY AND CAPABILITY

IN SCHOOLS OF NURSING

by Mary Louanne Friend

December 2013

Nursing education is experiencing rapid changes as nurses are expected to transform and lead health care delivery within the United States. The ability to produce graduates who can promote a culture of safety, and provide patient centered care in collaboration with others will require nursing administrators and faculty who are empowered and able to achieve goals. The Sieloff Theory of Group Empowerment within Organizations (Sieloff & Bularzik, 2011) provided the theoretical basis for this exploratory correlational study examining group empowerment capacity and empowerment in administrators and faculty within the United States. Empowerment was conceptualized as the ability of the group to achieve goals.

The Sieloff-King Assessment of Group Empowerment in Organizations (SKAGEO©) was adapted for use in an academic setting, and was administered online to a stratified sample of administrators and faculty in American Association of Colleges of Nursing (AACN) member schools that offer baccalaureate and graduate nursing programs. Nursing administrators from 79 schools and 312 full time nurse faculty members completed the survey.

Data analyses indicated participant's scores were within high ranges in both of the scales: Empowerment Capacity (EC) and Empowerment (E).

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Additionally, findings indicated there was a statistically significant difference in both scales between groups. Although there were no significant effects on empowerment by rank, tenure, geographic area, highest degree earned, or type of school funding, there were statistical differences between administrator and faculty subscales scores. Psychometric analyses indicated strong reliability of the SKAGEO© as adapted for use in educational settings with high Cronbach's alpha for both scales.

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Approved:

Katherine Nugent
Director

Bonnie Harbaugh

Sandra Bishop

Kyna Shelley

Christina Sieloff

Susan A Siltanen
Dean of the Graduate School

December 2013

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To all administrators and faculty who took time from their busy schedules to participate in my research and whose expertise I admire. I dedicate this to you as you work to achieve excellence with fewer resources and increased demands. I hope this study increases dialogue and understanding of empowered environments in nursing education and how we can work to support these workplaces.

To my husband, Dr. Richard Friend whose love, support and sacrifice made this journey possible. With all my love I want to especially thank my children who are my greatest legacy: Jessica, Michelle, Benjamin, and Mason.

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CHAPTER I

INTRODUCTION

Nurse educators have a responsibility to produce graduates who can promote a culture of safety and serve as leaders in health care reform (Cronenwett, Sherwood, & Gelmon, 2009; Institute of Medicine, 2010). The 2000 Institute of Medicine (IOM) report, *To Err is Human: Building a Safer Health care System*, described an American hospital system where as many as 98,000 people die annually as a result of preventable errors, and thousands more are injured (Kohn, Corrigan & Donaldson, 2000). Not only did this landmark report illuminate health care system's complexities, but it also identified the importance of effective team work for reducing system errors.

Griener and Knebel (2003) called for transformation in the education of health care providers. For example, authors recommended bridging the gap between education and practice, and focusing on interdisciplinary collaboration. Nurse educators have responded by including quality and patient safety content, and incorporating team building and multidisciplinary learning opportunities within the curriculum. However, in spite of these changes, oppressed group behaviors within nursing continue to jeopardize team work and patient outcomes. In addition, oppressed group behavior threatens nursing's ability to transform nursing practice and health care (Clark & Springer, 2007; Daiski, 2004; Fletcher, 2006; Roberts, 1983, 2000).

Oppressed group behavior (OGB) in nursing has been described (Roberts & DeMarco, 2003; Roberts, DeMarco, & Griffin, 2009; Torres, 1981). In 1983, Roberts first applied Friere's Theory of the Oppressed (1970) to describe nursing oppression. According to Roberts (1983), hospital hierarchal structures, often benefitting the organization and powerful physicians, creates dependent nurses. Roberts stated nurses, in

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efforts to become more dominant, often adopt the values of the oppressor (physicians). However, instead of experiencing more power, these nurses often feel a lack of self-esteem and eventually demonstrate passive-aggressive behaviors and develop self-hatred and dislike for other nurses.

The documented detrimental effects of OBG include horizontal violence, incivility, bullying, and passivity. These behaviors have been associated with deleterious effects on patient care and have also been identified as reasons for nurses leaving the profession (Hader, 2008; Tinsley & France, 2004). Nurse educators, who may have an opportunity to empower students, are reportedly also victims of uncivil behavior by administrators and students (Clark, 2008; Heinrich, 2007; Luparell, 2007). Nurse faculty who lack empowerment may contribute to the increase in uncivil behavior within the nursing profession. Therefore, to achieve an empowered workplace, it is essential that administrators create empowered environments in which faculty are able to achieve program outcomes.

Administrators in schools of nursing are responsible for maximizing resources to achieve program outcomes. If faculty believe they have the resources and the authority to teach, one can hypothesize graduates may also learn to achieve goals, empower themselves and transform health care organizations. Although much has been written about empowerment in hospitals (Manojilovich, 2007; Nedd, 2006; Patrick & Laschinger, 2006), there is little targeted research regarding environments that facilitate groups to empower themselves and best practices in nursing education. Furthermore, many studies related to nursing empowerment have been based upon theoretical frameworks from other disciplines.

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The significance of basing nursing knowledge upon conceptual frameworks of nursing has been well documented (Alligood & Tomey, 2010; Butts, Rich, & Fawcett, 2012; Fawcett, 1999). According to Fawcett, by definition, a profession has unique perspectives and subsequently, requires specific theoretical foundations in order to adequately examine their phenomena of interest. The present study was primarily based upon a mid-range nursing theory and focused upon group empowerment in schools of nursing.

Problem Statement

Nursing programs have the responsibility of preparing graduates for competent, safe, effective practice. The continued documentation of incivility and oppressed group behaviors within the nursing literature suggests that nurses do not work effectively as groups. The ability to work as teams has been identified as central to patient safety (Gustafson, Beaubien, Salas & Barach, 2005; IOM, 2000). In addition, the relationship of nursing empowerment to nursing satisfaction and better patient outcomes has been well defined and is a fundamental distinction of Magnet Hospitals, where best practices, shared governance, and nurse autonomy are valued (Aiken, Havens, & Sloane, 2000). Whereas it has been suggested that empowering environments have the potential to decrease or change oppressive behaviors in the next generation of nurses, it is also known that nursing faculty do not have significant impact, control or influence within their departments (Baker, Fitzpatrick, & Griffin, 2011). This study utilized a mid-range nursing theory to examine group empowerment capacity and group empowerment capability in schools of nursing.

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Purpose

The purposes of this exploratory study were to describe group empowerment in nurse faculty and administrators in schools of nursing that offer baccalaureate and graduate programs of study and are members of the American Association of Colleges of Nursing (AACN). This study examined empowerment capacity (EC), empowerment (E), mediating variables or group leader competencies, and the demographic variables related to the research questions of participants and of the institution.

Conceptual Framework

Sieloff's Theory of Group Empowerment in Organizations

The theoretical foundation for this research, the Sieloff Theory of Group Empowerment within Organizations (Sieloff & Bularzik, 2011), supports the ideal of generating nursing knowledge by using nursing generated theory. Sieloff initially developed the theory of nursing department power in 1989. Using synthesis and reformulation, Sieloff utilized King's conceptual framework and the Strategic Contingencies Theory of Power (Hickson, Hinings, Lee, Schneck, & Pennings, 1971) to explain nursing's lack of power. Later, Sieloff renamed the theory to Theory of Group Outcome Attainment (Sieloff, 1996) in response to nurses expressing a negative perception of power and the elimination of nursing departments in hospitals. Subsequently, Sieloff also theorized that empowerment was synonymous with a group's outcome attainment capability or actualized power (Sieloff & Bularzik, 2011).

According to King, nursing is a process that is interactional in nature and these interactions lead to transactions resulting in goal attainment (King, 1990, 1992). Concepts within King's conceptual framework include personal systems, interpersonal systems,

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social systems, the concept of goal attainment, and concepts of administration. Within the context of social systems, King identified power as a major concept. Likewise, Sieloff identified group power as a positive resource for nurses which is not zero-based or a fixed amount. Sieloff and Bularzik defined actualized empowerment as the ability of the group to achieve outcomes (2011).

The strategic contingencies theory of power (Hickson et al., 1971) was used by Sieloff to provide conceptual guidance to understand nursing's lack of power within organizations (Sieloff, 2007). The theory hypothesized that organizations consist of interdependent sub-units and that there is a distribution of power in the division of labor, thus shifting the emphasis of power from persons to groups. Three concepts were identified as contributors to the groups' ability to cope or power. These concepts are centrality, coping with uncertainty, and substitutability (Hickson et al., 1971).

Sieloff reconceptualized these three concepts to be consistent with King's systems framework in order to develop concepts of organizational power that addressed the human context of nursing (Sieloff, 1995). The three concepts of centrality, coping with uncertainty, and substitutability were relabeled as position, controlling the effects of environmental forces and role, respectively. In addition, Sieloff (1995) added resources as a fourth source of power. According to Sieloff, these four variables contribute to a group's empowerment capacity.

In an effort to explain why some groups are not empowered in spite of empowerment capacity, Sieloff (1999) identified four variables associated with group empowerment. Sieloff (1995) identified these variables through observations and labeled them based on the results of a factor analysis of instrument data. The variables were (a)

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communication competency, (b) goal/outcome competency, (c) nurse leaders' empowerment competency and (d) empowerment perspective. In summary, Sieloff's Theory of Group Empowerment in Organizations is conceptualized as the first four variables of 1) controlling the effects of environmental forces, 2) position, 3) resources, and 4) role contributing to a group's empowerment capacity. However, before a group's empowerment capacity can be actualized, or the group can empower itself (empowerment capability), four additional components must intervene. These four components are 1) communication competency, 2) goal/outcome competency, 3) group leader's empowerment competency, and 4) empowerment perspective (Sieloff, 2012).

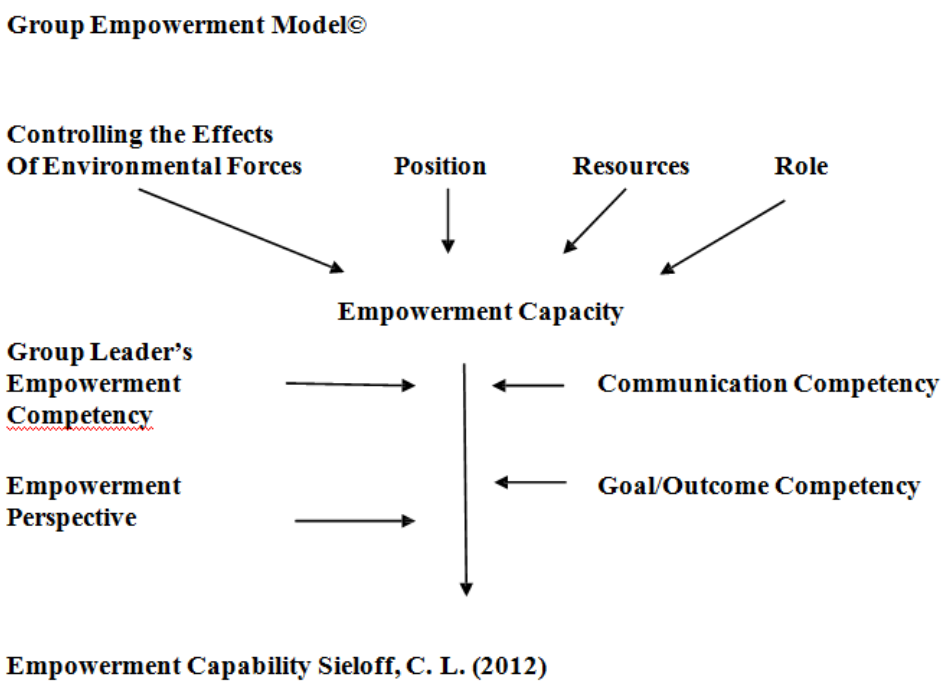

Figure 1. Model Theory of Group Empowerment within Organizations.

Sieloff and Dunn (2008) theorized that increasing group power would have an associated increase in quality outcomes, improved patient safety, and improved financial

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solvency of health care organizations. Sieloff's theory has implications for nursing education because power has not been viewed positively by nursing, and nursing texts generally refer to individual nurse power as opposed to group power (Sieloff & Bularzik, 2011). If nurse faculty also views power as negative, based on current textbooks, students may graduate without benefit of understanding the resource. Sieloff's related instrument the Sieloff -King Assessment of Group Empowerment within Organizations© can be used by educators to increase the visibility of nursing group's contribution to health care, and to develop and implement strategies to increase group empowerment (Sieloff & Bularzik, 2011).

Research Questions

The following research questions were measured in the study:

1. What are the reported levels of group empowerment capacity and capability in baccalaureate schools of nursing?

2. Is there a difference between levels of group empowerment capacity and capability of the administrators and faculty?

3. Is there a relationship between mediating variables and group empowerment?

Definition of Terms

For the purpose of this study, the conceptual and/or operational definitions are:

Empowerment is defined as the group's capability to achieve outcomes and is seen as a positive resource that is available to all groups (Sieloff, 2012). In this study, empowerment is also called group empowerment in organizations (nursing schools). Group empowerment is operationalized as being equal to the group's empowerment

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capacity interacting with four mediating variables and is measured by the total score on the instrument (Sieloff & Bularzik, 2011).

Empowerment Capacity is defined as "capacity of a group to achieve [outcomes]" (Sieloff, 1995, p. 54.). The operational definition of empowerment capacity is obtained by the total of four SKAGEO© subscale scores: a) controlling the effects of environmental forces, b) position, c) resources, and d) role.

Controlling The Effects Of Environmental Forces (CEEF) is defined as "effectively managing the potential negative consequences that result from the effect of changing health care trends on the ability of an [organization] to achieve its goals" (Evans,1989 as cited in Sieloff, 2007, p. 207). This construct is measured by items number 4, 8, 9, 10, and 16 on the instrument.

Position (P) is defined as "the centrality of a nursing [group] within the communication network of a [nursing program]" (Sieloff, 1995, p. 57; as cited by Sieloff, 2007, p. 207) and is measured by items number 6, 14, 32, and 33.

Resources (RE) are defined as any commodity that a nursing group can use for goal achievement (Maas, 1988, as cited in Sieloff, 2007, p. 207). Resources are measured by items number 5, 15, 19, 20, 21, and 27 on the instrument.

Role (RO) is "the degree to which the work of a nursing program is accomplished through the efforts of a nursing group" (Sieloff, 1995, p. 58 as cited in Sieloff, 2007, p. 207) for purposes of this study. Role is measured by items number 12, 13, and 22 on the instrument.

Rank refers to traditional collegiate rankings of instructor, assistant professor, associate professor and professor.

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Administrator is defined as the chief administrator of the nursing program as defined by the CCNE.

Group of Faculty is defined as the groups who hold full time positions with the privilege of full time faculty. This excludes part time, adjunct and others not considered full time.

Group leader, for purposes of this study, is the chief administrative officer for the school of nursing as defined by the CCNE.

School of Nursing is defined as a school or college of nursing with membership in the AACN, with 16 or more full time faculty, and offering baccalaureate and graduate programs.

Mediating Variable is defined as group leader/administrator competencies, and is operationalized from the scores on four subscales: group leader outcome attainment competency (GLOAC), communication competency (CC), goal/outcome competency (GOC), and empowerment perspective (OACP).

Group Leader's Empowerment Competency (GLOAC) is the knowledge and skills of the group leader in relation to the achievement of group goals/outcomes. This construct is measured by items number 1, 7, 18, and 28 on the instrument.

*Communication Competency (*CC*)* is defined as the knowledge and skill related to the giving of information from one group to another group (Sieloff, 1996). This construct is measured by items number 11, 26, and 29 on the instrument.

Goal/Outcome Competency (GOC) is defined as the knowledge and skill of a group in relation to the process of achieving "events that are valued, wanted or desired"

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(King, 1981, p. 145) by a group. This competency is measured by items number 2, 17, 30, and 31 on the instrument.

Empowerment Perspective (OACP) is the perception and value regarding the achievement of goals/outcomes. This construct is measured by items number 3, 23, 25, and 34 on the instrument.

Years of Service is the number of years with employment at the current organization.

The abbreviations for variables within Sieloff's theory, and their relationships to empowerment capacity and empowerment are summarized in Table 1.

Table 1

Sieloff Theory of Group Empowerment in Organizations Variables

Variable	Empowerment Capacity (EC)	Mediating Variables	Empowerment Capability or EMPOWERMENT (E)
GLOAC		X	X
CC		X	X
CEEF	X		X
GOC		X	X
P	X		X
OACP		X	X
RE	X		X
RO	X		X
EC	- - - -	- - - -	- - - -
E	- - - -	- - - -	- - - -

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Note. EC = Empowerment Capacity, E = Empowerment

Assumptions

The following assumptions apply to this study:

1. Individuals are capable of empowering themselves; therefore creation of empowering environments is important.

2. Participants will reply honestly to the survey because of assurance their responses will be confidential and anonymous.

3. Self-reporting is an effective means of gathering information which would otherwise be difficult, if not impossible, to obtain, and is consistent with King's belief (1981) that an individual's perceptions were valid and did not need to be substantiated further.

4. A nursing faculty is unique and has subjective perceptions of empowerment consistent with King's belief (1981).

5. The Sieloff-King Assessment of Group Empowerment within Organizations© has demonstrated validity and reliability in nursing groups and is a valid and reliable instrument for use in schools of nursing.

Scope and Delimitations

The study was limited to full time administrators and faculty within AACN schools of baccalaureate nursing in the United States. Only schools of nursing with sixteen or more full time faculty and who offer baccalaureate and graduate programs were utilized in order to obtain a homogenous sample. In addition, the study that is sensitive in topic, directly depended upon the dean or director's support to ensure adequate faculty participation, and was limited to volunteer participants. Faculty who

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were least empowered may have responded less frequently, making a representative sample difficult to obtain. Finally, the Sieloff-King Assessment of Group Empowerment (SKAGEO©) had never been utilized within nursing education, which is also a limitation.

Significance of the Study

The significance of the nursing profession's ability to achieve outcomes and influence health care has received unprecedented attention. The IOM's *The Future of Nursing, Leading Change Advancing Health* (2010) called for the transformation of nursing practice and education. Four key points identified within the study included:

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and information infrastructure (IOM, 2010). These recommendations have significant implications for nursing education administrators to work collaboratively to ensure that the percentage of baccalaureate prepared nurses increase from 50% to 80%, and to double the number of nurses with doctoral degrees by 2020. In addition, the report's authors advocated for the monitoring of accredited nursing education programs to ensure that at least 10% of their baccalaureate graduates continue their education within five years of graduation (IOM, 2010).

In order to meet these challenges, nursing education administrators must work with university trustees to create salary and benefit packages to recruit and retain

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qualified nurse faculty. Furthermore, administrators must promote environments which support faculty to participate in continuing professional development in order to remain competent in practice, teaching, and research (IOM, 2010). In summary, nursing education administrators are expected to provide resources and leadership that enable faculty and their graduates to engage in lifelong learning.

Ultimately, the ability of nursing education to redesign its programs in efforts to produce graduates who can provide safe, patient-centered care, and transform health care delivery may depend upon educator's abilities to achieve goals and transform their organizations. This study was completed in efforts to answer the following questions: a) how do nurses become empowered? b) does the process begin in nursing educational programs, and if so, c) what factors contribute to or hinder the process? By identifying levels of group empowerment in deans and faculty, this study may provide information regarding the presence (or lack) of empowering environments in baccalaureate schools of nursing, and leadership competencies associated with these environments. According to Price (2009), early socialization experiences have a strong influence on an individual's view of nursing and their professional socialization. Furthermore, according to Falk-Rafael, Chinn, Anderson, Laschinger and Rubotsky (2004), classroom empowerment is likely to extend beyond the classroom to work environments. Therefore, empowered nurse faculty may influence their student's ability to also empower themselves.

Significance of Empowerment for Administrators in Nursing Education

Nursing education administrators have the responsibility to facilitate achievement of program objectives by providing resources. The existing literature on nursing education administrators is broad and includes topics such as motivation and job

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satisfaction (Lamborn, 1991), level of career development and mentoring (Rawl & Peterson, 1992; Short, 1997), working with faculty (Doughty, May, Butell, & Tong, 2002), and Taiwanese nurse faculty satisfaction related to deans' and directors' leadership style (Chen, Beck, & Amos, 2005).

This study was completed to identify leadership competencies that facilitate empowering environments in efforts to describe surroundings which not only encourage nurse faculty to remain in education but also may support their desire to become administrators. According to Adams (2007), the disparity between supply and demand for qualified candidates for leadership roles is staggering. Adams also affirmed that today's nursing academic leaders must "create a shared vision, inspire others to embrace it and empower others to achieve it" (p. 309). A critical component of developing empowering environments is for oneself to be empowered.

Empowerment and the Faculty Shortage

The faculty shortage in nursing has been described as a crisis for health care (Yordy, 2006). According to The American Association Colleges of Nursing (AACN) faculty survey, factors contributing to the shortage include increasing age of current faculty and a limited supply of younger replacement faculty (AACN, 2012b). U. S. nursing schools turned away 75,587 qualified applicants from baccalaureate and graduate nursing programs in 2011 due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. Almost two-thirds of the nursing schools, responding to the AACN survey, pointed to faculty shortages as a reason for not accepting all qualified applicants into entry-level baccalaureate programs (AACN, 2012c). Not only does the current shortage of nursing

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faculty affect potential students, but also suggests there is a limited pool of leaders to replace current deans and directors of nursing programs.

In summary, this project was completed in efforts to identify current levels of group empowerment in administrators and faculty. In addition, leadership competencies associated with empowered workplaces were examined. The potential to identify best practices in nursing education may not only change the pattern of oppressed group behaviors, but also provide valuable information to help produce novice nurses who can transform their respective health care organizations.

Summary

This chapter has summarized current opportunities and challenges for nursing educators to transform health care, and the significance of describing and measuring empowerment in nursing education. In addition, The Sieloff Theory of Group Empowerment and related definitions (Sieloff, 2007) has been summarized. Research questions to be measured by the study have also been identified. Chapter II provides a review of the literature that supports the study.

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CHAPTER II

REVIEW OF RELATED LITERATURE

Introduction

The review of the literature provided background information supporting the study including nursing empowerment and the related concepts of oppression and oppressed group behaviors (OBG) in nursing. An integrated discussion of related empowerment theories, relevant previous studies, transformational and transactional leadership, and leadership competencies associated with empowerment has been reviewed. The research related to the theoretical framework this study is based upon was reviewed. Since the proposed study will examine empowerment in schools of nursing education, a brief history of professional nursing education and its current status in the United States follows.

Professional Nursing Education in the United States

According to Egenes, in Roux and Halstead (2009), formal nursing training began in the United States following the Civil War (1861-1865). The thousands of untrained women who cared for the wounded and dying, and their lack of training, not only illuminated the need for educated nurses but also helped change public perception that women should not work outside their homes. In 1868, the president of the American Medical Association, Dr. Samuel Gross advocated for the formation of nursing training schools. The first U.S. nursing education programs were based upon the British Nightingale tradition of apprenticeships, where student nurses trained in hospitals under the supervision of senior nurses, and learning occurred on the job.

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During the 20th century, the transformation of nursing education began with a landmark study known as The Goldmark Report (1919-1921). The report, sponsored by the Rockefeller Foundation, contained recommendations to separate nurse training from hospital management and to strengthen university schools of nursing (Goldmark, 1923).

Associate degree (AD) nursing programs expanded during the second half of the 20th century as a result of the nursing shortages and an increase in community colleges in the United States. According to Mahaffey (2002), AD nurses provided approximately 60% of entry level graduates and attracted a large number of minority groups and males. Today, many community colleges are looking for ways to partner with four year colleges to keep their graduates competitive and to provide the increased number of baccalaureate prepared nurses as called for by the IOM Future of Nursing report (2010). Nursing educators are actively working to increase the educational preparation of AD graduates. Recent data from the American Association of Colleges of Nursing (AACN, 2012a) indicates there is more RN to BSN programs (601) than traditional BSN programs (569), and as of 2011, 127 schools offer RN-to-Master's programs. In addition, schools of nursing which offer associate degree and baccalaureate degree schools are working collaboratively to attain the IOM goal of 80% of baccalaureate prepared nurses by 2020 (Cleary, McBride, McClure, & Reinhard, 2009; Sizemore, Robbins, Hoke, & Billings, 2007).

According to AACN (2012b) data, enrollments in entry level baccalaureate programs increased by 5.1% in 2011 and total enrollment in all nursing programs leading to the baccalaureate degree was 259,100, an increase from 238,799 in 2010. In addition, 94,480 students are enrolled in MSN programs, 4,907 in research-focused doctoral

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programs and 9,094 in practice focused doctorates in nursing. Heightened interest in advanced nursing education has been influenced by the Institute of Medicine report (2010) report whose authors advocated for baccalaureate preparation as the entry level of education for nursing practice.

Benner, Sutphen, Leonard, and Day (2010), reported that nursing education must be transformed in order to successfully prepare graduates. Specifically, they recommended the following changes within nursing education, shifting from: 1) The current focus on decontextualized knowledge to an emphasis on teaching for a sense of salience, situated cognition, and action in clinical situations, 2) A sharp separation of classroom and clinical teaching to integrative teaching in all settings, 3) An emphasis on critical thinking to an emphasis on clinical reasoning and multiple ways of thinking that include critical thinking, and 4) An emphasis on socialization and role taking to an emphasis on formation. They concluded that the changes that nursing education needs at the structural level are "radical and require new approaches to policy" (Benner et al., 2010, p. 214). However, the necessity for nursing education transformation is not new to the literature.

Nursing Education Pedagogies

Nurses were primarily educated in the apprenticeship model earning a diploma in nursing until the 1970s. However, with the advent of feminism, nursing educators began to advocate for changes to the oppressive and submissive pedagogy of nursing education (Allen, 2010). An additional catalyst for change in nursing education was the American Nurses Association's (ANA, 1965) recommendation that nursing education shift from hospitals to academic settings. As a result, during the 1980s to 2000 nursing education

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shifted from a focus on practice in the hospital to include the preparation of nurses who could provide care in the community setting, and perform nursing research (Allen, 2010).

According to the National League for Nursing (NLN, 2003), many nurses were educated based upon the Tyler curriculum model, which was teacher driven and heavily influenced by behavioral learning objectives contained within highly structured curricula. The NLN began advocating for pedagogical transformation in nursing education beginning in the late 1980s (Forbes & Hickey, 2009). According to Ironside (2004), nursing educators have spent years debating what to teach at the expense of discussing how to teach. Furthermore, in response to advances in biomedical and nursing knowledge, content has been added to curriculum, creating debate as to how to cover the information with fewer faculty and resources.

Peters (2000) advocated for a constructivist epistemology approach as an alternative to the traditional behaviorist pedagogy in baccalaureate nursing education. Peters argued constructivism enhances empowered learning by considering prior knowledge, adult learning principles, and student ownership of learning. According to Paniagua-Ramirez, Barone, and Torres (2004), there is a movement towards a learning paradigm through the integration of learning-centered themes into traditional instructional pedagogies in nursing. They stated that institutions of higher education may be changing from “teaching factories" to “learning communities" (p. 10).

In contrast, Ironside and McNelis (2010) conducted an evaluation of prelicensure nursing programs to specifically discover the barriers and challenges facing nurse faculty. A total of 2,386 nurse faculty participated representing all 50 states, and all types of prelicensure nursing programs. Respondents indicated the following five barriers to

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effective clinical education: a) lack of qualified clinical sites, b) lack of qualified faculty, c) ratio of faculty to students, d) restrictions on student experiences imposed by agencies, and e) time demands for students learning different agencies' policies and procedures. Faculty were also asked to list strategies to deal with these barriers, but unfortunately few teaching strategies were identified as *effective*, and the relationship between solutions and student learning was unclear. The authors concluded that clinical nursing education is complex and transformation can occur only if educators change how they think and become comfortable with having their teaching styles challenged. Furthermore, using innovative teaching strategies without considering their pedagogical basis is ineffective, and nursing pedagogy requires ongoing research and development.

Likewise, according to Allen (2010), nursing education has evolved from an apprenticeship to a holistic model in the college setting. Allen asserted that in order for nursing education leaders to meet the requirements of a generation of nurses who can provide safe, effective care, a paradigm shift must be created. Allen also advocated for a process where the "student is engaged in the process of developing autonomy and empowerment" (p. 36).

In summary, nursing literature supports radical changes in nursing education pedagogy that will prepare novice nurses to practice in environments of uncertainty. The literature described a paradox in nursing education where students are expected to practice in rapidly evolving environments using academic models that are predictable and familiar. However, the ability to effectively renovate nursing education requires nurse faculty who can not only effectively transform educational practices, but also do so with fewer resources.

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Nurse Faculty Shortage

The faculty shortage and its associated causes have been well documented in the nursing literature. For example, according to Berlin and Sechrist, "The deficiency of faculty is contributing to the general nursing shortage inasmuch as the inability to recruit and maintain adequate numbers of qualified faculty is restricting the number of students admitted to nursing programs" (2002, p. 50). The authors attributed the aging of faculty, inadequate numbers of doctoral nursing students, and the "sacrosanct traditions of nursing education" (p. 56) to the faculty shortage. Not only does the faculty shortage affect the ability to produce novice nurses, but it also influences the succession planning of all nursing leaders. According to Hinshaw (2001), "the shortage of nursing faculty will also limit the professional leaders who are able to shape health policy in the state, national, and international arenas" (p. 1).

According to the American Association of Colleges of Nursing (2012c), *Special Survey on Vacant Faculty Positions*, released in October 2012, a total of 1,181 faculty vacancies were identified in a survey of 662 nursing schools across the country (78.9% response rate). Most of these vacancies were for positions requiring or preferring a doctoral degree. The two main difficulties cited by respondents included not enough qualified candidates, followed by an inability to offer competitive salaries. Although the literature described the effects of too few doctoral prepared nurses, and academia's inability to compete with clinical based salaries, less has been written about the impact of faculty work environments on the nurse faculty shortage.

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Nurse Faculty Work Environments

The nursing literature is inconsistent regarding descriptions of nurse faculty work climates. For example, Brendtro and Hegge (2000) conducted a survey of nurses with graduate degrees as part of a statewide workforce study. The four research questions were: 1) "How does the age of nursing faculty compare with the age of graduate nurses employed in nonacademic settings; 2) What positions do nurses with graduate degrees currently hold and how satisfied are they with these positions; (3) What incentives could be employed to attract and retain nurse faculty; and 4) What ideas do graduate nurses have to increase the numbers of qualified nurse educators" (p. 99). A survey was mailed to all nurses with a graduate degree in South Dakota with a 61% return rate and sample of 288 nurses. The authors concluded less than one third of nurses with graduate degrees were in academic positions (*N*=75). There was no difference in satisfaction between those in academic positions (79.5% satisfied) with those in non-academic positions (76% satisfied), and there was no difference between educators' and non-educators' intentions to stay in their current jobs. Improved compensation, greater respect, closer proximity to work and more realistic expectations were suggested as methods to attract nurses to faculty positions.

In contrast, the literature also contained studies identifying issues within the work environments in schools of nursing. For example, Moody, Horton-Deutsch, and Pesut (2007) identified a challenge for nursing leaders created by the hierarchal bureaucracy between faculty and administration. They argued this divide between administrators and faculty prevents "cohesive, empowering personal-professional interrelationships associated with the historically patriarchal influence and alignments in traditional

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academic settings" (p. 320). In order to develop a more cohesive group, the authors recommended appreciate inquiry as an administrative process to achieve unity between faculty and administration.

Likewise, Cash, Daines, Doyle, von Tettenborn, and Reid (2009) conducted a mixed methods pilot study designed with 115 nurse educators to test their six-scale survey instrument, and to triangulate the elements of a quality workplace for nurse educators. They concluded nursing educators in Canada work under conditions less desirable than they would like, and there is a lack of congruence between what they believe is important and what they experience in their workplace. In addition, respondents expressed their desire for shared leadership based on faculty empowerment. The authors suggested organizations that provide an environment that facilitates empowerment may facilitate the recruitment and retention of nurse faculty and further research is warranted.

Cash, Doyle, vonTettenborn, Daines, and Faria (2011) examined the workplace environments of faculty and their impact on faculty recruitment and retention. They utilized a pilot study with 115 educators in British Columbia to evaluate qualitative and quantitative data related to the following: structural domain scales of academic commitments, nursing department/school/program leadership, and autonomy in teaching. They concluded that, although their study included a small sample, faculty identified the importance of leaders who support and advocate for faculty, and have transparency in communication with faculty. The authors concluded that "nurse educators will need to examine the hegemony underpinning work related bureaucratic arrangements enacted in their environments" (p. 263).

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In summary, the literature described the importance of nurse faculty who can work together to achieve goals in empowering work environments. This is especially crucial given the faculty shortage, and the concurrent opportunities for nurses to serve as health care leaders. However, coinciding with Committee (2011) and Benner et al. (2010), the nursing literature also describes oppressed group behaviors in practice, administration, and education. In order to understand the lack of nurse empowerment, the literature describing nurse oppression will be summarized.

Oppression

According to Webster, oppression is "the unjust or cruel exercise of authority or power; or a sense of being weighed down in body or mind" (Oppression, n.d.). According to Frye (1983), the root of the word oppression is the element *press*. Therefore, anything that oppresses effectively restrains, restricts or prevents motion or mobility. Frye described oppression using the analogy of a birdcage. Frye stated if one focuses on a single wire of the cage, the other wires become invisible, making the bird's freedom seem possible. However, by stepping back and viewing the entire cage, it becomes obvious that the bird is surrounded by a network of systematically related barriers. Frye described oppression as living one's life shaped by barriers which systematically restrict or penalize motion in any direction. The nursing profession, historically restrained by the barriers of hospital bureaucracy, physician and senior nurse authority, may be compared to this analogy.

Oppression has been described as a psychological, political, and social process with both external and internal dynamics. Young (1988) stated "all oppressed people share some inhibition of their ability to develop and exercise their capacities and express

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their needs, thoughts and feelings" (p. 271). Psychological oppression may refer to abuse that result in mental anguish (Hanna, Talley, & Guindon, 2000) or internalized restrictions where the person acts as his or her own personal censor (Prilleltensky & Gonick, 1996). According to Prilleltensky and Gonick, intrapersonal oppression occurs within the single individual and includes behaviors, such as learned helplessness. Interpersonal oppression often includes verbal or emotional abuse, and the phenomenon of self-fulfilling prophecies where oppression is solidified, such as in ethnic minorities.

Political oppression involves external forces where individuals are deprived of self-determination. Examples of politically oppressed groups include colonized Africans, South Americans, African Americans and American women (Roberts et al., 2009). According to Prilleltensky and Gonick (1996), oppression at the social level occurs when groups of people develop collective identities of inferiority.

Oppression and Education

The oppressive nature of education and oppressed group behaviors were described within Freire's *Pedagogy of the Oppressed* (1970). According to Freire, a Brazilian educator, oppression occurs in "any situation in which 'A' objectively exploits 'B' or hinders his and her pursuit of self-affirmation as a responsible person" (p. 55). Freire (1970) developed his theory of oppression while observing South Americans. He proposed that oppressed groups become caught in a vicious cycle of oppression because they believe they are inferior to their oppressors. Furthermore, the oppressed become dependent upon their oppressors and are reluctant to change the power structure. Further exacerbating the cycle is the aggression and anger exhibited by the oppressed against their peers. Freire stated education, referred to as "human liberation", was the way to

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break this cycle. Freire believed that understanding the cycle and replacing the negative images of one's culture with a positive sense of pride was the key to becoming empowered.

Nursing and Oppressed Group Behavior

Roberts (1983) first described oppressed group behaviors (OGB) in nursing. She affirmed that submissive, passive-aggressive behaviors in nursing develop in response to domineering practices of physicians and hospital administrators. Powerlessness in nursing has also been compared to sociological oppression (Duffy, 1995; Ratner, 2006; Roberts, 2000; Roberts et al., 2009). Factors associated with nursing's OGB included lack of empowerment, authoritative leadership, oppression, learned helplessness (Lewis, 2006), negative nursing unit culture and toxic work environment (Farrell, 1997, 1999; Freshwater, 2000; Hamlin, 2000), suppressed anger and gender issues (Rowell, 2005) and low self-esteem (Longo & Sherman, 2007; Nazarko, 2001). Terminology associated with these negative behaviors has also been described in the literature.

Horizontal violence is defined as overt and covert actions by nurses toward each other, especially toward those viewed as less powerful (Griffin, 2004). According to McKenna, Smith, Poole, and Coverdale (2003), horizontal violence is not just physical in nature, but also includes "verbal abuse, threats, intimidation, humiliation, excessive criticism, innuendo, exclusion, denial of access to opportunity, disinterest, discouragement and the withholding of information" (p. 90). Purpora, Blegen, and Stotts (2012) established horizontal violence was reported by 21.1% (n = 37) of participating nurses. Findings suggested (a) a positive relationship between beliefs consistent with an oppressed self and horizontal violence (r = .434, p < .05) and (b) a positive relationship

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between beliefs consistent with those of an oppressed group and horizontal violence (r = .453, p < .05). Purpora et al., concluded a "change in the oppressive social structure of hospitals may be needed to truly address horizontal violence in the best interest of the quality and safety of patient care" (p. 306).

Lateral violence, or nurse to nurse aggression, includes "non-verbal innuendo, verbal affront, undermining activities, withholding information, sabotage, infighting, scapegoating, backstabbing, failure to respect privacy, and broken confidences" (Griffin, 2004, p. 258) and has been described by multiple authors (Sheridan-Leos, 2008; Stanley, Martin, Michel, Welton, & Nemeth, 2007). Additional terms used to describe these behaviors are bullying (Hughes & Clancy, 2009; Johnson & Rae, 2009; Shewchuk, 2005), and verbal abuse (Ulrich et al., 2006). Literature related to oppressed group behavior in nursing education is generally referred to as "incivility" (Clark & Springer, 2007; Cooper, Walker, Askew, Robinson, & McNair, 2011). Regardless of the term used to describe these behaviors, consistent within the literature is the belief that negative behaviors in nursing are toxic.

Effects of Oppressed Group Behavior

The outcomes of OGB in nursing include increased intent to leave the profession (Sofield & Salmon, 2003; Watson, 2002); submissiveness (Matheson & Bobay, 2007), sadness (Rowe & Sherlock, 2005), decreased autonomy and job performance (Cortina, Magley, Williams, & Langout, 2001), and silencing behaviors (Buresh & Gordon, 2006; DeMarco, 1997, 2002; Gardezi et al., 2009). Horizontal violence has also been associated with negative health effects and interruption in work settings (Hutchinson, Vickers, Jackson, & Wilkes 2006). According to Roberts et al., (2009),

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nearly 70% of nurses had experienced workplace bullying (WPB). Effects of WPB included intention to leave, emotional exhaustion, depression, absenteeism, suicidal ideation, and other somatic complaints (Quine, 2001; Vessey, DeMarco, Gaffney, & Budin, 2009).

Novice Nurses and Oppressed Group Behaviors

New graduates are particularly susceptible to horizontal violence (Griffin, 2004; McKenna et al., 2003; Randle, 2003). Researchers discovered that about a third of novice nurses intend to leave their position after experiencing workplace bullying (WPB) (Johnson & Rae, 2009; Laschinger, Grau, Finegan, & Wilk, 2010; Simons 2008). Likewise, Pellico, Brewer, and Kovner (2009) discovered novice nurses reported high levels of mistreatment by their colleagues, including physicians and senior nurses.

According to Berry, Gillespie, Gates, and Schafer (2012), 21.3% of novice nurses are exposed to daily WPB; 44.7% self-identified as being a target of WPB; 18.2% reported being bullied “now and then” or “several times a week”; and 55.3% experienced no bullying at all (p. 82). The main perpetrators of bullying were staff nurses with only 6% of the bullying incidents associated with physicians.

Nursing Incivility in Nursing Education

Clark and Springer (2007) described faculty behaviors towards students including loss of patience, incompetence, rude condescending remarks, and poor teaching style. Students also reported bullying behaviors amongst themselves including cursing, swearing and belittling behaviors (Cooper et al., 2011). Luparell (2011) suggested these uncivil behaviors continue when students enter the nursing workforce. Students who feel

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unable to assume responsibility for their own learning, may in turn be unable to assume responsibility to influence changes within organizations post-graduation.

In response to the mounting evidence of pervasive OGB, scholars (Campbell, 2003; Laschinger, Finegan, Shamian, & Wilk, 2001; Laschinger, Almost, & Tuer-Hodes 2003; Manojlovich & Laschinger, 2002), have focused upon identifying variables associated with nurse empowerment, and environments which facilitate nurse empowerment. In order to best understand empowerment, the related concept of power will be summarized.

Power

In French and Raven's (1959) classic work, the authors defined power as the ability of an agent to influence a target within a certain system or context. French and Raven (1959) identified five power types, including reward, coercive, legitimate, expert and referent. French and Raven's typology is often considered negative because it implies legitimate authority to use positive and negative sanctions.

Likewise, Bass (1960) identified two sources of power, position and personal. According to Bass, power results in part because of one's position within an organization and, in part, because of personal power. Characteristics of positional power include control over resources, rewards, information and the physical environment. In contrast, personal power includes influence derived from expertise, friendship and loyalty. Historically, power had a negative connotation in the general and nursing literature and was associated with hierarchical organizations and authoritative leadership (Kuokkanen & Leino-Kilpi, 2000). Manojlovich (2007) stated that the historical role of nursing as *woman's work*, and the invisibility of nurses work have contributed to the profession's

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lack of power. She also stated that power has been viewed by nursing as being diametrically opposed to caring.

However, this patriarchal view of power as *power over* instead of *power to* is currently not supported in the nursing literature. For example, much has been written about the favorable impact of power sharing (Trofino, 2003), and shared governance (Church, Baker, & Berry, 2008; McDowell et al., 2010; Moore & Hutchinson, 2006). Both power sharing and shared governance connote positive characteristics related to mentorship, sharing of information, and shared decision making. In addition, according to Kuokkanen and Leino-Kilpi (2000) nursing empowerment results from emancipation, organizational productivity, or a process of personal growth.

Empowerment

Empowerment has been defined differently by scholars in social work, education, political science and business. The concept of empowerment first gained momentum during the social movement of the 1960s and 1970s with civil and human rights struggles. The concept also was widely used in religion where it referred to "sharing of real power" (Bartenuk & Spreitzer, 2006, p. 259). Empowerment as a dynamic concept involving power sharing was defined by Kieffer (1984) as the achievement of a multidimensional participatory competence. Community empowerment has been described by Rappaport (1987) and Rodwell (1996) as people uniting to achieve common goals. According to Bailey (1992), empowerment is defined by the people and context involved.

Empowerment in organizations has been associated with "increased commitment, better decisions, improved quality, more innovation, and increased job satisfaction"

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(Yukl & Becker, 2006, p. 210). According to Spreitzer and Doneson (2005), organizations have expanded empowerment practices to increase productivity and employee satisfaction during downsizing, and competition for lower costs. Within the general literature, empowerment is described by some to negate the effects of bureaucracies by giving workers the opportunity to participate in decision making, thus increasing their ability to try new things and to make needed change. Spreitzer and Doneson (2005) stated "rather than forcing or pushing people to change, empowerment provides a way of attracting them to want to change because they have ownership in the change process" (p. 2). However, this view of empowerment is limited as it focuses exclusively upon a top -down distribution of power within organizations.

Empowerment and Nursing

Empowerment entered the nursing literature at a time of hospital down-sizing, a nursing shortage and quality improvement projects (Bartunek & Spreitzer, 2006). According to McCarthy and Holbrook-Freeman (2008) empowerment in the nursing literature has been described in three categories: community empowerment, individual psychological empowerment, and organizational empowerment. Historically empowerment in nursing was viewed as something that nurses did for patients; however, empowerment in the nursing literature has shifted from a focus upon individual nurses' ability to empower patients to the recognition that nurses "cannot empower people, people can only empower themselves" (Rodwell, 1996, p. 310). According to Rodwell (1996) the empowerment process "provides the resources, skills and opportunity to develop a sense of control" (p. 310). Likewise, according to Rao (2012), empowerment has evolved within nursing and is defined "as a state in which an individual nurse has

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assumed control over his or her practice, enabling him or her to fulfill professional nursing responsibilities within an organization successfully" (p. 399).

In contrast to a focus on individual empowerment, for purposes of this study, empowerment is defined as implementation of the capacity of a group to achieve its goals. (Sieloff & Dunn, 2008), and is viewed as both a process and an outcome. In addition, empowerment is conceptualized as an active process as opposed to the passing of authority and responsibility to individuals at lower levels in the organizational hierarchy (Wellins, Byham, & Wilson, 1991).

Levels of Empowerment

Empowerment has been identified as a multi-level construct where each level of the construct is "interdependent with the others" (Zimmerman, 1995, p. 43). Individual empowerment has been defined as "a process where individuals learn to see a closer correspondence between their goals, and a sense of how to achieve them, and a relationship between their efforts and life outcomes (Mechanic, 1991, p. 641). According to Zimmerman (1990) examples of individual empowerment include "participatory behavior, motivations and feelings of efficacy and control" (p. 169). Classic research addressing individual empowerment was conducted by Conger and Kanungo (1988) and Thomas and Velthouse (1990). Findings from these projects supported an association between psychological empowerment with innovative behavior in spite of organizational and environmental obstacles (Conger & Kanungo, 1988; Thomas & Velthouse, 1990). Individual psychological empowerment has been associated with concepts such as self-efficacy, self-esteem, competency and locus of control (McCarthy & Holbrook-Freeman, 2008). According to Peterson and Zimmerman (2004) although empowerment is a multi-

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level construct, most of the empowerment theory research has been conducted at the individual level.

Organizational Empowerment

Organizational empowerment includes shared leadership and effective community influence (Zimmerman, 1990). Later, Zimmerman (1995) stated organizational empowerment referred to increased organizational effectiveness by "effectively competing for resources, networking with other organizations, or expanding its influence" (p. 582). The concept of organizational empowerment became popular during the 1980s as American companies competed with other industrialized nations. During this time, scholars sought to identify methods by which to motivate employees in order to improve group performance (Paul, Niehoff, & Turnley, 2000). During this era, experts in leadership believed encouraging individual decision making and workforce participation would lead to more humane work environments where work performance and quality of work life would improve (Paul et al., 2000). Although researchers are becoming interested in how individual empowerment contributes to group empowerment, and how this increase in empowerment can enhance the functioning of its individual members (Gutierrez, 1990), according to Perkins and Zimmerman (1995) research related to empowerment was badly needed at the organizational level. The significance of empowered nursing educational environments may be best understood when one believes that empowered organizations are "those that influence the larger system of which they are a part" (Peterson & Zimmerman, 2004, p. 130).

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Community Empowerment

The third level of empowerment, community empowerment, involves individuals working together collectively to improve their lives. According to Perkins and Zimmerman (1995), community empowerment may include processes such as "collective action to access government and other community resources" (p. 575). Examples of nursing and community empowerment began during the early 20th century, when public health nursing focused upon preventive health initiatives (Buhler-Wilkerson, 1985).

Contemporary nursing efforts to increase community empowerment focused on increasing a vulnerable population's access to healthcare. For example, patients with mental illness, AIDS, and physical disabilities have been described in nursing literature regarding community empowerment (Finfgeld, 2004). In addition, nursing research related to community empowerment and community health promotion included volunteerism in the emergency department (McKenna, 1993), nursing care of elder home patients (Markle-Reid et al., 2006), Mexican American farm workers (Postma, 2008), and patients with chronic mental disorders (Tilley, Pollock, Ross, & Tait, 1999).

Chen and Li (2009) conducted a systematic review of 25 studies regarding the empowerment concept and interventions for patients with chronic disease. Within these studies, empowerment was defined as "a process providing help to people through empowering them, thereby generating hope, confidence and encouragement for the person" (p. 1446). Studies that utilized education, support groups and consultation as interventions were reviewed. Results indicated interventions utilized at the group level for patients with diabetes, high cholesterol and hypertension had better physiological outcomes than ones directed to individuals. However, both individual and group

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intervention increased patients' knowledge regarding their diseases. In summary, nursing literature related to community empowerment has been associated with improving a patient's quality of life and healthcare outcomes utilizing group support.

Nursing Empowerment Research

Social-Structural Perspective and Nursing Empowerment

A classic empowerment theory based upon the social structural perspective is Kanter's (1977) theory, an ethnographic work which was completed in an industrial organization at a time when women were new to the corporate workforce. The social-structural perspective of empowerment focuses upon how social, political and organizational forces can decrease conditions that create powerlessness in an organization. Furthermore, this perspective emphasizes changing organizational policies and practices that support top-down control systems, where power is held by few.

Kanter (1979) defined power as the capacity to mobilize resources to accomplish work. According to Kanter, this capacity is influenced by the degree of formal and informal power an individual has within an organization. Formal power is derived by accomplishing highly visible job related activities that are relevant to the organization. In contrast, informal power results from social alliances with peers and other subordinates. Power is required for effective work behaviors and is available from three sources including access to support from others, information, and resources (Kanter, 1977, 1993). According to Kanter, empowerment is related to the structures within the work environment, not personal predispositions. Kanter's work has been utilized as the conceptual framework in many nursing studies.

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Chandler (1986) first utilized Kanter's theory (1977, 1993) to examine 268 nurses' perceptions of power. Chandler discovered nurses perceived three factors as important to effective work conditions: support, information, and opportunity. She also discovered critical care nurses perceived they had more support and information than nurses in the medical, surgical, or obstetrics units. She concluded there was a correlation between the work environment and the individual, suggesting support for Kanter's theory.

Laschinger, Finegan, and Shamian (2001a) surveyed a sample of 600 nurses working in urban hospitals in Ontario. They received 404 responses (210 female, 194 male). The instruments utilized in this study were The Conditions for Work Effectiveness Questionnaire II (CWEQ-II) (Laschinger & Wong, 1999; Laschinger et al., 2001a) to measure structural empowerment (α=.79-.82), The Psychological Empowerment Scale (Spreitzer, 1995) (α=.71-.92), the Job Satisfaction questionnaire (Specter, 1985)(α=.82), and a modified job content questionnaire created by the researchers (α=.71). The authors found in the proposed model that workplace empowerment had a direct effect on job satisfaction and an indirect effect on job satisfaction through trust (X^2 = 13.8, *GFI* = .987, *AGFI* = .934, *RMSEA* = .095, R^2 = .40). The authors concluded there was support for Kanter's theory (2001a).

Likewise, Laschinger, Finegan, and Shamian (2001b) utilized the same population to test a theoretical model specifying relationships among structural and psychological empowerment, job strain, and work satisfaction. The Conditions of Work Effectiveness Questionnaire-II (Laschinger & Wong, 1999; Laschinger et al., 2001a), the Psychological Empowerment Questionnaire (Spreitzer, 1995), the Job Content Questionnaire (Karasek

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et al., 1998), and The Global Satisfaction Scale (Hackman & Oldham, 1975) were used to measure the major study variables. Path analysis techniques revealed a good fit of the model to the data based on various fit indices (X^2=17.9, *CFI*=.95, *IFI*=.95). The amount of variance accounted for in the model was 38%. Staff nurses felt that structural and psychological empowerment strongly influenced nurse job strain and work satisfaction. However, job strain did not have a direct effect on work satisfaction. The authors concluded support for Kanter's model (2001a) and psychological empowerment as variables influencing nurse satisfaction and psychological empowerment.

Manojlovich and Laschinger (2002) conducted a secondary analysis to analyze Kanter's theory (1977, 1993) and Spreitzer's theory (1995) of psychological empowerment to explain the outcomes of managerial efforts to create structural conditions of empowerment. The researchers utilized the following instruments: 1) Conditions for Work Effectiveness Questionnaire (Chandler, 1986), 2) Psychological Empowerment Questionnaire (Spreitzer, 1995), 3) Personal Mastery Scale (Pearlin & Schooler, 1978), 4) an achievement scale, and 5) Global Satisfaction Scale (Pond & Geyer, 1991). The sample of 347 nurses (58% response rate) came from all specialty areas. The researchers found that structural and psychological empowerment predicted 38% of the variance in job satisfaction and suggested empowerment can result in greater job satisfaction and positive patient outcomes.

Likewise, Laschinger et al., (2003) used Kanter's theory (1977, 1993) to test a theoretical model linking nurses' perceptions of workplace empowerment, Magnet hospital characteristics, and job satisfaction in three independent studies of nurses in different work settings. Two of the samples consisted of staff nurses and one sample

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consisted of acute care nurse practitioners working in Ontario, Canada. The Conditions of Work Effectiveness Questionnaire-II (Laschinger & Wong, 1999; Laschinger et al., 2001a), the Nursing Work Index Revised (NWI-R), (Aiken & Patrician, 2000), and measures of job satisfaction (Hinshaw & Atwood, 1983) were used to measure the major study variables. Measures of structural empowerment and Magnet hospital characteristics were the same for each of the three studies, allowing comparison of results. The alpha reliability coefficients for the empowerment measures ranged from 0.65 to 0.85, 0.82 for the total scale. The CWEQ-II also correlated positively with the measure of global empowerment (r = .58), further supporting the construct validity of the modified instrument. Alpha reliability coefficients for the NWI-R were 0.87 for the total scale, 0.78 for the autonomy subscale, 0.75 for the control over practice subscale, and 0.85 for the collaboration subscale. Nurse practitioners' ratings of work empowerment were higher than those in either sample of staff nurses (M = 20.96, SD = 3.08) as were their ratings of workplace Magnet hospital characteristics (M = 3.20, SD = 0.46). Their empowerment scores were similar to those of nurse managers in previous research. The results of all three studies supported the relationships between structural empowerment and Magnet hospital characteristics of autonomy, control over practice environment and positive nurse-physician relationships.

Kluska, Laschinger, and Kerr (2004) tested an expanded model of Kanter's theory (1977, 1993) by examining the relationship between nurses' empowerment and their perceptions of effort-reward imbalance. They utilized a sample of 112 staff nurses in teaching hospitals in Ontario (58% response rate.) The following five instruments were utilized: Conditions of Work Effectiveness II (Laschinger & Wong, 1999; Laschinger et

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al., 2001a), the Job Activities Scale II (Laschinger et al., 2001a), and the Organizational Relationships Scale II (Laschinger et al., 2001a), the Effort-Reward Imbalance (ERI) scale (Siegrist, 1996), and a demographic questionnaire. The researchers concluded the nurses were moderately empowered and 24.1% perceived their work to have more efforts than rewards. The final model revealed that structural empowerment had significant direct effects on both ERI and psychological empowerment (*b*= .46) and ERI (*b*= -.31). They concluded that contrary to Kanter (1977, 1993), both structural empowerment and a personal dispositional variable were significant to nurses' reports of effort to reward imbalance.

In contrast, Ledwell, Andrusyzyn, and Iwasiw (2006) utilized qualitative methods to examine Post-RN baccalaureate nursing student's experiences of empowerment with distance education and computer conferencing based upon Kanter's constructs (1977, 1993). Seven post-RNs from Canadian distance education nursing programs were interviewed. They discovered feedback from instructors, access to library facilities and support from employers and family was essential to an empowering educational experience. In addition to Kanter's theory, they also identified two additional themes unrelated to Kanter's theory including self-direction and determination to succeed.

The University of Western Ontario Workplace Empowerment research program included multiple studies based on Kanter (1977, 1993), and results indicated staff required increased access to opportunity, information, resources, support, formal and informal power to become empowered (Wagner et al., 2010). According to Wagner et al., job satisfaction, commitment, trust, and low burnout are also influenced by the above six components of structural empowerment. In summary, Kanter's theory (1977, 1993) has

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been demonstrated to be a valuable foundation for nurse research. However, it does not account for all variables associated with empowerment and it focuses on individuals rather than groups.

Psychological Empowerment and Nursing

Psychological empowerment was first described by Conger and Kanungo (1988) who stated empowering processes involve more than delegating or sharing power with subordinates. According to Conger and Kanungo, it is not always possible to remove external conditions that created powerlessness in individuals. Therefore, the process of empowerment should consider the psychological state of the empowering experience, its antecedent conditions and behavioral consequences.

Thomas and Velthouse (1990) expanded upon Conger and Kanungo (1988) by conceptualizing psychological empowerment as intrinsic task motivation consisting of four dimensions: meaning, competence, self-determination, and impact. Although these four concepts were not considered predictors or outcomes of empowerment, they were considered to represent its essence. According to Thomas and Velthouse (1990), meaning referred to how one's role fits within one's beliefs and values. Competence referred to the belief that one possesses the skills to do a job well. Self-determination referred to the autonomy to do their work, and impact consisted of one's control over organizational objectives.

Spreitzer (1996) built upon Thomas and Velthouse (1990) by reviewing interdisciplinary literature and confirmed that psychological empowerment consisted of four dimensions including meaning, competence, self-determination and impact. According to Spreitzer, all four dimensions must be present in order for empowerment to

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occur. Spreitzer acknowledged theoretical limitations of social-structural empowerment theory and psychological empowerment stating, “We need to understand how social-structural empowerment can enable psychological empowerment – as well as understand how beliefs of psychological empowerment can enable the development of more social-structural empowerment through proactive behaviors aimed at changing the systems” (2008, p. 8). Spreitzer also developed an instrument, the Psychological Empowerment Scale (PES) (1995), to measure these four constructs and the instrument has been widely utilized in nursing research.

Nursing Research and Psychological Empowerment

Laschinger, Finegan, Shamian, and Wilk (2003) conducted a longitudinal study with 412 registered nurses initially and 239 nurses three years later. They administered the CWEQ II (Laschinger & Wong, 1999; Laschinger et al., 2001) and the PES (Spreitzer, 1995) and used structural equation modeling for statistical analysis. They determined structural empowerment had a direct effect on burnout and nurses’ feelings of empowerment predicted their reported levels of burnout three years later.

Knol and Van Linge (2009) investigated the relationship between structural empowerment, psychological empowerment, and innovative behavior. The researchers sampled 519 registered nurses in the Netherlands. The instruments used were the Conditions of Work Effectiveness Questionnaire II (Laschinger & Wong, 1999; Laschinger et al., 2001), the Psychological Empowerment Scale (Spreitzer, 1995) and the Innovative Behavior Questionnaire (Scott & Bruce, 1994). Four hypotheses were tested using descriptive statistics, bivariate and multiple regression and one-way analysis of variance. They discovered structural empowerment accounted for 20.2% of the variance

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in innovation, and informal power was the most important dimension. Pearson correlation analysis revealed that structural empowerment was statistically significantly related to innovative behavior (r =0.45, $p < 0.01$), with informal power as the most important sub-variable. Control for job, working hours and age led to a correlation coefficient of r=0.40 ($p < 0.001$). A bivariate linear regression analysis revealed a strong effect on structural empowerment on innovative behavior, F (1,475) = 120.323, $p < 0.001$, with 20.2% of the variance in innovative behavior being explained by structural empowerment. In multiple regression analysis, 30.4% of the variance in innovative behavior was explained by the six sub-variables of structural empowerment. In this weighted sum, informal power emerged as a strong predictor of innovative behavior (β=0.419, $p < 0.001$, p.364). Their findings did not support a relationship between structural empowerment and the extent to which psychological empowerment led to innovative behaviors. The authors concluded that organizations need to create the right conditions to be able to strengthen nurses' empowerment. In summary, the research indicated psychological empowerment had a direct effect on job satisfaction and a negative effect on job strain. In addition, structural empowerment had a positive effect on psychological empowerment and on nurse burnout.

Likewise, Laschinger, Finegan, and Wilk (2009) examined the combined effect of supportive professional practice environments, civil working relationships and empowerment on new graduate's experiences of burnout at work. The researchers conducted an analysis of a subset of cross sectional data collected from staff nurses in 2006 in Ontario (n=3180). Nurses who had been in practice for less than two years were selected. The Dillman Total Design Methodology (Dillman, 2000) was used to increase

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return rates. Most of the respondents were less than 30, had 1.5 years of nursing experience, and had 1.3 years in their current position. In addition, most of the respondents were female, worked full time and were baccalaureate prepared. The Practice Environment Scale of the Nursing Work Index (Lake, 2002) was used to identify Magnet hospital characteristics in the work setting. Civility was measured using four items from Shortell, Rousseau, Gillies, Devers, and Simons (1991) ICU Nurse-Physician questionnaire. Overall, perceptions of empowerment were measured by the Conditions of Work Effectiveness Questionnaire (CWEQ-I:, Chandler, 1986). The analysis provided support for the model predicting supportive professional practice environments, low levels of incivility and an overall sense of workplace empowerment explained variance of new graduates' experience of burnout at work. These findings suggest managerial strategies that create a professional practice environment can facilitate nurses' empowerment and are needed to ensure nurses' health and wellbeing.

Smith, Andrusyzyn, and Laschinger (2010) conducted a study to test an expanded model of Kanter's theory (1977, 1993) by examining the influence of structural empowerment, psychological empowerment and workplace incivility on the organizational commitment of newly-graduated nurses. A predictive non-experimental design was used to examine the impact of structural empowerment, psychological empowerment and workplace incivility on the affective commitment of newly-graduated nurses (n=117) working in acute care hospitals. They discovered 23.1% of the variance in affective commitment was explained by structural empowerment, psychological empowerment and workplace incivility [R^2=0.231, F (5,107) = 6.43, p =0.000]. Access to opportunity was the most empowering factor, with access to support and formal power

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perceived as least empowering. Perceived co-worker incivility was greater than perceived supervisor incivility. The authors concluded that specific strategies in place to combat incivility and disempowerment in the workplace were necessary to prevent further organizational attrition of new members.

Empowerment and Nursing Education

Brancato (2007) examined the use of empowering teaching behaviors of baccalaureate nursing faculty, their psychological empowerment, and the relationships among their use of empowering teaching behaviors, their psychological empowerment, and selected demographic characteristics among 531 randomly selected nursing faculty. Surveys were mailed to 706 faculty with a response rate of 75% (*n*=531). Empowering teaching behaviors were measured using Part II of the Status and Promotion of Professional Nursing Practice Questionnaire (Carlson-Catalano, 1988) 40 teaching strategies used to promote empowerment. The total score was computed by the number of times a faculty member checked the column entitled *I do this often* for each of the 40 questions. For this study, the mean for all 531 faculty was 19.5 (*SD* = 9.01). The average number of empowering teaching behaviors was 19.5 (of a possible 40), indicating limited use. Psychological empowerment was measured using Spreitzer's (1995) Psychological Empowerment Scale .The mean score was 92.38 (of a possible 112), indicating that faculty perceived psychological empowerment in regard to their work role. However, data analysis revealed nearly 25% of the faculty surveyed reported they had little influence over decision making processes within their department. Brancato (2007) discovered that change strategies and sponsorship strategies were not

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often used and recommended faculty provide students with more opportunities “to influence health care delivery and reform” (p. 543).

In contrast, Bradbury-Jones, Sambrook, and Irvine ,(2007)utilized a critical incident technique to examine 109 written incidents by 66 nursing students, in Japan and the United Kingdom, to explore their clinical experiences and the meaning of empowerment . For this study, empowerment for students was defined as “being able to learn as a result of being understood and encouraged” (p. 349). The authors concluded although these students are exposed to different educational and clinical environments, their experiences of empowerment and disempowerment was similar. Conceptually, the researchers identified that empowerment and disempowerment can be viewed as a continuum as opposed to a cycle. Learning in practice, team membership and power are associated with student empowerment. Additional factors associated with student empowerment included continuity of placement, the presence of a mentor and clinical time supporting empowering experiences. The authors concluded that student nurse empowerment may transcend cultural differences, and that learning in practice, team membership and power may be important for the empowerment of nursing students globally.

Baker et al., (2011) completed a descriptive correlational design study to determine associate degree in nursing educators’ perception of empowerment, job satisfaction and relationships between them. Four instruments were used including Sprietzers (1995) Psychological Empowerment Scale; Laschinger et al.’s (2001) Conditions of Work Effectiveness II; Hackman and Oldham’s (1975) Jobs Diagnostic Survey (JDS), and a researcher developed background data questionnaire. The sample

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included 139 respondents with ranks from instructor (30.2%) to professor (45.3%). The majority was tenured (71.9%) and had a mean of 11.1 years of teaching experience. Data analysis revealed that educators experienced job satisfaction as determined by a total JDS score of 15.44 (*M*=3.99.*S.D.* =0.92). Results indicated a majority of the respondent's experienced psychological empowerment particularly in the areas of Meaning (*M*=4.65) and Competence (*M*=4.52). Almost all educators' reported that their job work was important and meaningful to them (92.1-98.6%). In addition, 73.4-87.1% reported they had autonomy and freedom in their job, and fewer believed they had significant impact, control or influence within their departments (41.7 -57.6%). Psychological empowerment demonstrated the strongest positive correlation with job satisfaction (*r*=.73, *p*=.05). There were no significant differences in empowerment or job satisfaction based on educator's tenure status, educational level, and evidence of scholarship or academic rank. Baker et al., concluded faculty had concerns about resources needed to accomplish their work, and "not all faculty perceived they had as much power control or impact in their departments as they would have liked" (p. 239).

St. Germain, Young, and Landrum (2011) utilized Sprietzer's instrument (1995) to examine undergraduate nursing students by conducting a longitudinal, four year cohort study. Psychological Empowerment, as measured by Spreitzer's 12 item PE Questionnaire, is composed of four orientations (meaning, competence, self-determination, and impact) that play a key role in mediating behavioral responses to a situation. The purpose of their study was to describe the relationship between stressors and student success, and stress resiliency, was measured by the Stress Resiliency Profile (Thomas & Tymon, 1992). The Stress Resiliency Profile reflects how individuals

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appraise their situation through the lens of three perceptions: (a) deficiency focusing where negative thinking dominates over positive aspects, (b) necessitating that focuses on perceived demands as being inflexible and obligatory, and (c) skill recognition where personal capabilities are associated with ability to manage tasks. Student success was measured by grade point average, attrition, and semester absenteeism. Data collection was provided by face-to-face interviews conducted by 40 investigative team members. The team members gathered baseline data for a caseload of three to five students who were followed by repeated data collection at the end of the fall and spring semesters. The population consisted of 125 junior nursing students entering an upper division baccalaureate program taught on two health science campuses located in two large metropolitan areas. The researchers discovered that psychological empowerment and stress resiliency have the potential to influence students' perceived capabilities in responding to academic demands of nursing programs and ensuring success.

In summary, organizational empowerment and nursing has been primarily described within the theoretical framework of research completed by Kanter (1977, 1993), Spreitzer (1995), and Thomas and Velthouse (1990).In addition, much of the writings described empowerment as a passive process that leaders perform for their followers. The empirical literature supported the relationship between structural and psychological empowerment to job satisfaction, Magnet hospital characteristics of autonomy, control over practice environment and positive nurse-physician relationships. In addition, the literature suggested that nurse faculty reported little autonomy and freedom in their job and even fewer believe they had significant impact, control or

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influence within their departments. The review of empowering leadership attributes will now be summarized within the nursing literature.

Theoretical Review of Empowering Leadership Attributes

According to Yukl and Becker (2006), many studies have examined the relationship of leadership and empowerment. Characteristics of empowering institutions included organizations where leaders have limited periods of appointment and followers have the power to assess leader's performance. Furthermore, organizations with decentralized power provided more opportunities and had increased employee empowerment.

In addition, Yukl and Becker (2006) described ongoing difficulty with advancing empowerment research due to a lack of a consistent definition of the construct. They also cited the need for research on the effectiveness of leader-empowering behaviors at the individual, team, and organizational level and how these behaviors contributed to the overall effectiveness of the organization. According to Bass (1999) and Avolio (1999), transformational leadership theory (Bass, 1985) emphasizes the role of empowerment as a central mechanism of building commitment to the organization's objectives.

Transformational and Transactional Leadership Theories

Transformational leadership was initially developed by Burns (1978) who studied the characteristics of political leaders. He stated leaders can be evaluated by their ability to encourage social change and he described two types of leadership: transactional and transformational. According to Burns (1978), transactional leadership occurs when one person acts in efforts to obtain a reward from another, and the two are not bound by mutual goals. According to Burns (1978), the transformational leader "looks for potential

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motives in followers, seeks to satisfy higher needs, and engages the full person of the follower" (p. 4). Burns' theory of transactional and transformational leaders has been expanded by Bass and colleagues (Avolio & Bass, 1988; Bass & Avolio, 1994).

According to Bass (1990), there were four characteristics of transactional leaders. The first, known as contingent reward, described leaders who promised something of value for good performance. Active management by exception was a second characteristic of transactional leaders, and referred to leaders who actively searched for and responded to employee poor performance with disciplinary action. The third type of transactional leadership, passive management by exception, described leaders who only responded when a problem was identified in their organizations. Bass described these leaders as ineffective and their organizations mediocre. Bass characterized a fourth type of transactional leaders as laissez faire. He described these leaders as abdicating responsibility and avoiding decision making.

In contrast, Bass (1990) identified transformational leaders as those who "broaden and elevate the interests of their employees, generate awareness and acceptance of the purposes and mission of the group, and stir their employees to look beyond their own self interests" (p. 21). Four characteristics of transformational leaders are charisma, inspiration, intellectual stimulation and individualized consideration (Bass, 1990, p. 22). Charisma refers to leaders who provide vision and instill trust. Inspiration refers to the communication of high ideals. Intellectual stimulation described leaders who promote intelligence and practice careful problem solving. Individualized consideration refers to leaders who treat each employee as an individual (Bass, 1990).

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Bass and Avolio (1995) developed The Multifactor Leadership Questionnaire (MLQ) which they utilized to measure differences between transactional and transformational leaders. The instrument measures five factors: two traits of transactional leadership (Contingent Reward and Management-by-Exception) and three characteristics of transformational leadership (Charismatic Leadership, Individualized Consideration, and Intellectual Stimulation). Additional behaviors have been added to the tool by Bass (1996) and Bass and Avolio (1990). Nursing research utilizing the MLQ will now be summarized.

Nursing Research Multifactor Leadership Questionnaire

Medley and LaRochelle (1995) administered the 70 item MLQ and the 44 item Index of Work Satisfaction (Stamps & Piedmonte, 1986) to 122 staff nurses working in acute care settings. Staff nurses level of satisfaction correlated highly to transformational attributes (charismatic leadership, idealized influence, intellectual stimulation; r= .4010, p <.001). Staff nurses' satisfaction did not correlate with transactional leadership style (contingent reward and management by exception; r= .0469, p <.001). The authors summarized their research findings demonstrated a major difference in respect to the factor Contingent Reward as compared with other studies. They attributed this difference to the nature of nursing where it is unusual for an individual to be rewarded tangibly for outstanding performance. They concluded transformational leadership styles were associated with higher job satisfaction.

Larrabee et al. (2003), conducted a nonexperimental, predictive design in a nonrandom sample of 90 registered staff nurses to examine the relative influence of nurse attitudes, context of care, and structure of care on job satisfaction and intent to leave.

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They utilized the MLQ 5 X (Bass & Avolio, 2000), Intent to Leave (Blau, 1993) and Job Satisfaction Work Quality Index (Stamps & Piedmonte, 1986). The major predictor of intent to leave was job dissatisfaction, and the major predictor of job satisfaction was psychological empowerment. Predictors of psychological empowerment were hardiness, transformational leadership style, nurse/physician collaboration, and group cohesion.

Avolio, Zhu, Koh, and Bhatia (2004) utilized a sample of 502 nurses including two hundred and fifty-five nurses rated as junior staff nurses, 117 senior staff nurses (SSNs, direct immediate level) and 54 nursing officers (NOs, indirect senior level) in one Singapore hospital. The purpose of the study was to examine the "underlying process through which transformational leaders influence followers' organizational commitment by focusing on psychological empowerment" (Avolio et al., 2004, p. 952).The participants completed a modified 20 item MLQ (Bass & Avolio, 1997) a 12 item scale to measure psychological empowerment (Spreitzer, 1995), and a nine item scale to measure organizational commitment (Cook & Wall, 1980). The data were coded for ratings of leadership for the same senior nurses and NOs in order to link them and to help match followers to leaders. The researchers discovered that psychological empowerment was significantly related to organizational commitment for SSN level (G_{100}= 0.10, X^2= (241) = 350.25, p <0.05, R^2= 0.02) and for the nursing officer (NO) level (G_{10}= 06, X^2(236) = 345.21, p <0.05). They concluded a positive association existed between transformational leadership and organizational commitment. However, contrary to initial expectations, "the relationship between transformational leadership at the SSN (direct immediate level) was only modestly related to followers' level of empowerment and organizational

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commitment based on correlational analyses and was not significantly related in the HLM analyses" (Avolio et al., 2004, p. 962).

Kleinman (2004) utilized the MLQ (Bass & Avolio, 1997) to describe perceptions of managerial leadership behaviors associated with staff nurse turnover and to compare nurse manager leadership behaviors as perceived by managers and their staff nurses. The study utilized a 465-bed community hospital in the northeastern United States. The study sample comprised 79 staff nurses and ten nurse managers, who completed demographic forms and the 45-item MLQ. Active management by exception, as perceived by staff nurses, was the only managerial leadership style associated with staff nurse turnover (r =.26, p= 0.03). In addition, the transactional leadership style of active management by exception appeared to be a deterrent to staff nurse retention.

Casida and Pinto-Zipp (2008) conducted correlational analyses to determine the relationship between nurse managers' leadership styles and the organizational culture (OC) of nursing units within an acute care hospital. The sample consisted of 37 nurse managers and 278 staff nurses with a return rate of 70% from four hospitals. They utilized the MLQ Form 5x (Bass & Avolio, 1995) and Denison's' Organizational Culture Survey (Denison, 1996). They concluded the tools were valid (CFI= .91; Goodness of fit= .92 for the MLQ and CFI+ .91, Goodness of fit = .99 for Denison's tool). Correlational analyses showed that statistically significant correlations existed between leadership and OC variables. Transformational leadership showed a positive, moderately strong correlation with OC (r= 0.60, p= 0.00), while transactional leadership showed a positive, but little or weak correlation with OC (r= 0.16, p= 0.006). Conversely, laissez faire leadership showed a negative correlation with OC (r= -0.34, p= 0.000) (p.11). The

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authors concluded that transformational leadership, generally, is associated with desirable nursing units' OC as measured by Denison's Organizational Culture Survey (DOCS).

Chen et al. (2005), utilized a descriptive, correlational, and cross-sectional study with self-administered questionnaires to determine nursing faculty job satisfaction and their perceptions of nursing deans' and directors' leadership styles in Taiwan. The sample consisted of 286 nursing faculty members with a return rate of 73%. The MLQ 5 X Chinese Version (Shieh, Mills, & Waltz 2001), and Minnesota Satisfaction Questionnaire (Weiss, Dawis, England, & Lofquist, 1967) were administered. The data analysis indicated, after controlling for demographic and organizational characteristics, the leadership subscales of contingent reward (β= .228, p< .05) and individualized consideration (β= .194, p< .05) significantly and positively contributed to nursing faculty job satisfaction, but the passive management by exception (β= −.143, p< .05) leadership style significantly and negatively contributed to nursing faculty job satisfaction. The three types of leadership styles explained 21.2% of the variance in nursing faculty job satisfaction (Adjusted R^2= .212, F = 12.03, p< .01) but the strongest explanatory variable was the contingent reward style. The results indicated that 21.2% of the variance in job satisfaction levels was attributed to the leadership styles of high contingent reward, low passive management by exception, and high individualized consideration.

In summary, nursing research exploring transformational and transactional leadership theories suggested that relationship-focused leadership practices contribute to improving outcomes for the nursing workforce, the work environment and effectiveness of health care organizations (Cummings et al., 2010). However, according to Hutchinson and Jackson (2012), the uncritical acceptance of transformational leadership has resulted

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in a limited interpretation of nursing leadership. They summarized the following weaknesses with the concept of transformational leadership as measured by the MLQ (Bass & Avolio, 1997): 1) Transformational leadership traits and narcissistic leadership have been identified to share many similar characteristics; 2) cultures, outside the U. S., may place less value on transformation; 3) the validity of the MLQ has been questioned regarding its discriminant validity and psychometric properties and; 4) common method bias undermines the validity of findings from nursing studies. Hutchinson and Jackson (2012) concluded that nurse researchers must be open to "embrace or lead new ways of thinking about leadership" (p. 9). Nursing research describing leadership behaviors will now be summarized.

Nurse Leader Empowerment Behaviors

Chiok (2001) conducted a study with a sample of 20 managers and 97 registered nurses to determine the effect of leadership behaviors on employee outcomes in Singapore. The author utilized five leadership behaviors identified by Posner and Kouzes, (1988) including challenging the process, inspiring a shared vision, enabling others to act, modeling the way, and encouraging the heart. Utilizing ANOVA and regression statistics, she concluded the use of leadership behaviors and employee outcomes were correlated. The regression results indicated that 29% of job satisfaction, 22% of organizational commitment and 9% of productivity were explained by the use of leadership behaviors.

Force (2005) conducted a literature review describing nursing research that studied characteristics of nurse managers' leadership traits that supported hospital nurse retention. Themes associated with nurse retention and job satisfaction were identified including transformational leadership style, extroverted personality traits, Magnet

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hospital organizational structures that support nurse empowerment, autonomy and group cohesion, tenure, and graduate education.

Manojlovich (2005) utilized a nonexperimental, comparative survey design to understand the effect of unit-level nursing leadership on the relationship of structural empowerment and nursing self-efficacy to professional nursing practice behaviors. Instruments included the Conditions for Work Effectiveness-II (Laschinger & Wong, 1999; Laschinger et al., 2001a), Caring Efficacy Scale (Coates, 1997), Manager's Activities Scale (Laschinger, 2004), and Nurse Activity Scale (Miranda, Nap, de Rijk, Schaufeli, & Iapichino, 2003). T-test and correlation path analysis were utilized for data analysis. Manojlovich (2005) concluded that nursing leadership helped to explain 46% of the variance in nursing practice behaviors overall.

Greco, Laschinger, and Wong (2006) utilized Kanter's theory (1977, 1993) to conduct a cross sectional, correlational study to test a model examining the relationship between nurse leader's empowerment behaviors, perception of staff empowerment, areas of work life and work engagement. Conducted in Ontario, the study consisted of 322 questionnaires from full time acute care nurses. The authors utilized the Leader Empowering Behavior Scale developed by Hui (1994). Hui identified five categories of leader empowering behaviors including enhancing meaningfulness of work, fostering participation in decision making, facilitating goal accomplishment and providing autonomy and freedom from bureaucratic constraints. They also utilized the CWEQ-II (Laschinger & Wong, 1999; Laschinger et al., 2001a), the Areas of Work life Survey (Leiter & Maslach, 2004), and the Emotional Exhaustion subscale of the Maslach

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Burnout Inventory (Maslach, Jackson, & Leiter 1986). They concluded that the leader's empowering behaviors can enhance person-job fit and prevent burnout.

Nielson, Yarker, Brenner, Randall, and Borg (2008) evaluated data from a questionnaire of 447 staff in Denmark collected in 2005. A model of the relationships between leadership, working conditions, job satisfaction and well-being was tested using structural equation modeling. The authors concluded transformational leadership style was closely associated with followers' working conditions, namely involvement, influence and meaningfulness. A direct path between leadership behavior and employee well-being was also found.

Young-Ritchie, Laschinger, and Wong (2009) tested a model to examine the relationship between emotional intelligence, workplace empowerment and commitment. A random sample of 300 emergency staff nurses in Ontario was utilized. A path analysis supported the model ($X^{2=}$ 2.3, df= 1, p> .05, CFI= .99, IFI= .99). They concluded that emotionally intelligent leadership supported structural empowerment, which had a strong effect on organizational commitment.

In summary, nursing research has demonstrated a positive relationship between leadership empowering behaviors and person job fit, decreased burnout, job satisfaction and organizational commitment. Empowered employees have higher levels of commitment to their organizations, and transformational leadership has been associated with nurse retention, job satisfaction, and followers' working conditions, namely involvement, influence and meaningfulness. A direct path between leadership behavior and employee well-being was also found, and job satisfaction has been linked to the ability to achieve goals. However, according to Hutchinson and Jackson (2012), the

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uncritical acceptance of transformational leadership has resulted in a limited interpretation of nursing leadership, and they stressed the importance of nursing utilizing other instruments to measure nurse leadership. The literature examining nursing leadership in nursing education will now be summarized.

Leadership and Nursing Education

Duke (1988) examined the relationship between leadership behaviors of nurse education administrators and the empowerment of nursing faculty and students. She randomly selected groups from nine states in the western region of the U. S. One hundred twenty-six schools of nursing participated and four instruments were utilized including the Leader Behavior Analysis II Self and Other (Blanchard, Hambleton, Zigarmi, & Forsyth, (1999), and the Barrett Power as Knowing Participation in Change Tool Kit (PKPCT) (Barrett, 1990). Responses were gathered from 101 programs. Duke suggested the PKPCT, which permitted for one word responses, which were quickly given and without thought, may not be appropriate for measuring leadership behavior and empowerment in students in nursing. She recommended the development of instruments to measure empowerment in nurse educators.

Johnson (2001) explored the organizational culture and job satisfaction of associate degree nursing educators in order to assess their impact on faculty empowerment. Using a sample of 407 nursing educators in 70 A.D. programs, data were collected using the Organizational Culture Assessment Instrument (Cameron & Quinn, 1999), Job Satisfaction Scale (MacDonald & MacIntyre, 1997), and Sprietzer's (1995) psychological empowerment instrument. Multiple regression analyses reveled 25% of the variance in empowerment of AD faulty was explained by the collective effects of

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organizational culture and job satisfaction. Johnson concluded that organizational culture and job satisfaction have a significant impact on empowerment of AD nursing faculty.

Gormley (2003) completed a meta-analysis of factors associated with job satisfaction in nurse faculty in the U.S. The researcher included six studies completed from 1976 to 1996, and concluded the perception/expectation of the leader's role in curriculum and instruction appears to significantly affect nursing faculty job satisfaction with an effect size of 0.738. Other leadership factors that have high effect size are consideration and initiating structure behaviors with .802 and .688, respectively.

Disch, Edwardson, and Adwan (2004) utilized The Survey of Nursing Faculty in Minnesota, developed by the authors, to determine the perception by faculty of the status of individual, institutional, and leadership factors known to affect faculty satisfaction. According to the authors, the survey was modified from one successfully utilized within the medical school the year before (Bland, Seaquist, Pacala, Center, & Finstad, 2001). There were no data regarding reliability or validity data provided for the instrument. The authors also investigated if those perceptions varied among faculty teaching in different kinds of programs. They discovered that the majority of respondents would choose nursing as a career path again (82%), and only 9% would not choose nursing education. A majority (62 %) felt a commonly held vision in their schools, and 70 % had a clear sense of how their work fits into the bigger picture. Nursing faculty also reported feeling their opinions were routinely solicited (65 %) and seriously considered (66 %).

Sarmiento, Laschinger, and Iwasiw (2004) completed a descriptive correlation designed study to test a theoretical model specifying relationships among structural empowerment, burnout and work satisfaction. They sampled 89 full time Canadian nurse

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educators employed in community colleges. They administered the Conditions of Work Effectiveness Questionnaire (Laschinger et al., 2001a), Job Security Scale (Probst, 2003) Organizational Relationship Scale (Bruning & Ledingham, 1999), Maslach Burnout Inventory Educator Survey (Maslach, et al., 1986) and Global Job Satisfaction Questionnaire (Pond & Geyer, 1991). They concluded nurse educators reported moderate levels of empowerment and moderate levels of burnout and job satisfaction. High empowerment was significantly related to low burnout and greater work satisfaction.

Johnson and Rae (2009) explored the relationship of organizational climate and empowerment in AD nurse faculty using the Competing Values Framework (Quinn & Rohrbaugh, 1983), and Sprietzer's Psychological Empowerment Theory (1995). The authors utilized a demographic instrument, The Organizational Cultural Assessment Instrument (Cameron & Quinn, 1999), and Sprietzer's (1996) Psychological Inventory on a sample of 407 nurse faculty. Findings included rank and years employed as AD nursing faculty were found to be significant contributors to faculty empowerment. The regression analysis of faculty empowerment to organizational culture indicated that organizational culture was a statistically significant contributor to faculty empowerment ($F = 43.86$, $p < .01$). Organizational culture was found to have a moderate impact on faculty empowerment for this sample of educators.

In summary, research evaluating leadership behaviors in nursing education indicated organizational culture and job satisfaction have significant impact on empowerment of AD nurse faculty. In addition, high empowerment was significantly related to low burnout and greater work satisfaction, and organizational culture had a moderate impact on faculty empowerment. Leader's roles in curriculum and instruction,

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consideration, and initiating structure behaviors are also associated with nurse faculty job satisfaction.

A large proportion of the nursing research describing empowerment has been conducted using Kanter's Theory of Structural Empowerment (1977, 1993) and Sprietzer's Theory of Psychological Empowerment (1995). Therefore, empowerment in nursing has largely been studied as a result of environmental factors or a result of one's emotional state. Transformational leadership theory (Bass & Avolio, 1994) has also been widely utilized in nursing research. However, there were few studies examining baccalaureate faculty and empowerment. In addition, there was scant research examining leadership competencies associated with empowerment in nurse faculty. Although nursing research has consistently described a positive relationship between transformational leadership and empowerment, to date, no study examining specific leadership competencies and empowerment, based upon a conceptual framework of nursing, has been completed. The significance of acquiring nursing knowledge with nursing generated theory supports the theoretical foundation for this research, the Sieloff (2012) Theory of Group Empowerment within Organizations. A review of the literature related to the theory will now be presented.

Sieloff's Theory of Group Empowerment within Organizations

Bogue, Joseph, and Sieloff (2009) conducted a study to validate an instrument measuring the effectiveness of nursing practice councils and a framework for measuring shared governance. The authors cited the current lack of instruments measuring nurses' practice of power, and theorized that empowerment results from the vertical alignment of nursing group power and nursing unit power practices. Two cross sectional surveys of

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nurse managers and nursing practice council members (n_1 =119; n_2=248) were used to pilot test and finalize the Nursing Practice Council Effectiveness Scale (NPCes). Utilizing scale development procedures, item analysis, correlations and regressions, the index of shared governance at the unit level was developed. The NPCes was validated using convergent validity with the Conditions of Work Effectiveness Questionnaire II (Laschinger & Wong, 1999; Laschinger et al., 2001a) in study one, and the Sieloff King Assessment of Group Power (SKAGPO) in study two. NPCes correlated strongly with both scales CWEQ II, (r=0.736, p<.001); SKAGPO, (r=0.505, p<.001). The researchers concluded the NPCes and the SKAGPO can be utilized to examine shared governance.

Gianfermi and Buchholz (2011) examined the relationship of job satisfaction to group outcome attainment capability based upon Sieloff's (2010) theory of group power using the Sieloff–King Assessment of Group Outcome Attainment within Organizations (SKAGOAO)© to measure nursing group outcome attainment capability (NOAC). The sample, nurse administrators (n=20) employed in mid-size urban and suburban hospitals, were recruited using convenience sampling. Using an on-line format, participants completed the Minnesota Satisfaction Questionnaire (Weiss et al., 1967) to measure job satisfaction and the SKAGOAO© to measure NOAC. Moderately strong and strong significant correlations (p < 0.003) were found between job satisfaction and nursing group outcome attainment capability (intrinsic satisfaction r = 0.800; extrinsic satisfaction r = 0.650; total satisfaction r = 0.770). The researchers concluded that increased job satisfaction is related to the ability to achieve goals and "engaging in outcome attainment capability enables nurse administrators to actualize capacity through improved production, activity and autonomy" (p. 1016).

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Likewise, Campbell (2011) utilized the Sieloff-King Assessment of Group Outcome Attainment within Organizations (SKAGOAO) to measure overall perception of outcome attainment in eight system interdisciplinary partnership councils. Cronbach's alpha for testing reliability of the instrument with interdisciplinary groups was completed to validate the tool for use in an interdisciplinary council structure. The alpha was 0.964 indicating a high reliability in the interdisciplinary group (personal communication: Susan Campbell, RN, MSN, NEAA Senior Vice President, Corporate Chief Nursing Officer, OSF Healthcare System (November 4, 2011).

Bularzik, Tullai-McGuiness, and Sieloff (2013) completed a pilot study using a descriptive correlational design to measure staff nurses' perception of professional autonomy, their perception of nursing group outcome attainment capability, and the relationship of these two variables. The researcher's utilized the Sieloff–King Group Goal Attainment Capability in Organizations ($SKAG_2ACO$) instrument, in addition to the Nursing Activity Scale (NAS), developed by Schutzenhofer (1987). Staff nurses mean scores on the $SKAG_2ACO$ was 135.62 ($N = 90$) indicating high empowerment capability. Six of the eight subscales were in the high goal attainment range. The weighted mean score of the NAS was 190.40 ($N = 90$) indicating high professional autonomy. However, statistical analyses revealed a weak positive relationship between the two variables ($r = 0.24$, $P < 0.05$).The researchers concluded that although this was the first time the $SKAG_2ACO$ was used with this population, the Cronbach's alpha (.937) demonstrated high reliability.

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Summary

Chapter II has provided a review of the literature related to the proposed study's major concepts including oppressed group behaviors in nursing and their sequela. Theories of empowerment, related nursing research and what is not known about empowerment in nursing education has been described. In addition, nursing research utilizing Sieloff's theory and related instrument has been described. Chapter III describes the study population and sample, sampling procedure, instrumentation, research procedure and methods used for collection and analysis of data.

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CHAPTER III

METHODOLOGY

Overview

This chapter includes a description of the research design and approach, the setting for the study, the sample under investigation, instrumentation, procedures used for data collection, data analysis, and protection of human subjects.

The purpose of this study was to describe group empowerment in nursing schools that offer baccalaureate and graduate programs of study and are members of the American Association of Colleges of Nursing (AACN). This study examined empowerment capacity, empowerment and mediating variables, in addition to demographic variables related to the research questions.

The population of this study was American Association Colleges of Nursing (AACN) baccalaureate faculty and administrators in programs that offer baccalaureate and graduate degrees with a minimum of 16 full time nursing faculty members. An introductory letter was sent electronically to eligible deans describing the study, and also asking them to participate. Quantitative research methods were used to answer the research questions. Data analysis was conducted using Predictive Analytics Software (PASW), version 18.0, for descriptive and correlation analysis (PASW Version 18.0. Chicago: SPSS Inc).

Protection of Human Subjects

Approval from the University of Southern Mississippi Institutional Review Board (IRB) to conduct this research was obtained prior to data collection. This project was reviewed by the Human Subjects Protection Review Committee, which ensures that

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research projects involving human subjects follow federal regulations. Participants were informed to bring questions or concerns about rights as a research subject to the chair of the Institutional Review Board, The University of Southern Mississippi. Consent to participate in the study was assumed when participants completed the survey. A letter was sent to administrators and faculty in the sample population, assuring confidentiality in the disclosure and reporting of data, and that only aggregate data would be reported. Subjects were informed that their responses would remain confidential through the use of a unique ID number for each sample member and coding to ensure anonymity. The participants were also notified that their participation was voluntary and could be terminated at any time.

Population and Sample

The population of this study included deans of nursing and full time faculty in 335 schools which offered baccalaureate and higher programs of study (Yan Li, personal communication, April 11, 2013, Research Assistant, Research and Data Services, American Association of Colleges of Nursing). Population schools were members of the AACN, offered baccalaureate and graduate programs of study, and had 16 or more full time faculty. The 335 schools and administrators were also stratified by geographic location as follows: North Atlantic schools 71 (21.19%); Southern schools 120 (35.82%); Mid-West 96(28.67%), and West 48 (14.32%). There were 15,247 full time faculty stratified per geographic area as follows: North Atlantic 2,399 (15.73%); South 4,713 (30.91%); Midwest 5,945 (38.99%) and West 2,190 (14.37%). The total study population was 15,282 and the sampling design was single stage.

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Calculation of Sample

The minimum sample for this study was calculated based upon Cochran's formula (1977). According to Bartlett, Kotrlik, and Higgins (2001), the formula is based upon two factors including the risk the researcher is willing to accept in the study, commonly called the margin of error, and (2) "the alpha level, the level of acceptable risk the researcher is willing to accept that the true margin of error exceeds the acceptable margin of error; i.e., the probability that differences revealed by statistical analyses really do not exist; also known as Type I error" (p. 45).

The acceptable margin of error for this study was determined based upon a standard in educational research of 0.3 % when using continuous data (Krejcie & Morgan, 1970). The alpha level for this research has been determined *a priori* to be 0.05.

Utilizing a table completed by Bartlett et al., the minimum returned sample size for this study was calculated based upon a population of approximately 14,000 which included nurse faculty and their deans (data provided by AACN, 2013), an alpha level of .05, *t* level of 1.96 and a calculated margin of error level of 0.03. Based upon this data, the minimum necessary sample size was calculated to be 119 (p.48).

Estimating Response Rate

Estimating response rates is "not an exact science" (Bartlett et al., 2001, p. 47). As a result, oversampling is sometimes used in order to account for a non-response rate. For this study, the researcher calculated the non-response rate based upon "response rates from previous studies of the same or a similar population" (p. 47). For example, according to Badger and Werrett (2005), there was a lack of consensus regarding acceptable response rates in nursing research. The authors reviewed three peer reviewed nursing journals from 2002 and discovered half of the papers did not report a response

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rate. However, of those that did, three quarters had response rates of 60% or more. Likewise, according to Baruch and Holtom (2008), in organizational research, "average response rates for studies that utilized data collected from individuals was 52.7% with a standard deviation of 20.4, while the average response rate for studies that utilized data collected from organizations was 35.7% with a standard deviation of 18.8"(2008, p. 1139). Therefore, based upon this information, the response rate for this study was anticipated to be somewhere between 40-60%. As a result of this anticipated low response rate, and the necessity for the school administrators to agree to participate in order to obtain faculty support, cover letters requesting participation in the project were electronically sent to all three hundred thirty five deans of nursing. Of these emails sent, 15 deans were out of the office, or no longer in the dean position, reducing the sample size to three hundred twenty schools.

Procedure

A letter describing the study was sent to the administrator of each of the eligible institutions. The correspondence included the purpose of the study, the name of the researcher and organization, the relevance to nursing, information about the instruments, number of items, and the approximate time commitment. The letter requested interested administrators to name an institutional gatekeeper, or facilitator, to distribute the surveys to faculty.

Once the facilitator was identified, a letter describing the study, along with a hyperlink to the survey was sent to be electronically forwarded to nurse faculty from each of the participating schools of nursing. The letter explained the purposes of the study, the benefits of participating, the amount of time required, and assurance that only aggregate

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data was reported and that confidentiality was maintained. Because surveys were sent electronically to participants, completing the questionnaire signified consent to be in the study. A separate researcher-developed questionnaire was utilized to obtain demographic data including questions to elicit age, ethnicity, gender, initial level of nursing education, highest degree earned academic rank, and tenure status. Descriptive data about the organizations was collected including funding status (public versus private), school type (college or health science center), geographic location (rural versus urban) and number of students enrolled in generic baccalaureate program. The questionnaires were administered via Qualtrics (Qualtrics, Provo, UT).

Participant Information

Participants were informed of the approximate time commitment required for completing the survey. In addition, participants were advised they were able to discontinue the survey at any point in the questionnaire and return to the same place. An incentive to participate was offered to respondents by offering a chance to win one of four iPods. According to Dillman, Smyth, and Christian (2009) incentives have been shown to modestly increase response rates.

Follow up e-mails and letters were sent to the facilitators as needed to increase the return rate. The Tailored Design Method of survey (Dillman et al., 2009) method of conducting survey research was utilized. In this method, subjects received research email reminders in order to further improve the return rate of the materials. The data collection occurred over a twelve week period during the spring and summer semesters of 2013.

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Research Design

The research design of this study was exploratory and correlational in nature. Descriptive and correlation statistics were used to answer the research questions and to report demographic data related to the research questions. Information related to administrator and faculty rank, age, educational preparation, and tenure status was collected. In addition, institutional data such as funding status (public versus private), school type (college, department, school, comprehensive university, health science university), geographic location, (rural versus urban), and number of students enrolled was collected using a researcher- developed questionnaire. Demographics were also examined for differences and relationships to the SKAGEO©.

Instrumentation

The Sieloff-King Assessment of Group Empowerment (SKAGEO©) was the instrument chosen for this study. Permission was obtained to use and to adapt the instrument (C. Sieloff, personal communication, October 10, 2012). According to Sieloff and Dunn (2008) the instrument is designed to be completed by any group, within any organization, to measure their level of empowerment or capacity to achieve organizational goals (2008). The SKAGEO© is the latest edition (2012) of the Sieloff - King Assessment of Group Power in Organizations (SKAGPO©), a 36 item instrument which assesses the level of the concepts theorized to contribute to a group's actualized empowerment. The instrument also provides data to support areas to improve for any group to increase their empowerment. Psychometric testing has consistently demonstrated reliability and validity (Sieloff, 2003; Sieloff & Dunn, 2008).

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Item Development

The initial instrument, the SKADP (Sieloff-King Assessment of Departmental Power) was developed through a review of the literature (Sieloff, 2007). Sieloff first selected 442 items, which were later reduced to 125. These items were then reviewed by ten content validity judges consisting of five power experts and five experts on King's conceptual framework. The instrument was piloted, and as a result, thirty-six items were selected for the final instrument in 1996 (Sieloff, 2007). As stated earlier, Sieloff first revised the name of the instrument in 1999, due to subjects' hesitance to participate because of a lack of comfort with the term *power* and organizational changes that resulted in the elimination of nursing departments. These changes prompted Sieloff to make the following revisions: (a) change the word department to group, (b) change the word hospital to organization, and (c) rename the instrument the Sieloff-King Assessment of Group Power within Organizations (SKAGPO©) (Sieloff, 2007).

Reliability of SKAGPO

The psychometric testing of the finalized instrument was conducted with a stratified random sampling of 600 chief nurse executives (CNE) from hospitals across the United States (Sieloff, 1999). In this research, the instrument's Cronbach's alpha was .92 (n= 334) and the split-half analysis was .92 (n= 334). The criterion related validity was also calculated to be .625 (p= .10, n= 321) (Sieloff, 2007). The confirmatory factor analysis of the SKAGPO involved structural equation modeling to analyze the relationships. This process was completed to determine whether the relationships in the proposed model were compatible with data variance and covariance matrix. Data regarding the overall fit of the final proposed model, with ten items deleted, were χ^2=

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504.7, *df*= 291, *p*≤. 00. Goodness of Fit Index= .9, Normed Fit Index= .86, Normed Fit Index= .86, Incremental Fit Index= .94, Normed Fit Index= .86, and Root Mean Square Error of Approximation = .05. As the result of this research, support was demonstrated for the proposed relationships measured by the SKAGPO (Sieloff & Dunn, 2008).

Validity of SKAGOAO

Sieloff and Bularzik (2011) recently published the results of a content validity analysis conducted on the renamed, revised instrument (Sieloff-King Assessment of Group Outcome Attainment within Organizations (SKAGOAO©). The results demonstrated an overall Content Validity Index (CVI) of 93.75%, indicating that the semantic changes made to the instrument were conceptually sound. The authors also theorized that group outcome attainment is conceptually similar to group empowerment as reflected in the name of the latest instrument.

Adapting the SKAGEO© to Educational Environments

Establishing Content Validity

In preparation of utilizing the SKAGEO© in an educational setting, the researcher adapted the instrument by changing the words *client records* to *student outcomes* and *competencies*, *client care* to *curriculum*, *clinical competence* to *teaching effectiveness* and *client needs/acuity data* to *student numbers.* As a result of these modifications, the instrument was evaluated for content validity prior to use. Content validity was established by recruiting experts within the field of nursing education to evaluate each item for sufficiency, relevance and clarity.

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Determining Content Validity Index

Content Validity is generally agreed to represent the degree to which a sample of items taken together, constitute an adequate operational definition of a construct (Polit & Beck, 2006). Validity is considered crucial in the application of an instrument and is the extent to which that instruments measures what it is intended to measure (Lynn, 1986). According to Lynn, content validity is completed in two steps. The first step, item development, includes three steps of domain identification, item generation, and instrument formation. The second step of content validation was utilized to determine the validity of the instrument for utilization in colleges of nursing. This stage has been called by Lynn (1986) the Judgment-Quantification Stage and involves utilizing experts who assert that the items are content valid. For this study, six experts participated and according to Lynn (1986), a minimum of three experts is required. Polit and Beck (2006) stated the most widely used measure of content validity among nursing researchers is the content validity index or CVI (2006). According to Lynn (1986) when there are six or more judges, the CVI should be no lower than 0.78.

Procedure

An online request for assistance to members of the King International Nursing Group, in addition to colleagues of Dr. Christina Sieloff (personal communication February 7, 2013) was mailed electronically February 7, 2013. Experts in nursing education and administration were asked to participate. In addition scholars with a history of publications regarding empowerment in referred journals, national presentations and research regarding empowerment were solicited. Faculty with experience teaching at the baccalaureate level or above was invited to participate.

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A total of ten experts responded to the request to participate. However, of these only seven were selected based upon their nursing education experience. One of the seven experts was too ill to complete the survey by the designated due date. Demographic data collected included participant age, gender, job position, years in nursing education, current rank, initial level of nursing education, highest level of education, area of clinical expertise, tenure status, major area of publication/research ,number of publications/presentations completed in major area of research within the past five years and academic settings of each participant.

Expert Characteristics

Content experts ranged in age from 59 to 72, and all were female. The experts held academic ranks of clinical instructor (*n*= 1), assistant professor (*n*=1), associate professor (*n*= 1) chairperson (*n*= 1), associate Dean (*n*= 1), and one retired nurse executive. Their years of experience in nursing education ranged from 5 to 50 years. Educational preparation of the experts were as follows: Three experts earned a PhD in nursing, one held a PhD in another discipline, one the Doctor of Nursing Practice (DNP), and one was a master's prepared family nurse practitioner. The group's major areas of research included healthcare issues and health promoting behaviors, group power and empowerment, Roy's Adaptation Model, academic nursing centers, and nursing leadership. Each of the content experts had published or presented in their major area of interest twice in the past year.

The experts were provided with a list of behavioral objectives that guided the instrument development, a definition of terms, and a list of items designed to test the objectives (Waltz, Strickland, & Lenz, 2010) via Qualtrics online software (Qualtrics,

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Provo, UT). The survey was distributed March 4, 2013 and was completed by all participants by March 15, 2013. Participants were asked to rate each item on a scale of one to four. According to Lynn (1986), the use of a four point scale is important because it avoids having a middle, neutral point. The scale utilized the following 1) Not relevant, 2) Unable to assess relevance without item revision or item is in need of such revision that it would no longer be relevant, 3) Relevant but needs minor revision, and 4) Relevant.

The Content Validity Index for Scales

The content validity of the overall scale is referred to as the S-CVI (Polit & Beck, 2006.) This number represents the "proportion of total items judged content valid" (Lynn 1986, p. 384). According to Polit and Beck (2006), this number represents the CVI for scales as S-CVI/UA (universal agreement).There are three ways to calculate the S-CIV/UA. This researcher added the number of I CVI's and then divided by the number of items: This value was calculated as being 0.971. This number is identical to the average congruency percentage offered by Waltz et al. (2010, p. 178). According to Waltz et al., this number should be at least 0.90.

In summary, the CVI for the SKAGEO© as used in educational environments had a value of .83 to 1.00, which meets Lynn's criteria of a minimum I-CVI of .78 for six to ten experts. Furthermore, the S-CVI has been calculated to be .971, which meets Waltz et al., criteria of 0.90.

Summary of Experts Suggestions for Item Revision

The items identified by the most experts as being unclear included numbers 30, 36, 37, and 40. After review, the researcher accepted the experts' recommendations in

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order to clarify items identified as wordy and/ or circuitous. This included excluding the language *attainment of outcomes* and substituting the word *empowerment*. In addition, item number 40, which addressed budgeting, was changed to *Budgeted positions for the groups are determined by student needs*. This modification addressed experts' concerns that the item did not adequately address clinical courses and well as non-clinical ones.

Data Analysis

The research questions included the following:

1) What are the reported levels of group empowerment in baccalaureate schools of nursing? This was measured by computing the average group SKAGEO© score obtained using measures of central tendency including mean and standard deviation.

2) Is there a difference in perceptions of group empowerment between administrators and faculty? This was measured using independent samples t test statistical analysis to compare means of the total SKAGEO© scores of participants using PASW Statistics for Windows, Version 18.0. Chicago. Demographic data related to the research questions were also analyzed using descriptive techniques.

3) Is there a relationship between empowerment capacity, mediating variables and group empowerment (capability)? This question was measured using a two-tailed Pearson Correlation test using a significance of .05.

Psychometric evaluation of the instrument was measured by computing a content validity index. Reliability was also evaluated using Cronbach's alpha, and Split-Half Method, Equal Length Spearman Brown Correction Formula. The results of these analyses were compared to previous psychometric tests.

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Summary

Chapter III has described information regarding obtaining IRB approval and ensuring participant anonymity and confidentiality. In addition, the population and identification of the sample of interest was described. In addition, the data collection process and how the research questions were measured have been explained. The procedure for establishing content validity was also summarized. Chapter IV presents the data and the analyses used to answer the research questions.

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CHAPTER IV

DATA ANALYSIS AND FINDINGS

The presentation of the data and the analyses of each research question are provided in this chapter. The purpose of this study was to explore group empowerment capacity and capability in American Association of Colleges of Nursing (AACN) member schools of nursing, selected from a stratified sample representing four geographic regions in the United States. The difference between administrator and faculty scores, relationship of mediating variables (leadership competencies) to group empowerment, and the psychometric data for the instrument were also examined. Data associated with research questions were analyzed using descriptive statistics, independent samples t test, ANOVA, and Pearson correlation. Analysis of demographic data associated with research questions was also completed. In addition, psychometric analysis was conducted using Cronbach's alpha, and split half method equal length Spearman Brown Correction Formula. A significance level of 0.05 was selected *a priori* to test statistical significance for all research questions.

Description of Sample

The population for this study was approximately 15,282 administrators and faculty from 320 AACN member schools offering baccalaureate and higher degrees in the United States. The sample included 79 of 320 administrators from the targeted academic institutions, representing a 25% return rate. The number of faculty respondents was 312, representing a 14.5% response rate from a population of 2,146. The sample included administrators representing the following population areas: rural (28.7%); urban (43.8. %); metropolitan (22.5%) and other (5%) including urban/suburban (n= 1), urban

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in a rural area (*n*= 2), and city (*n*= 1). The 79 respondents represented the following geographic regions: North Atlantic (16.8%), Mid-West (20.2%), South (48.6%) and the West (14.4 %). Faculty participants reported working in urban areas (52.2%) followed by rural (21.8%) and cosmopolitan (6.2%). Faculty also represented the following geographic areas: North Atlantic (19.6%); Mid-West (18.2%); South (57.9%) and West (4.3%).

Demographic Data

For purposes of discussion, descriptive data by administrator and faculty groups are presented separately. Demographic data collected for all participants included age, primary racial/ethnic heritage, gender, tenure status, rank, initial level of nursing education, and highest degree obtained. In addition, faculty was asked to report years of experience in nursing education, and area of clinical expertise. Administrators were also asked if they were the chief administrator as defined by the Commission on Collegiate Nursing Education (CCNE). Institutional data was collected from all participants regarding type of academic setting, funding source of academic setting, and geographic area of their organization. Because there is a national emphasis on increasing the number of baccalaureate nursing graduates, administrators were asked to report numbers of baccalaureate students in their programs

Tables 2 and 3 present the findings associated with administrator age and racial/ethnic heritage. Typically, the administrator was female (*n*= 77; 98%), Caucasian (95%), and between the ages of 51-60 (47.5%).

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Table 2

Frequency Distribution of Administrator Participants by Age

Age in Years	*N*	%
39-50	5	6.3
51-60	38	47.5
61-70	34	42.5
71+	2	2.5
No Response	1	1.2
Total	79	100.

Table 3

Frequency Distribution of Administrators by Primary Racial/Ethnic Heritage

Racial/Ethnic History	*N*	%
Caucasian	75	94.9.
Hispanic	1	1.3
Native-American	1	1.3
Other	1	1.3
Would rather not say	1	1.3
Total	79	100

Tables 4 through 7 present findings associated with administrator rank, tenure status, entry level of education and highest level of education. Typically respondents were full professors (71%) and were tenured (87.3%). Ten respondents were non-tenured

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and one participant reported their institution did not grant tenure. The majority of respondents reported the baccalaureate degree as their entry level of nursing education (46.1%), followed by diploma (20%) and associate degree (13.8%). The majority of administrators had terminal degrees in nursing (53.8%).

Table 4

Frequency Distribution of Administrator Participants by Rank

Rank	*N*	*%*
Assistant Professor	2	2.5
Associate Professor	19	24.1
Full Professor	57	72.1
Other	1	1.3
Total	79	100.

Table 5

Frequency Distribution by Tenure Status Administrator Participants

Tenure Status	*N*	*%*
Tenure	69	87.3%
Non Tenured	10	12.7%
Total	79	100

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Table 6

Frequency Distribution by Initial Level Nursing Education Administrator Participants

Degree	*N*	%
Diploma	15	19.0
Associates Degree	11	13.9
Baccalaureate Degree	53	67.1
Total	79	100

Table 7

Frequency Distribution by Highest Degree Earned Administrator Participants

Degree	*N*	*%*
PhD Nursing	43	54.4
PhD Other Discipline	34	43.1
Masters in Nursing	2	2.5
Total	79	100

Tables 8 and 9 report institutional data including type of organization, and numbers of baccalaureate students as reported by administrator participants. The majority of administrators worked at state supported institutions (54.4%), and had 300-500 baccalaureate students enrolled in their programs.

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Table 8

Frequency Distribution by Type of Academic Organization

Type of Academic Organization	*N*	*%*
State Supported University	43	54.4
Private	31	39.2
Health Science Center/University	3	3.8
Research University	1	1.3
Total	79	100

Table 9

Frequency Distribution of Sample Schools by Numbers of Baccalaureate Students

Numbers of Students	*N*	*%*
<200	6	7.62
201-300	17	21.5
301-400	19	24.0
401-500	19	24.
501-600	5	6.3
601-700	6	7.7
>701	7	8.9
Total	79	100

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Descriptive Data Faculty Group

Tables 10 and 11 present the data on faculty age and racial/ethnic heritage. The majority of respondents were female (*n*=293, 93.9%) with males accounting for 6.1% of the sample (*n*=19). Respondents were also primarily Caucasian (92.4%). The ages of faculty respondents ranged from 27 to 72 years. Comparable to the administrator sample, the majority of faculty was 51-60 years of age (47.2%).

Table 10

Frequency Distribution by Age for Faculty Participants

Age	*N*	%
20-30	6	1.9
31-40	28	8.9
41-50	66	21.2
51-60	147	47.2
61-70	60	19.2
No response	5	1.6
Total	312	100

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Table 11

Frequency Distribution by Faculty Primary Racial/Ethnic Heritage

Primary/Racial Ethnic Group	N	%
Caucasian	292	92.4
Asian	4	1.3
Hispanic	5	1.6
Native-American	1	0.3
Other	5	1.4
Total	312	100

Tables12-14 present the data on faculty years of nursing education experience, rank and tenure status. Of note, the preponderance of faculty had been in nursing education less than 10 years (41.8%).In addition 27% were tenured, 68.9% were non tenured (68.9%) and 55.7% were in non-tenured track positions.

Table 12

Frequency Distribution Years of Academic Experience Faculty Participants

Years of Experience	*N*	*%*
<1 year	3	.09
1-9	132	41.8
10-19	76	24
20-29	40	12.7
30 and above	4	1.2
Total	312	100

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Table 13

Frequency Distribution by Faculty Rank

Rank	*N*	*%*
Instructor	73	23.5
Assistant Professor	106	33.9
Associate Professor	70	22.4
Full Professor	50	16.0
Other	12	3.9
No Response	1	0.3
Total	312	100

Table 14

Frequency Distribution by Faculty Tenure Status

Tenure Status	*N*	*%*
Tenure	85	27.24
Non Tenured	215	68.9
Total	312	100

Tables 15-16 present data regarding type of initial nursing education, and highest degree earned by faculty participants. Similar to the administrators, the majority of faculty was educated initially at the baccalaureate level (65.9%), and had terminal degrees (57.5 %).

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Table 15

Frequency Distribution by Entry Level Nursing Education Faculty

Education	*N*	%
Diploma	47	14.9
Associates Degree	57	18
Baccalaureate Degree	208	65.9
Total	312	100

Table 16

Distribution Frequency by Highest Degree Earned Faculty Participants

Degree	*N*	%
PhD Nursing	117	37.0
PhD Other Discipline	57	18.0
DNP	8	2.5
Master's Degree Nursing	126	39.9
Master's Degree Other Discipline	3	.9
Total	312	100

Table 17 describes the frequency distribution by clinical specialty for faculty participants.

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Table 17

Frequency Distribution by Area of Clinical Expertise

Clinical Area	*N*	%
Adult Health	70	22.4
Maternal Child	63	20.2
Community	38	12.2
Mental Health	26	8.3
Critical Care	32	10.3
Other	80	25.76
No Response	3	1,14
Total	312	100

Research Questions

1) What are the reported levels of group empowerment capacity (EC) and empowerment (E) in schools of nursing? Summary statistics including mean and standard deviation were calculated using Predictive Analytics Software (PASW) to measure empowerment capacity and empowerment in the sample. Findings indicated that participant mean scores were indicative of high empowerment for both empowerment capacity (*M*= 76.39, *S.D.* = 11.48, *N*= 391) and empowerment capability (*M*= 142.63, *S.D.* = 19.32, *N*= 391.).Table 18 summarizes data for participant empowerment capacity and empowerment scores. The data output indicates the distributions for both scales are negatively skewed indicating most of the scores were at the high end of the distribution. The 5% trimmed means for both scales were also close to the mean, indicating extreme scores did not have a strong influence on the mean. Both distributions were also peaked

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indicating less variability than in a normal curve. Empowerment had a high variance indicating a wide range of scores.

Table 18

Descriptive Data Empowerment Capacity and Capability

E Capacity			Standard Error	
	Mean		76.39	.580
	95% Confidence Interval for Mean	Lower Bound	75.25	
		Upper Bound	77.53	
	5% Trimmed Mean		76.82	
	Median		77.50	
	Variance		131.665	
	Std. Deviation		11.475	
	Minimum		30	
	Maximum		100	
	Range		70	
	Skewness		-.593	.123
	Kurtosis		..748	..246
E	Mean		142.63	.976
	95% Confidence Interval for Mean	Lower Bound	140.71	
		Upper Bound	144.55	
	5% Trimmed Mean		143.36	
	Variance		373.358	
	E Std. Deviation		19.322	
	Minimum		58	
	Maximum		180	
	Range		122	
	Skewness		-.616	.123
	Kurtosis		.924	.246

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Histograms for Empowerment Capacity and Empowerment are included in Figures 2 and 3.

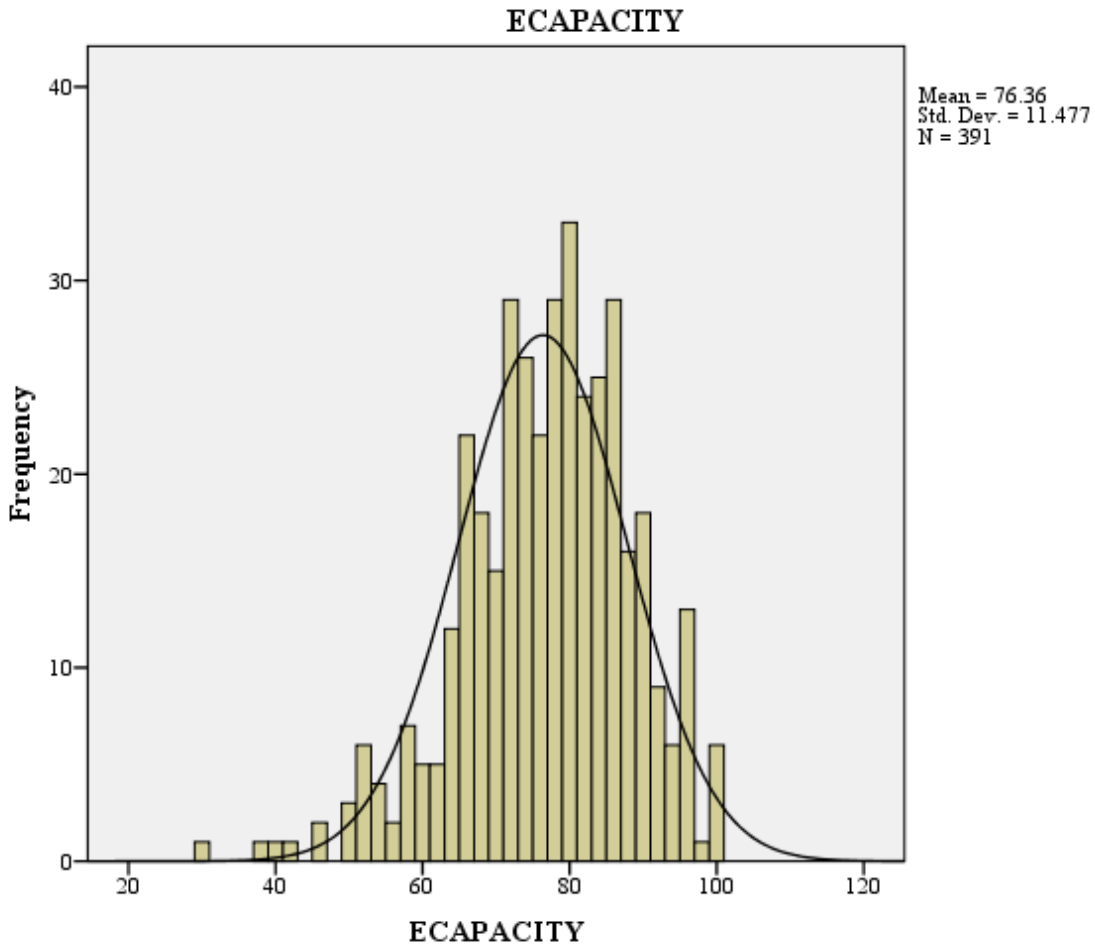

Figure 2. Histogram Empowerment Capacity.

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Figure 3. Histogram Empowerment.

Subscale Data Analyses

According to the theoretical constructs, four factors contribute to a group's empowerment capacity, and four mediating variables, or leadership competencies, affect empowerment capability to facilitate group empowerment. In order to determine if variables represented low, medium or high empowerment, participants' scores for each subscale were summed, averaged and then compared using the scoring grid described in Appendix E. Data analyses indicated participant's mean scores fell within the range of high empowerment for all subscales except for Resources (RE) and Position (P), which fell within the choice of medium empowerment. Table 19 presents the data.

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Table 19

Participant Scores Subscales Related to Empowerment Capacity

Subscale	*N*	Range	Min	Max	Mean	Std. Deviation	Variance
CEEF	391	22	13	35	27.31	4.448	19.785
POSITION	391	16	4	20	14.97	2.945	8.672
RESOURCES	391	24	6	30	19.24	4.302	18.506
ROLE	391	11	4	15	12.72	2.103	4.421

Note. CEEF =Controlling the Effects of Environmental Forces, P=Position, RE=Resources, RO=Role

Data were also compiled related to subscale scores for mediating variables related to empowerment. Participant mean scores were indicative of high empowerment on all subscales and are summarized in Table 20.

Table 20

Participant Scores for Mediating Variables Related to Empowerment

Subscale	*N*	Range	Min	Max	*M*	Std.Deviation	Variance
GLOAC	391	14	6	20	16.01	2.973	8.841
CC	391	12	3	15	12.47	2.032	4.127
GOC	391	11	9	20	16.29	2.380	5.663
OACP	391	16	9	25	21.31	2.846	8.098

Note. GLOAC-Group Leader's Outcome Attainment Competency, CC=Communication Competency, GOC=Goals/Outcomes Competency, OACP=Outcomes Attainment Perspective.

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Assessing Normality Sample Distribution

In preparation for inferential statistical analyses, testing to determine normality of the sample distribution was performed using PASW. Table 21 contains the PASW output information regarding the Kilmogorov-Smirnov statistic. The KS statistic was not significant ($p < .05$), and therefore the distribution for the sample can be considered normal.

Table 21

Tests of Normality

	TYPE	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
		Statistic	Df	Sig.	Statistic	df	Sig.
ECAPACITY	1	.074	79	.200*	.970	79	.060
	2	.046	308	.200*	.984	308	.002
EMPOWERMENT	1	.046	79	.200*	.987	79	.621
	2	.046	308	.200*	.982	308	.001

a. Lilliefors Significance Correction
*. This is a lower bound of the true significance.

Note. Type 1=Administrator, Type 2=Faculty.

Research Question

2. Is there a difference between perceptions of group empowerment capacity and capability of administrators and faculty? An independent samples t test was conducted to compare the group empowerment capacity and group empowerment capability scores for administrators and faculty. There was a significant difference in empowerment capacity (EC) scores for administrators (M= 80.16, $S.D.$ = 8.456) and faculty (M= 75.42, $S.D.$ = *11.94; t (389) = 3.341, p= .001)).* There was also a significant difference in empowerment (E) scores for administrators (M= 150.11, $S.D.$ = 13.15) and faculty (M= 140.71, $S.D.$ = 20.18 t (389) = 3.953, $p < .001$. The magnitude of the differences in the means of empowerment capacity (EC) (mean difference= 4.828, 95% CI: [2.514 to

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7.512] was moderate [*d*= .47]) (Cohen, 1988). The magnitude of the differences in the means of empowerment (E) (mean difference = 9.656, 95% CI [5.949 to 13.363] was also moderate [d= .57]).

Table 22

PASW Output Independent Samples T Test

		Levene's Test for Equality of Variances		t-test for Equality of Means					95% C.I.	
							Mean	Std. Error	Difference	
		F	*Sig.*	*t*	*df*	Sig.	Difference	Difference	Lower	Upper
EC	Equal variances assumed	10.356	.001	3.341	389	.001	4.743	1.420	1.951	7.534
E	Equal variances assumed	13.719	.000	3.953	389	.000	9.398	2.377	4.724	14.072

Subscale Scores for Administrators and Faculty

For purposes of discussion, a comparison of Empowerment Capacity (EC) and Empowerment (E) subscales scores was compiled for administrator and faculty groups. Administrator scores for subscales related to group empowerment capacity (EC) will be presented first. The data are reported using minimum, maximum, range, mean and standard deviation. Administrator scores for Controlling the Effect of Environmental Forces (CEEF) (*M*= 24.79, *S.D*= 3.271), and Resources (RE) (*M*= 17.88, *S.D.* = 3.616) were indicative of medium empowerment range. However, subscale mean scores for Position (P) (*M*= 16.35, *S.D.* = 2.063) and Role (RO) (*M*= 13.69, *S.D.* = 1.572) were in the high empowerment range (Table 23).

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Table 23

Variables Affecting Administrator Group Empowerment Capacity

	CEEF	P	RE	RO
N	79	79	79	79
Mean	24.79	16.35	17.88	13.69
Std. Deviation	3.271	2.063	3.616	1.572
Range	17	11	16	9
Minimum	13	9	9	6
Maximum	30	20	25	15

Note. CEEF=Controlling the Effect of Environmental Forces, P= Position, RE=Resources, and RO=Role.

Administrator Mediating Variables

Descriptive data summarizing mediating variables affecting administrator empowerment (E) is summarized in Table 24. Data is described using range, minimum, maximum, mean, and standard deviation. All four subscale mean scores were within the high empowerment range including Group Leader's Outcome Attainment Competency (GLOAC) (*M*= 17.23, *S.D.* = 2.000), Communication Competency (CC) (*M*= 13.36, *S.D.* = 1.443,) Goals/Outcomes Competency (GOC) (*M*= 17.14, *S.D.* = 1.565) and Outcome Attainment Perspective (OACP) (*M*= 22.28, S.D. = 2.044).

Table 24

Variables Affecting Administrator Empowerment

Subscale	GLOAC	CC	GOC	OACP
N	79	79	79	79
Mean	17.23	13.36	17.14	22.28
Std. Deviation	2.000	1.443	1.565	2.044
Range	7	5	6	7
Minimum	13	10	14	18
Maximum	20	15	20	25

Note. GLOAC=Group Leader Outcome Attainment Competency, CC=Communication Competency, GOC =Goal/Outcome Competency and OACP=Outcome Attainment Perspective.

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Faculty Group Empowerment Capacity Scores

Table 25 summarizes the variables affecting faculty group empowerment capacity using minimum, maximum, range, mean and standard deviation. Faculty mean scores for subscales Controlling the Effects of Environmental Forces (CEEF) (*M*= 27.95, *S.D.* = 4.479), Role (RO) (*M*= 12.47, *S.D.* = 2.150) indicated high levels of group empowerment. However, comparable to the administrator group, faculty mean scores on subscale Resources (RE) (*M*= 17.88, *S.D.* = 3.616) indicated medium group empowerment. In contrast to the administrator group which had lower scores (*M*= 24.79, *S.D*= 3.271), for subscale Controlling the Effects of Environmental Forces (CEEF), the faculty group scored lower on subscale Position (P) (*M*= 14.61, *S.D.* = 3.027).

Table 25

Variables Affecting Faculty Group Empowerment Capacity

Subscale	CEEF	POSITION	RESOURCES	ROLE
N	312	312	312	312
Mean	27.95	14.61	20.28	12.47
Std. Deviation	4.479	3.027	4.928	2.150
Range	22	16	24	11
Minimum	13	4	6	4
Maximum	35	20	30	15

Note. CEEF =Controlling the Effects of Environmental Forces, P=Position, RE=Resources, and RO=Role.

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Faculty Group Empowerment Scores

Descriptive data regarding variables which mediate group empowerment capacity (EC) for the faculty participants are summarized in Table 26. Faculty mean scores for all subscales including Group Leader Outcome Attainment Competency (GLOAC) (*M*= 15.69, *S.D.* = 3.102), Communication Competency (CC) (*M*= 12.24, *S.D.* = 2.098), Goals/Outcome Competency (GOC) (*M*= 16.07, *S.D.* = 2.504) and Outcome Attainment Perspective (OACP) (*M*= 21.07, *S.D.* = 2.968) indicated high levels of group empowerment.

Table 26

Mediating Variables Affecting Faculty Group Empowerment

Subscale	GLOAC	CC	GOC	OACP
N	312	312	312	312
Mean	15.69	12.24	16.07	21.07
Std. Deviation	3.102	2.098	2.504	2.968
Range	14	12	11	16
Minimum	6	3	9	9
Maximum	20	15	20	25

Note. GLOAC=Group Leader Outcome Attainment Competency, CC=Communication Competency, GOC =Goal/Outcome Competency and OACP=Outcome Attainment Perspective.

Independent Sample t Test Subscales Related to Empowerment Capacity

Independent samples t tests were conducted to compare subscale scores related to group empowerment capacity in administrator and faculty groups. There was a significant

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difference in scores for three subscales including Controlling the Effect of Environmental Forces (CEEF) in administrators (*M*= 24.79, *S.D.* = 3.27) and faculty (*M*= 29.75, *S.D.* = 4.48); *t* (389) = 5.92, *p*= .012.The magnitude of the differences in the means (mean difference= 3.171, 95% CI [-2.11-4.21]-(*d*= .599) were medium. There was also a statistically significant difference in scores for subscale Position (P) for administrators (*M*= 16.35, *S.D.* = 2.063) and faculty (*M*= 14.61, *S.D.* = 3.027); *t* (389) = 4.935, *p< .001*. The magnitude of the differences in the means (mean difference= 1.76, 95% CI [1.064, 2.474]) were also medium (*d*= .489). There was a statistically significant difference in scores for subscale Role (RO) for administrators (*M*= 13.69, *S.D.* = 1.572) and faculty (*M*= 12.47, *S.D.* = 2.150); *t* (389) = 4.728, *p <.001*. The magnitude of the differences in the means (mean difference= 1.213, 95% CI [.709, 1.718]) were small (*d*= .481). There was no significant difference in scores for subscale Resources (RE) for administrator (*M*= 17.88, *S.D.* = 3.616) and faculty (*M*= 19.66, *S.D.* = 4.53); *t* (389) = 3.22, *p*= .09 (Table 27).

Table 27

PASW Output Independent Samples T Test Subscales Empowerment Capacity

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	*Sig.*	*t*	*Df*	Sig.	Mean Difference	Std. Error Difference	Lower	Upper
CEEF	Equal variances assumed	6.361	.012	5.932	389	.000	-3.171	.535	4.222	-2.120
POSITION	Equal variances assumed	20.415	.000	4.935	389	.000	1.769	.358	1.064	2.474

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Table 27(Continued)

		F	*Sig*	*t*	*Df*	Sig.	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference Lower	Upper
RE	Equal variances assumed	2.754	.098	3.225	389	.001	-1.718	.533	2.765	-.671
ROLE	Equal variances assumed	7.101	.008	4.728	390	.000	1.213	.257	.709	1.718

Note. CEEF =Controlling the Effects of Environmental Forces, P=Position, RE=Resources, and RO=Role.

Independent Samples T Test Subscales Empowerment

Differences in means between subscale scores related to mediating variables were also measured in administrator and faculty groups. There were statistically significant differences between administrators and faculty in three of the four subscales. There was a statistical difference in subscales scores Group Leader Outcome Attainment Competency (GLOAC) between administrator (*M*= 17.23, *S.D.* = 2.00) and faculty (*M*= 15.69, *S.D.* = 3.10); *t* (389) = 4.109, *p* <.*001*. The magnitude of the differences in the means (mean difference= 1.504, 95% CI [.784, 2.223]) were small (d= .481) There was a statistically significant difference in subscale scores Goals/Outcome Competency (GOC) between administrators (*M*= 17.14, *S.D.* = 1.56) and faculty (*M*= 16.07, *S.D.* = 2.50); *t* (389) = 3.620, *p*= .001. The magnitude of the differences in the means(mean difference= 1.064,95% CI[.486,1.641])was small(*d*= .409).There was also a statistically significant difference in scores for subscale Outcome Attainment Perspective(OACP)

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between administrators(*M*= 22.28,*S.D.*= 2.044) and faculty(*M*= 21.07, *S.D.*= 2.96);*t*(389)= 3.416, *p*= .04.The magnitude of the differences in the means(mean difference)= 1.208,95% CI[.513,1.903])was small(d= .366).There was no significant difference in scores for subscale Communication Competency(CC) between administrators(*M*= 13.36,*S.D.*= 1.443) and faculty(*M*= 12.24,*S.D.*= 2.098);t(389)= 4.502,p=. 054. (Table 28)

Table 28

PASW Output Independent T Tests Subscales Related to Empowerment

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	*Sig.*	*t*	*df*		Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
GLOAC	Equal variances assumed	13.586	.000	4.109	390	.000	1.504	.366	.784	2.223
CC	Equal variances assumed	3.768	.053	4.481	389	.000	1.115	.249	.626	1.604
GOC	Equal variances assumed	11.386	.001	3.620	389	.000	1.064	.294	.486	1.641
OACP	Equal variances assumed	4.206	.041	3.354	390	.001	1.179	.352	.488	1.871

Note. GLOAC=Group Leader Outcome Attainment Competency, CC=Communication Competency, GOC =Goal/Outcome Competency and OACP=Outcome Attainment Perspective.

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Categorical Variables and Administrator Group Empowerment

In order to determine if tenure status, rank, geographic area, or type of funding had an effect on administrator group empowerment, analysis of variance and independent samples t tests were completed. There was not a significant effect of tenure on empowerment (F (1, 78) = 1.962, p= .165. Further, there was no significant difference in empowerment scores by rank between associate professors (M= 153.72, $S.D.$ = 11.145) and full professors (M= 147.82.$S.D.$ = 13.887; t (77) = 1.362, p= .177, two-tailed.) There was no significant difference in scores for administrators in state supported (M = 149.95, $S.D.$ = 11.816) and administrators in privately funded organizations (M= 149.94, S.D. = 13.942); t (77) = .005, p= .996.) Finally, there was no significant effect of geographic location on administrator empowerment F (3, 76) =.101, p= .959. In conclusion, no significant effects of tenure, rank, geographic area of academic organization, and institution funding on administrator empowerment were found.

Categorical Variables and Faculty Group Empowerment

There was no significant effect of faculty rank on empowerment at the p< .05 level F (4,308) = 2.285, p= .060 or tenure status on faculty empowerment F (1,311) = 1.548, p= 214.Analysis of variance testing to determine effect of geographic area (rural, urban, cosmopolitan) of faculty and empowerment was done and again, no statistical difference was found F (3,309) = .153, p= 328. There was no significant difference in empowerment capability (E) scores between faculty in state supported organizations (M= 139.92, $S.D.$ = 19.709) and faculty in private institutions (M= 141.09, $S.D.$ = 21.553; t (310) = .441, p= .659). Finally, a one way analysis of variance was conducted to investigate the effect of highest degree earned on faculty empowerment. There was no

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significant difference in empowerment scores between faculty with masters degrees (*M*= 140.67, *S.D.* = 18.56), faculty with doctoral degrees in nursing (*M*= 137.84, *S.D.* = 21.57) and faculty with doctoral degrees in another discipline (*M*= 142.21, *S.D.* = 20.74) *F* (3,309) = 1.187, *p*= .315. In conclusion, no effects for rank, tenure, geographic area of academic organization, type of institution or highest degree earned on faculty empowerment were found at the level *p* <.05. Additional analyses were completed to examine differences in participants' subscale scores.

Research Question

3. Is there a relationship between empowerment capability (E) and mediating variables Group Leader Outcome Attainment Competency (GLOAC), Communication Competency (CC), Goals Outcome Competency, (GOC) and Outcome Attainment Perspective (OACP)? This question was measured using a two-tailed Pearson Correlation test using a significance of .05.

A strong positive correlation was found between administrator group empowerment and Group Leader's Outcome Attainment Competency (GLOAC) *r* (77) = 767, *p* <.01, and between empowerment and Goals/Outcomes Competency (GOC) *r* (77) = .814, *p* <.01. A moderate positive correlation was found between empowerment and Outcome Attainment Perspective (OACP) *r* (77) = .649, *p* <.01, and empowerment and Communication Competency (CC) *r* (77) = .664, *p* <.01 (Table 29).

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Table 29

Correlation between Mediating Variables and Administrator Empowerment

	N	*r*	r^2	*p*
GLOAC	79	.767**	.588	.000
CC	79	.664**	.440	.000
GOC	79	.814**	.662	.000
OACP	79	.649**	.421	.000

Note. **p<.01

The coefficient of determination ranged from 42 % (r^2=.421, *n*= 79) to 66 % (r2= .662, *n*= 79); therefore, up to 66% of the variance in empowerment was related to mediating group leader competencies.

Correlation between Mediating Variables and Faculty Group Empowerment

A Pearson correlation coefficient was also calculated for the relationship between faculty group empowerment scores and mediating variables of Group Leaders Outcome Attainment Competency (GLOAC), Communication Competency (CC), Goals/Outcome Competency (GOC) and Outcome Attainment Perspective (OACP) (Table 30). There were strong positive correlations between empowerment and Group Leader's Outcome Attainment Competency (GLOAC) *r* (310) = .828, p <.01, between empowerment and Communication Competency (CC) *r* (310) = .740, p <.01, between empowerment and Goals/Outcome Competency (GOC) *r* (310) = .866, p <.01, and between empowerment and Outcome Attainment Perspective (OACP) *r* (310) = .753, p <.01.

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Coefficient of Determination

There was a significant positive linear relationship between mediating variables and group empowerment. The coefficient of determination ranged from 55 % (*r2*= .547, *n*= 312) to 75 % (r2=.749, *n*=312); therefore, up to 75% of the variance of empowerment can be explained by mediating variables of group leader competencies

Table 30

Correlation between Mediating Variables and Faculty Empowerment

Subscale	*N*	*r*	r^2	*p*
GLOAC	312	.828**	.685	.000
CC	312	.740**	.547	.000
GOC	312	.866**	.749	.000
OACP	312	.753**	.567	.000

Note. Group Leader Outcome Attainment Competency= (GLOAC), Communication Competency= (CC), Goals/Outcome Competency= (GOC), and Outcome Attainment Perspective= (OACP).

In conclusion, there were moderate to strong positive correlations identified between all mediating variables and group empowerment in both administrator and faculty participants.

Cronbach's Alpha Reliability Coefficients

The Cronbach's alpha reliability coefficients for the scale and eight subscales in the administrator sample were as follows: Group Leader's Outcome Attainment Competency (GLOAC),0.74; Communication Competency(CC), 0.63, Controlling the Effects of Environmental Forces (CEEF), 0.91, Goals/Outcomes Competency (GOC), 0.59, Position (P), 0.71, Outcome Attainment Perspective (OACP), 0.81, Resources (RE), 0.79, Role (RO) 0,87, and Empowerment, (E) 0.92.

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According to George and Mallery (2003), alpha coefficients less than .60 are considered questionable. However, since Communication Competency Subscale has a small number of items (*n*=4), the inter-item correlation was also calculated, and was .353, with a range of .241. According to Briggs and Cheek (1986) an optimal range is 0 .2 to 0.4. In addition, of note, item three had the lowest mean score (*M*= 4.34, *S.D.* = .550) and had a corrected item correlation less than the recommended value of 0.4 (Gliem & Gliem, 2003). Finally, the Cronbach's alpha with item three omitted would be higher at 0.69 as opposed to 0.63 (Table 31).

Table 31

Item Statistics Communication Competency Subscale for Administrators

Item	Mean	Std. Deviation	N
Representatives of the group hold voting privileges on organizational decision-making bodies.	4.50	.729	79
Representatives of the group hold voting-privileges on organizational intergroup committees.	4.53	.616	79
Empowerment is enhanced through communication with other organizational groups.	4.34	.550	79

Table 32 contains the PASW output for item total statistics for subscale Communication Competency for administrators.

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Table 32

Item Total Statistics Communication Competency Subscale Administrators

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
Representatives of the group hold voting privileges on organizational decision-making bodies.	8.86	.854	.517	.306	.405
Representatives of the group hold voting-privileges on organizational intergroup committees.	8.84	1.049	.518	.300	.410
Empowerment is enhanced through communication with other organizational groups.	9.03	1.392	.299	.089	.691

Item Statistical Output Subscale Goals/Outcome Competency

The PASW item total statistical output for subscale Goals/Outcome Competency is summarized in Tables 33 and 34. Again, due to the small number of items within the subscale, the mean inter item correlation for the subscale was calculated to be .247 with a range of .139. In addition, items two, three, and four had corrected inter item correlations less than the recommended value of less than .04. Finally, the Cronbach's alpha would not rise above .592 with any of these items deleted.

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Table 33

Item Statistics Goals/Outcome Competency Subscale Administrators

Item	*M*	Std. Deviation	*N*
Desired outcomes of the group are developed with the opportunity for input from all group members.	4.51	.503	79
The desired outcomes for the group provide for the development of teaching, scholarship and service.	4.15	.638	79
In order for the group to empower itself, the group must have clearly defined desired outcomes.	4.43	591	79

Table 34

Item Total Statistics Goals/Outcome Competency Administrators

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Desired outcomes of the group are developed with the opportunity for input from all group members.	12.63	1.630	.441	.480
In order for the group to empower itself, the group must have clearly defined desired outcomes.	12.71	1.549	.375	.520
The desired outcomes of the group address the effective use of resources.	13.09	1.524	.392	.506

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Cronbach's Alpha Reliability Coefficients Faculty Participants

Cronbach's alpha reliability coefficients for the total scale and eight subscales in the faculty sample were as follows: Group Leader's Outcome Attainment Competency (GLOAC), 0.79, Communication Competency (CC), 0.77, Goals/Outcome Competency (GOC) 0.68, Outcome Attainment Perspective (OACP), 0.80, Controlling the Effects of Environmental Forces (CEEF), 0.90, Position (P) 0.81, Resources (RE) 0.86, Role (RO) 0.88, and total scale (E) 0.96.Table 35 contains the PASW output for item statistics for subscale Goals/Outcome Competency. Table 36 describes the item summary statistics for the subscale, and of note, the third item had a corrected item total correlation less than the recommended level of 0.4., and deletion of this item would raise the correlation coefficient.

Table 35

Item Statistics Goals/Outcome Competency Faculty

	Mean	Std. Deviation	N
Desired outcomes of the group are developed with the opportunity for input from all group members....	3.88	1.047	312
The desired outcomes for the group provide for the development of teaching, scholarship and service...	3.82	.943	312
In order for the group to empower itself, the group must have clearly defined desired outcomes.	4.40	.618	312
The desired outcomes of the group address the effective use of resources.	3.97	.827	312

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Table 36

PASW Output Item Summary Goals/ Outcome Competency Subscale Faculty

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
Desired outcomes of the group are developed with the opportunity for input from all group members...	12.19	3.290	.496	.260	.609
The desired outcomes for the group provide for the development of teaching, scholarship and service.	12.25	3.571	.507	.286	.592
In order for the group to empower itself, the group must have clearly defined desired outcomes.	11.68	4.825	.391	.203	.670
The desired outcomes of the group address the effective use of resources.	12.10	3.903	.515	.301	.590

Split-Half Spearman Brown Analysis of SKAGEO©

Split half Spearman Brown and Guttmann Split half coefficient analyses for the scales with both administrator and faculty groups were conducted (Tables 37 and 38).

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Table 37

Reliability Split Half Method SKAGEO© Administrators

Cronbach's Alpha		
	Part 1 Value	.869
	N of items	18
	Part 2 Value	.846
	N of items	18[b]
Correlation Between Forms		.830.
Spearman Brown Coefficient	Equal Length	.907
Guttmann Split half coefficient	Unequal Length	907
N		.79

Table 38

Reliability Split Half Method SKAGEO© Faculty.

Cronbach's Alpha		
	Part 1 Value	.922
	N of items	18
	Part 2 Value	.909
	N of items	18[b]
Correlation Between Forms	Equal Length	
Spearman Brown Coefficient	Unequal Length	.878
Guttmann Split half coefficient		.935
		.906
N		312
		.
		.

This study's reliability statistics were compared to those reported by previous authors as presented in Table 39

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Table 39

Cronbach's alpha for Studies Utilizing Sieloff's Instrument

Author	Instrument Name	Subjects	Cronbach's alpha
Sieloff,2003	Sieloff–King Assessment of (Nursing) Department Power (SKADP)	120 CNEs	0.96
Sieloff,2003	Sieloff–King Assessment of (Nursing) Department Power (SKADP	600 CNEs	0.91
Sieloff, 2003	Sieloff–King Assessment of Group Power within Organizations (SKAGPO)	600 CNEs	0.92
Bularzik (unpublished data)	Sieloff–King Assessment of Group Goal Attainment Capacity within Organizations ($SKAG_2ACO$)	90 Staff RNs	0.937
Current Study	Sieloff King Assessment of Group Empowerment(SKAGEO© within Educational Environments	79 Nurse Educator Administrators 312 Nurse Faculty	0.92 0.96

Summary

The study sample consisted of 79-nursing administrators and 312 full time nursing faculty. The majority of respondents were female, Caucasian, doctoral prepared, and employed in state supported organizations. The Sieloff King Assessment of Group Empowerment within Organizations (SKAGEO©) was adapted for use with permission. Three research questions guided this study, and psychometric analyses were also conducted. Descriptive statistics were utilized to answer research question one which explored the empowerment capacity and capability scores of participants. Results indicated that participant's scores were within high ranges in both Empowerment

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Capacity and Empowerment scales. Prior to conducting parametric analyses for the data, the sample scores for the dependent variable scores Empowerment Capacity (EC) and Empowerment (E) was tested for normality.

Independent samples t test and analysis of variance were conducted to answer research question two. Research question two examined whether there was a difference in scores on both scales between the administrator and faculty groups. The conclusions indicated there was a statistically significant difference in both scales between groups with administrators scoring higher than faculty. Additional analyses found no significant effect of rank, tenure, geographic area, highest degree earned, or type of school funding on empowerment. However, there were statistical differences in subscales scores between administrators and faculty in six of the eight subscales: Faculty scored higher on subscales measuring Controlling the Effect of Environmental Forces (CEEF) and Resources (RE). Administrators scored higher on subscales measuring Role, (RO) Position (P), Group Leader Outcome Attainment Competency (GLOAC), Outcome Attainment Perspective (OACP), Goals/Outcome Competency (GOC) and Communication Competency (CC).

Research question three examined if there were relationships between mediating variables and empowerment in both groups and was measured using a two-tailed Pearson Correlation test using a significance of .05. The findings indicated all mediating variables had strong positive correlations with empowerment scores within the faculty sample. All mediating variables had strong positive correlations with the administrator group except for Outcome Attainment Perspective (OACP) and Communication Competency (CC), which had a medium positive correlation with empowerment. The

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coefficient of determination ranged from 42 %(r^2=.421, *n*= 79) to 66 %(r^2= .662, *n*= 79); therefore, up to 66% of the variance in empowerment was related to mediating group leader competencies in the administrator group. Likewise, the coefficient of determination ranged from 55 %(r^2= .547, *n*= 312) to 75 %(r^2=.749, *n*=312); therefore, up to 75% of the variance of empowerment in the faculty group can be explained by mediating variables of group leader competencies

Reliability of the instrument within the sample was established by computing Cronbach's alpha for each subscale and the total scale. In addition, Spearman Split Half Analyses was also conducted. Reliability measures were also compared to previous psychometric analyses of the instrument. These measures indicated strong reliability of the instrument in the administrator and faculty groups.

Chapter V discusses research findings and compares the findings of this research to previous studies. Conclusions, limitations, implications and recommendations for future research are addressed.

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CHAPTER V

DISCUSSION, CONCLUSIONS, LIMITATIONS, IMPLICATIONS AND FUTURE RESEARCH

Introduction

This chapter will provide conclusions, discussion, and recommendations based on the findings of this research. The purpose of this study was to explore group empowerment capacity and capability in baccalaureate and higher degree schools of nursing. Specifically, the difference between administrator and faculty group empowerment and the effect of mediating variables on group empowerment was explored. A summary of the literature review supporting the study is provided.

Summary of Literature Review

The review of the literature revealed an American healthcare system where thousands of patients die each year due to preventable errors, often attributed to a lack of effective teamwork (Kohn, Corrigan & Donaldson, 2000).The need for patient centered care based on solid evidence and cooperation of practitioners has also been described (Greiner & Knebel, 2003). Furthermore, hospitals with nurses who are prepared at the baccalaureate and graduate degree levels experience lower mortality rates, fewer medication errors, and positive patient outcomes (Aiken, Clarke, Sloane, Lake, & Cheney, 2008).

The literature also described multiple challenges currently facing nursing education administrators. For example, chief administrators in schools of nursing have numerous responsibilities including obtaining and managing external funds, developing long range goals, and representing their colleges to the university (Montez, Wolverton, &

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Gmelch, 2003) Nursing education is expensive, with clinical coursework different than many other academic disciplines. Administrators of nursing programs are challenged to justify their budgets to university officials and stakeholders, who demand baccalaureate prepared nurses capable of providing safe, patient centered care, and willing to commit to lifelong learning (IOM, 2010). Nurse faculty shortages and increased demands for higher enrollment are also realities facing administrators (AACN, 2012a).

Nursing faculty has accountability for the academic preparation of students and their beginning professional socialization within complex healthcare environments. In spite of these overwhelming responsibilities, nurse educators are compensated for significantly less pay than earned by master's educated nurse practitioners (Allen, 2010) while expected to maintain clinical competence, teaching acumen ,and the tripartite mission of higher education. Concurrently, experts are advocating for transformation of nursing pedagogy (Allen, 2010; Benner et al., 2010), while more nurse faculty are preparing to retire.

Whereas hospitals with Magnet Hospital status are known for their ability to attract and retain top talent, as well as increased levels of job satisfaction and nurse empowerment (Aiken et al., 2000; Upenieks, 2003), less is known about best practices in nursing education. Sadly, what is known about nurse faculty, described by some as a vulnerable population (DalPezzo & Jett, 2010), is that they often contend not only with uncivil behaviors from their students, but also from their peers and administrators. The most characteristic types of horizontal violence include competitiveness, ostracism, blaming, silencing and lack of support. Faculty also reported experiences of lack of support and abuse of power by administrators (Glass, 2007). The resulting detrimental

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effects on faculty include job dissatisfaction, psychological, and physical stress (Longo & Sherman, 2007). While these oppressed group behaviors are believed to be related to lack of power or empowerment (Duffy, 1995; Ratner, 2006; Roberts, 2000; Roberts et al., 2009), this study was conducted in efforts to examine group empowerment in nursing education. The purpose of the study was to not only assess levels of group empowerment, but also to identify leadership competencies associated with empowered faculty.

The nursing literature suggests that nurses respond positively to transformational leadership where participatory decision making is practiced (Marquis & Huston, 2009). However, there have also been limitations identified with the Multifactor Leadership Questionnaire (MLQ) which measures transactional and transformational leadership behaviors, suggesting that nursing leadership could benefit from additional perspectives of inquiry. According to Hutchinson and Jackson (2012), the uncritical acceptance of transformational leadership has resulted in a limited interpretation of nursing leadership.

The conviction that nursing knowledge should be based upon discipline specific theory reinforced employing a mid-level nursing theory as the conceptual framework for the study. A review of the literature revealed that the majority of studies exploring nurse empowerment have been based upon structural empowerment theory (Almost & Laschinger, 2002; Laschinger at al., 2001, 2003; Sarmiento et al., 2004), and psychological empowerment theory (Manojlovich, 2007).

In summary, current demands for advanced practice nurses who can fulfill expanding roles depends upon the preparation of baccalaureate prepared nurses who are empowered to work effectively as teams, while collaborating with members of other

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disciplines. Currently, recognized threats to the profession's capability to meet these demands include a critical lack of nursing faculty, inadequacies within existing nursing pedagogy, and the continuing documentation of oppressed group behaviors within nursing (Berlin & Sechrist, 2002; Clark & Springer, 2007; Cooper et al., 2011). Gaps in the literature illustrated there were no studies exploring group empowerment in baccalaureate nursing education, and there were no studies that compared group empowerment in deans and faculty. The purpose of this study was to close this gap by describing group empowerment capacity and capability in schools of nursing using a mid range nurse theory.

A sample of administrators and faculty from schools with 16 or more faculty, offering baccalaureate and higher degrees, was selected from a list of AACN member schools representing four geographic areas within the United States. The Sieloff King Assessment of Group Empowerment within Organizations (SKAGEO©) was adapted for use in educational settings after content validity was established. The survey was administered online beginning the spring semester of 2013. In order to obtain additional participants from the mid-west and west, data collection was extended through June 30 2013. Demographic data was collected using a researcher developed survey.

Conclusions

Demographic Data

The demographic characteristics of the sample are relevant as they reflect current national norms within nursing education, particularly as it reflects an aging workforce and a lack of diversity. The administrator group was primarily female (*N*=78, 98%) and over 50 years of age (92.5%). Likewise, the sample faculty group also reflected an aging

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workforce (*M*=53years.), who were also primarily female (93%).and of Caucasian descent (93%). This data is congruent with nationwide figures which indicated the average ages of doctoral -prepared nurse faculty holding ranks of professor, associate professor and assistant professor were 60.5, 57.1, and 51.5 years respectively(AACN 2012a). Likewise, master's prepared faculty with professor, associate professor, and assistant professor rank were 57.7, 56.4, and 50.9 years of age respectively (AACN, 2012b).

As the administrator and faculty samples both illustrate, nursing education lacks diversity. According to the AACN, nursing students representing minority backgrounds comprised 28.3% of entry level baccalaureate programs, 29.3% of master's students, and 27.7% of students in research-focused doctoral programs (2012). However, according to 2011 data, only 11.8% of full-time nursing school faculty represent minority backgrounds, and only 5.1% are male (AACN). This discovery is significant since the study sample of administrators and faculty do not represent their patient population which has become increasingly diverse (37%), or their nursing student population (AACN, 2012a).Whereas the need to increase diversity in nursing in order to deliver culturally competent care has been widely discussed, less emphasis has been focused upon the potential relationship lack of diversity to group empowerment. If as suggested, being female is correlated with lack of nursing empowerment (Manojlovich, 2007), the study sample suggests demographics may not be changing favorably within the profession.

However, in contrast to national data, faculty sample participants were primarily educated at the doctoral level (58%). According to the AACN (2012a), nationalized data indicates there is a limited pool of doctoral prepared faculty with 56.3% of participating

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schools reporting full time vacant faculty positions for faculty with earned doctorates. These study findings may either suggest an effect of the increased emphasis on doctoral preparation for nurse faculty, or just that doctoral prepared nurses were more prone to participate with the survey, and may be better prepared to empower themselves.

Research Question One

What are the reported levels of group empowerment capacity and capability in baccalaureate schools of nursing? Participant's scores were indicative of high empowerment for both Empowerment Capacity (*M*= 76.31, *S.D.* = 11.48) and Empowerment (*M*= 142.43, S.D. = 19.29). However, participant's mean scores for subscales Resources (RE) (*M*=19.27, S.D. = 4.40) were indicative of medium empowerment, suggesting they perceived needed resources were limited. Administrator mean scores on the items for subscale resources (RE) ranged from 3.05 to 3.93. The item with the lowest mean score was item five, "Financial resources available to the group are sufficient" (*M*= 3.05, *S.D.* = 1.16). Likewise, faculty mean scores for items on subscale RE ranged from 2.90 to 3.73, and item five also had the lowest mean score in the faculty group (*M*=2.90, *S.D.* =1.15). This finding is also widely supported by the literature. According to the National Advisory Council on Nurse Education and Practice (NACNEP):

> Inadequate institutional funding prevents supporting and establishing additional faculty positions to employ qualified professionals even when schools of nursing are able to identify qualified candidates. Nursing education programs also encounter obstacles within university systems when attempting to create collaborative partnerships to provide access to

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> nurse educator programs. These include institutional barriers related to tuition sharing, admission and enrollment management, and sharing faculty. (2010, p. 22)

This verdict has also been supported by Buerhaus, Staiger, and Auerbach (2009) who cited earning disparities as a contributing factor to the nurse faculty. The impact of less pay for qualified nursing faculty on the shortage of educators has also been well documented in the literature. For example, national data from the AACN (2012c) indicated 27.6% of schools reported noncompetitive salaries as one of their most critical issues related to faculty recruitment. For example, according to the 2012c AACN faculty vacancy survey, of 662 participating schools, only 182 (27.5%) reported having no full time vacant faculty positions or needing additional faculty. Furthermore, schools with baccalaureate programs had the highest rate of faculty vacancies (*N*=341, 30.2%), followed by schools offering baccalaureate and masters programs (*N*=259, 22.9%). Likewise, an overwhelming majority of participating schools reported needs for faculty who were able to do classroom and clinical instruction (*N*=820, 72.6%). In summary, current nursing faculty and administrators are expected to achieve outcomes with inadequate numbers of faculty.

Participant scores for subscale Position (P) also indicated medium empowerment (*M*= 14.96, *S.D.* = 2.941) This conclusion is important as it suggests participants perceived their contributions were not valued by other groups within the organization, nor was their work viewed as central to the delivery of services by other organizational groups. Results also suggested participants perceived they were not valued for their expertise within their organizations, their work was not perceived as central to the organization, and their input was not sought by others within the organization. Similarly

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Brancato (2007), and Baker et al., (2011) reported faculty who perceived psychological empowerment in their roles, but who indicated they had little influence on decisions made within their organizations. Cash et al. (2009), concluded nursing educators in Canada work under conditions less desirable than they would like, and there is a lack of congruence between what they believe is important and what they experience in their workplace. In addition, respondents expressed their desire for shared leadership based on faculty empowerment. Baker et al. (2011), concluded from a sample of 139 A.D. nursing faculty fewer reported that they had autonomy and freedom in their job (73.4-87.1%) and even fewer believed they had significant impact, control or influence within their departments (41.7 -57.6%). In contrast, this study's findings differ from Disch et al., (2004) who reported faculty feeling their opinions were routinely solicited (65%) and seriously considered (66%). However these authors did not report reliability or validity data for the instrument utilized in their research. In conclusion, this study suggests administrators and faculty desire more input into organizational decision making and improved acknowledgment for their unique contributions to their organizations.

Scores for mediating variables were indicative of high empowerment including Group Leader's Outcome Attainment Competency (GLOAC) (*M*=16.01.*S.D.* =2.97), Communication Competency (CC) (*M*=12.47, *S.D.* = 2.032), Goals/Outcome Competency (GOC) (*M*=16.29, *S.D.* = 2.380) and Outcome Attainment Perspective (OACP) (*M*=21.31, *S.D.* = 2.846). These results suggest that participants perceived group leaders used collaboration with other groups, were actively involved in administrative decision making for the overall organization, and had support of individuals within the group. The findings also disclose that group members had voting privileges on

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organizational decision making bodies, communicated with other organizational groups, and were able to achieve goals. This outcome is similar to leadership research which has described the positive relationship between leader's who are able to effectively communicate goals and share information with their followers, and empowerment (Yukl & Becker, 2006). The positive relationship of leadership competencies to group empowerment has ramifications for leadership development in view of the fact that leaders who collaborate with others, are actively involved in decision making, and encourage communication with other organizational groups actually support empowering environments. Likewise, Chen et al. (2005) reported 286 nursing faculty members identified leaders who demonstrated individualized consideration contributed to nursing faculty job satisfaction. Similarly, Greco et al. (2006), reported leader's empowering behaviors can enhance person-job fit and prevent burnout in acute care nurses. Casida and Pinto-Zipp (2008) also concluded that transformational leadership is associated with desirable nursing units' OC as measured by Denison's Organizational Culture Survey (DOCS). Larrabee et al. (2003) discovered the major predictor of intent to leave was job dissatisfaction, and the major predictor of job satisfaction was psychological empowerment. Predictors of psychological empowerment were hardiness, transformational leadership style, nurse/physician collaboration, and group cohesion.

In conclusion, although statistics supported the presence of group empowerment in nursing schools, the findings also suggests that nurse administrators and faculty are experiencing the effects of lack of resources including the nurse faculty shortage. Furthermore, participants may benefit from having their expertise valued by others, and need to be perceived as central to the delivery of services by others within their

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organizations. In addition, participants needed additional information to provide input into their organization's decision making. Furthermore, high scores on mediating variables support the magnitude of leadership competencies to empowered work environments.

Research Question Two

Is there a difference between perceptions of group empowerment capacity and capability of administrators and faculty? There was a significant difference in empowerment capacity (EC) scores for administrators (*M*= 80.16, *S.D.* =8.510) and faculty (*M*=75.34, *S.D. =11.94; t (389) = 4.210, p< .001).* There was also a significant difference in empowerment (E) scores for administrators (*M*= 150.11, *S.D.* = 13.24) and faculty (*M*= 140.46, *S.D.* = 20.10; *t* (385) = 5.140, *p*< .001.Although there were no studies found to compare these specific findings, differences in administrator and faculty empowerment have been suggested by Moody et al. (2007), who described "a dual bureaucracy of faculty and administration in nursing education" (p. 319). The authors described environments where nurse administrators and faculty feel disconnected from each other which may result from differences in perceived empowerment. Likewise, Glass (2001, 2003) documented inequitable treatment of faculty by administrators including failure to give faculty credit for ideas or accomplishments suggesting an abuse of administrator power. Although causation for these differences in empowerment cannot be identified by this study, these results suggest shared power and governance, hallmarks of Magnet hospitals, may be lacking in nursing education.

Administrator participants had medium empowerment scores on subscale Controlling the Effects of Environmental Forces (CEEF) (*M*= 24.79, *S.D*= 3.271)

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suggesting a need for refinement of skills. Items included within this subscale address groups' capacity to adjust to and anticipate changing healthcare trends. Although there are limited research studies in the nursing literature to compare, this discovery is supported in academic leadership research exploring the role of dean's tasks. Montez et al.(2003), surveyed 360 institutions, and, according to the authors, "It is clear that the most controversial part of their work focused on roles that fell within the realm of external and political relations; almost one-quarter of the data's variance was accounted for by this factor" (p. 246). Likewise the authors stated the deans ranked external and political relations as one of their top three tasks. This finding is especially significant since organizations have become more complex.

The item with the lowest mean score within subscale Controlling the Effective of Environmental Forces (CEEF) was item 16: "The results of research are integrated into current group practice" (*M*=3.95, *S.D.* =.58). This outcome is also supported within the literature regarding the lack of evidenced based practice in nursing education. For example, The Institute of Medicine reported teaching within the health sciences continues to be based upon individuals' own learning experience, as opposed to evidenced based research (2003). Furthermore nursing leaders continue to advocate for transformation in nursing pedagogy (Allen, 2010; Benner et al., 2010; Ironside, 2004) citing current methods' weaknesses in preparing nurses for the 21st century.

This study's conclusions regarding the lack of effect of tenure, rank and educational level is in contrast to Johnson and Rae (2009) who explored the relationship of organizational climate and empowerment in associated degree (AD) nurse faculty. These authors discovered rank and years employed as AD nursing faculty were found to

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be significant contributors to faculty empowerment. However, Baker et al. (2011), who examined empowerment in associate degree faculty, also found no significant differences in empowerment or job satisfaction based on educators' tenure status, educational level, evidence of scholarship, or academic rank.

Conclusions of no significant differences in subscale scores between administrators and faculty except for Resources (RE) and Communication Competency (CC) not only reinforces the critical need for more resources, but also emphasizes the value of valuable communication. This conclusion is also supported within the nursing literature. Although there are few research studies evaluating leadership in nursing education, Chiok (2001) discovered use of leadership behaviors and employee outcomes were correlated. Her study utilized regression analysis which indicated that 29% of job satisfaction, 22% of organizational commitment and 9% of productivity were explained by the use of leadership behaviors. Likewise, Force (2005) identified themes associated with nurse retention and job satisfaction including transformational leadership style and extroverted personality traits. In addition, Magnet hospital organizational structures that support nurse empowerment, autonomy and group cohesion, tenure, and graduate education were associated with job satisfaction. Gormley (2003) completed a meta-analysis of factors associated with job satisfaction in nurse faculty in the U.S. The author concluded the perception/expectation of the leader's role in curriculum and instruction appears to significantly affect nursing faculty job satisfaction with an effect size of 0.738. Other leadership factors that have high effect size are consideration and initiating structure behaviors with .802 and .688, respectively Laschinger et al. (2009) analysis provided support for the model predicting supportive professional practice environments,

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low levels of incivility and an overall sense of workplace empowerment explained variance of new graduates' experience of burnout at work.

Research Question Three

Is there a relationship between mediating variables and group empowerment? A strong positive correlation was found between administrator empowerment and Group Leader Outcome Attainment Competency, (GLOAC) r (77) = .767, p< .01, Communication Competency (CC), r (77) = .742, p< .01, and Goals/Outcome Competency (GOC), r (77) = .814, p< .01. A moderate positive correlation was found between empowerment and OACP r (77) = .649, p< .01. These results support the theoretical relationship between leadership competencies and group empowerment capability. Specifically high correlations between Group Leader Outcome Attainment Perspective, Communication Competency and Goals/Outcome Competency proposes group leaders who value empowerment and are capable of communicating effectively with others support empowered work environments. There were no studies found to compare dean's leadership competencies with faculty empowerment; however, Bularzik et al., reported staff nurses had high goal attainment capability and high professional autonomy. They also discovered a positive significant but weak correlation (r = 0.24, P < 0.05) between nurses' perceptions of group goal attainment capability and perceptions of professional autonomy. Three of the eight group goal attainment subscales were positively correlated with professional autonomy including: group leaders' goal attainment capability competency, goals/outcomes competency and goal attainment capability (Bularzik, Tullai-McGuiness, & Sieloff, 2012).

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Likewise, the effect of leadership behaviors on hospital nurse retention and job satisfaction has been described (Force, 2005; Laschinger, Wong, & Greco, 2006; Manojlovich, 2007). In conclusion, these findings suggest administrators who viewed empowerment as a positive concept, and were able to successfully communicate department goals with their faculty and other key members within their organizations were created an empowering environment. The coefficient of determination ranged from 4% (r^2=.421, *n*=79) to 6% (r2=.662, n=80); therefore, up to 66% of the variance in empowerment was related to group leader competencies in the administrator group.

Similarly the strong positive correlation between empowerment and Group Leaders Outcome Attainment Competency (GLOAC), Communication Competency (CC), Goals/Outcome Competency and Outcome Attainment Perspective (OACP) in the faculty group suggests the importance of these leadership competencies to faculty group empowerment. The coefficient of determination ranged from 5% (*r2*=.547, *n*=308) to 75% (r^2=.749, *n*=308); therefore, up to 75% of the variance of empowerment in the administrator group can be explained by mediating variables of group leader competencies.

The significance of leadership behaviors are also supported by Gormley (2003) who completed a meta-analysis of factors associated with job satisfaction in nurse faculty in the U.S. The researcher concluded the perception/expectation of the leader's role in curriculum and instruction appears to significantly affect nursing faculty job satisfaction with an effect size of 0.738. Other leadership factors that have high effect size are consideration and initiating structure behaviors with .802 and .688, respectively. Although there are few studies comparing nurse education administrator's leadership

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with faculty empowerment, nursing literature does support a relationship between leadership behaviors and job satisfaction in clinical practice (Chiok 2001; Force, 2005; Nielson et al., 2008).

Limitations

The first limitation regards the low response rate of faculty in participating schools in this study sample. This may be attributed to the timing of data collection during the end of spring semester when faculty was busy.

Second, low response rates may be a result of not having direct access to faculty. Faculty who felt less empowered may have been reluctant to participate in the survey which was primarily distributed by administrators or their designated gatekeepers. Furthermore, as with faculty, less empowered administrators may have also been reluctant to participate

Third, incomplete responses prohibited analyzing surveys from 25 administrators and 62 faculty members. This may be attributed to the online distribution and participants who were either uncomfortable with the format or had questions regarding the survey items. For example, one dean participant emailed the researcher stating she could not complete the survey as she was a dean with multiple campuses with many types of nurses and as a result, did not know how to define *groups*.

Fourth, the sampling method prohibits generalization since deans were recruited from a stratified list of schools using single staged sampling in order to increase faculty participation.

Fifth, Descriptive correlational statistical analyses does not allow for causality of the variables. Therefore, although there was significant difference in administrator and

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dean scores, the specific leadership skills were not identified even though they explained much of the variance.

Sixth, Low Cronbach's alpha on subscales Communication Competency, and Goals/Outcome Competency may suggest a need for item refinement to ensure reliability.

Seventh, by not including open ended questions, valuable qualitative data which may have helped to explain the variance in empowerment scores was not collected.

Discussion

The normality of the sample distribution and calculated confidence intervals suggests the sample is representative of the population. This is significant since one can infer this study is an accurate description of group empowerment in schools of nursing with 16 or more faculty. Although there was variability in scores, the negatively skewed distribution indicated most of the scores were high.

The proposition of the presence of high group empowerment in nursing educators is best understood when compared to nursing literature that described nursing faculty as vulnerable (DalPezzo & Jett, 2010), and victims of incivility (Clark & Springer, 2007). This study conclusion suggests that faculty and administrator groups are able to achieve goals, anticipate changing healthcare tends, and effect student outcomes and competencies by their interventions. Also, one can infer that nursing faculty teaches in empowered environments where they can model preferred behaviors to their students. The ability of nursing education administrators and faculty to effectively achieve goals also suggested these schools may have valuable skills and strategies to share with others who are also under pressure to cope with finite resources in complex environments

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The association of leadership competencies to empowered work environments is strengthened by this study and also suggests these schools are more proficient at adapting to changing, complex environments. According to the literature, as organizations evolve from bureaucracies with clear limitations to those with fluid and flexible boundaries, the skill set of successful leaders must also change and grow (Schneider & Somers, 2006). According to complexity theory, leaders must rely less on managerial authority to a new set of ideas that "transcends the physical, biological, and social sciences (2006, p. 360).

This study finding that administrators scored lower on subscale, Controlling the Effects of Environmental Forces (CEEF) also suggests the work of the chief administrator of a school of nursing may be particularly demanding. However, the ability of these leaders to gauge if their schools adapt to and anticipate external influences, may encourage important conversation between leaders regarding ways to successfully manage the demands of the role and strategies to adjust to change. Likewise, although administrators scored lower than faculty on this subscale, according to complexity theory, some events are unknowable until they occur and may also be unknowable in advance (Schneider & Somers, 2006). As a result, controlling the effect of external influences may not be a reasonable goal, but effectively adapting to these forces may be a realistic ambition. The authors also proposed leadership can be performed by people in rotation or in tandem, and that successful leaders in complex organizations influence others and lead without authority. Using the analogy of a community garden, these authors suggest a defining characteristic of a complex system is one that brings about "myriad benefits at different system levels" (Schneider & Somers, 2006, p. 359). Again, the significance of shared leadership is suggested.

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According to Yukl and Becker (2006), leaders who involve others in decision making cannot only improve the quality of decision making, but also help followers to accept decisions, and increase employee satisfaction. Likewise, according to Porter O'Grady (2001), shared decision making in nursing is not only relevant but essential He reported that in spite of the expressed support by nursing leaders of the concept of shared governance, not much has actually changed in regards to the actual practice of this strategy He attributes this lack of change to nurses who hold the power while keeping others from getting it. According to Porter O'Grady (2001), leaders who select and nurture followers who do not challenge the status quo are the same select few who derail organizational goals. Sadly, as a result, although nursing has some powerful individuals, the profession continues to lack power. Equally, Yukl and Becker (2006) reported true empowerment requires leaders who relinquish control to their followers. This study finding suggests leaders in this sample were those who actively sought feedback from others, and allowed greater participation in decision making.

The outcomes of this study regarding inadequate financial resources representing schools of nursing across the country, working in both privately and public funded institutions, lends support to the need for innovative nurse pedagogies. Inventive methods of teaching may allow for better use of scarce and finite resources. For example, according to Gubrud-Howe and Schoessler (2008), the collaborative effort between eight community colleges and the Oregon Health and Science School of Nursing, known as the Oregon Consortium for Nursing Education (OCNE), has successfully transformed their curriculum. In addition, use of Dedicated Education Units (DEU) at the University of Portland School of Nursing has demonstrated great success. According to Warner and

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Moscato (2009), these dedicated units provide for collaboration between faculty, students and hospital staff. Furthermore, this innovate model has resulted in tripled enrollment, quadrupled graduation rates and lower overall faculty to student ratios. Although more evidenced based research regarding nursing education pedagogy is becoming available within the nursing literature, there remains a limited amount of research providing evidenced based best practice (Rogers & Vinten, 2009).

The positive correlation identified between mediating variables including Communication Competency, Group Leader Outcome Attainment Competency, Outcome Attainment Perspective and Goals/Outcome Competency and group empowerment, provides administrators with valuable information to generate empowering work environments. By increasing group empowerment, administrators may also raise faculty job satisfaction preventing worsening of the nurse faculty shortage. The ability to augment faculty job satisfaction may also expand the potential pool of administrative successors. To conclude, by identifying leadership competencies with lower empowerment scores, administrators may be able to recognize and strengthen their leadership skills thereby increasing faculty satisfaction.

This study suggested nurse faculty desire increased acknowledgment within their organizations for their unique contributions. As a result, nurse faculty may need to actively participate in decision making not only within their respective departments, but also at the university level. As a result, administrators may want to vigorously encourage faculty to be present at intraorganizational activities, but only if protected time from clinical and classroom responsibilities can be provided. According to Kaufman (2009), nurse faculty considered their workload to be higher than that of non-nursing faculty at

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the same institution. This conclusion proposes faculty who are overwhelmed by current workloads may not be willing or able to participate in organizational committee work and extracurricular activities. In conclusion, nurse faculty may need accommodating environments where socialization with others within their organization is not only encouraged but also supported.

In addition, the opportunity for nursing faculty to openly discuss group empowerment with their administrators may be a powerful, team building experience which also supports group empowerment. Results from this study, indicating that both groups perceived resources to be inadequate, reveal a chance for partnership between leaders and faculty to work collectively to increase their ability to accomplish goals.

Findings supported the theoretical framework of this study, The Sieloff King Theory of Group Empowerment within Organizations. The theory was developed in efforts to measure and help improve nursing groups' empowerment, where empowerment is composed of two components, capacity and capability. Four factors are theorized to contribute to group empowerment capacity, including controlling the effect of environmental forces, positions in organizations, roles, and resources. The theory also hypothesized mediating variables affect actualized group empowerment, including group leader communication competency, goals outcome competency, group leader outcome attainment competency and outcome attainment perspective. According to Fawcett, by definition, a profession has unique perspectives and subsequently, requires specific theoretical foundations in order to adequately examine their phenomena of interest. This study based upon a mid-range nursing theory, enhances the discipline specific knowledge of group empowerment in nursing. This research is equally significant, because

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according to Peterson and Zimmerman (2004), although empowerment is a multi-level construct, most of the empowerment theory research has been conducted at the individual level (2004). In addition, research related to empowerment is required at the organizational level. Also, the repercussion of empowered nursing educational environments may be best understood when one considers that empowered organizations are "those that influence the larger system of which they are a part" (Peterson & Zimmerman, 2004, p. 130).

The psychometric analysis of the total scale also support reliability and validity for the SKAGEO© as used in educational environments. The Cronbach's alpha coefficient for the total scale in the administrator sample was 0.92 and 0.96 and in the faculty group. Of particular interest, this study findings of Cronbach's alphas for subscales in the administrator group for Communication Competency (α=.63) subscale and Goals/Outcome Competency (α=.59), and the faculty group, Communication Competency (α=, 0.78), Goals/Outcome Competency (α= 0.68), are similar to those of Sieloff and Bularzik (2011). They also calculated lower coefficients for subscales Goals/Outcome competency (α=.61) and Communication Competency (α=.74). Split half analysis using PASW version 18 produced Spearman Brown corrected correlations for the SKAGEO © as used in educational environments of .907(*N*=79) for the administrators group and 0.935(*N*=308) for the faculty group. In conclusion, the findings of the study support the theoretical constructs and their relationships. In addition, the outcomes suggest the revised SKAGEO© is a reliable instrument to be used within nursing education. This study increases the understanding of group empowerment within nursing education based upon a nursing theory and a single instrument incorporating multiple

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measures. The capability to measure group empowerment with one instrument may assist incorporating the construct within the nursing curriculum. According to Sieloff and Bularzik (2011), current nursing management texts refer to power within the context of the individual. The ability to measure and discuss nurse group empowerment may enable environments where students become exposed to group empowerment as a positive resource early in their courses.

Recommendations for Further Study

Several recommendations for future projects are supported by this research. Upcoming studies should continue to explore group empowerment capacity and capability within schools of nursing. Duplication of this study within associate degree programs and accelerated programs is suggested According to Auerbach, Buerhaus, and Staiger (2007) many students enter nursing by graduating from two year associate degree programs, or through accelerated bachelors of science degrees. Therefore, the recognition of these groups' empowerment capacity and capability is essential as they provide the first educational experience to numerous potential baccalaureate students.

Another recommendation for future studies is to pair administrators with their faculty in a multi-level nested design, thereby possibly identifying additional sources of variability in scores. This activity could be employed by schools to boost problem solving group activities, and to identify assets and weaknesses. Additionally, the capability to complete the surveys as a group may promote desirable dialogue and collaboration between administrators and their faculty, decreasing any perceived power imbalances.

Group empowerment of students should also be explored due to the reported incidence of incivility towards new graduates, and their vulnerability to these toxic

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behaviors. The literature suggests students are currently ill prepared to cope with work environments upon graduation. By identifying their levels of group empowerment prior to finishing their programs, possibly these novice nurses could be better equipped for their initial work experiences

Additionally, although the findings of this study suggest faculty groups are empowered, studies exploring the relationship between oppressed group behaviors in nursing education and group empowerment are warranted. According to Roberts et al. (2009), job satisfaction and group cohesiveness are negatively impacted by oppressed group behavior and oppressed group behaviors may result from a lack of power. Therefore, future research should examine if there is an association between group empowerment and oppressed group behavior. In addition, group empowerment as related to faculty job satisfaction should also be explored in efforts to identify variables which will support the recruitment and retention of increasingly insufficient numbers of nursing faculty.

Summary

The results of this study have noteworthy implications to nursing education administrators, faculty and researchers. The ability to effectively measure group empowerment capacity and capability with one instrument may assist administrators as they compete for prospective faculty and preserve current nurse faculty. In addition, group empowerment may assist administrators to reinforce their visibility within their individual organizations by measuring their capability to achieve outcomes. Likewise, the instrument may be employed to measure their faculty's perception of the efficacy of their leadership. Finally, the ability to detect and then cultivate leadership competencies which

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facilitate empowering work places may support administrators to sustain and grow their programs while they compete for restricted resources.

Implications for faculty include being able to identify areas requiring development in order to empower themselves. Additionally, having the opportunity to evaluate their leaders may be an empowering action. According to Yukl and Becker (2006), characteristics of empowering institutions included organizations where leaders have limited periods of appointment and followers have the power to assess leader's performance. Similarly, faculty may be able to increase their impact within their organizations by increasing their understanding of the empowerment process. Furthermore, in efforts to strengthen students' understanding of group empowerment as a positive resource, faculty may integrate the theory and its related instrument within nursing curricula. Lastly, those nursing schools which facilitate faculty group empowerment may encourage more nurses to choose academics and administrative positions as a viable career option, thereby strengthening the future of the profession.

Implications for nursing researchers include the significance of replicating this study in other types of nursing programs including associate degree and accelerated programs The ability to produce additional baccalaureate nurses by 2020 may be contingent upon the expansion of empowering work places where best practices in nursing education exist in all educational programs

In summary, by exploring the relationship of group empowerment to oppressed group behavior, researchers may provide valuable information to address the toxic behaviors of horizontal violence within nursing education. Administrator's abilities to provide empowering surroundings for nurse faculty who can achieve goals is essential to

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the profession's capability to educate graduates who can safely care for patients, and implement changes in the complex healthcare systems of the 21st century.

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APPENDIX A

INSTITUTIONAL REIVEW BOARD NOTICE OF COMMITTEE ACTION

THE UNIVERSITY OF
SOUTHERN MISSISSIPPI

INSTITUTIONAL REVIEW BOARD
118 College Drive #5147 | Hattiesburg, MS 39406-0001
Phone: 601.266.6820 | Fax: 601.266.4377 | www.usm.edu/irb

NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months.
  Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: **13012905**
PROJECT TITLE: **Group Empowerment Capacity and Capability in Schools of Nursing**
PROJECT TYPE: **Dissertation**
RESEARCHER(S): **Mary Louanne Friend**
COLLEGE/DIVISION: **College of Health**
DEPARTMENT: **School of Nursing**
FUNDING AGENCY/SPONSOR: **N/A**
IRB COMMITTEE ACTION: **Expedited Review Approval**
PERIOD OF APPROVAL: **01/31/2013 to 01/30/2014**

Lawrence A. Hosman, Ph.D.
Institutional Review Board

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APPENDIX B

SIELOFF-KING ASSESSMENT OF GROUP EMPOWERMENT WITHIN EDUCATIONAL ORGANIZATIONS©

The following items ask your opinion about what you personally believe exists within your organization. After reading each item, please select the response that most closely resembles your opinion regarding the item. Any reference to a 'group' refers to the individuals, as a group, within your organization, not to specific individuals within that group. *Group leader, for purposes of this study, is the chief administrative officer for the school of nursing as defined by the CCNE.

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
1. The group leader uses collaboration with other groups within the organization to achieve outcomes.					
2. Desired outcomes of the group are developed with the opportunity for input from all group members.					
3. The attainment of outcomes is essential to assure that the desired outcomes of the organization, the group and the individual members within the group are consistent.					
4. The group adjusts to changing health care trends to better achieve group outcomes.					
5. Financial resources available to the group are sufficient.					
6. The group's expertise is valued by other groups within the organizations.					
7. The group leader is actively involved in administrative decision making for the overall organization.					
8. The group anticipates changing health care trends in relation to group outcomes.					
9. Student outcomes and competencies are directly linked to the group's interventions.					
10. The group adjusts to changing health care trends to					

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assist the organization to achieve its desired outcomes.					
11. Representatives of the group hold voting privileges on organizational decision-making bodies.					
12. The group coordinates the delivery of the curriculum.					
13. The members of the group are responsible for developing the group's desired outcomes.					
14. The work of the group is viewed as central to the delivery of quality services by other organizational groups.					
15. The group has the resources needed to achieve desired group outcomes.					
16. The results of research are integrated into current group practice.					
17. The desired outcomes for the group provide for the development of the teaching, scholarship, and service of the group members.					
18. The group leader understands how other groups utilize their group's empowerment.					
19. Professional development programs adequately respond to the needs of the group members.					
20. The technology support for the group is adequate to meet the group's changing needs for information.					
21. The group leader maintains adequate resources for the group.					
22. The group directs the delivery of the curriculum.					
23. Empowerment is essential to assure that organizational regulations facilitate the achievement of the group's desired outcomes.					
24. Empowerment is essential to assure that relationships within the **organization** are maintained					

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to achieve the group's desired outcomes.					
25. Empowerment is essential to assure that relationships within the group are maintained to achieve the group's desired outcomes.					
26. Representatives of the group hold voting privileges on organizational intergroup committees.					
27. Budgeted positions for the group are determined by student needs.					
28. The group leader has the support of key individuals within the group.					
29. Empowerment is enhanced through communication with other organizational groups.					
30. In order for the group to empower itself, the group must have clearly defined desired outcomes.					
31. The desired outcomes of the group address the effective use of resources.					
32. The group's input is sought by other groups within the organization.					
33. Information provided to the group is adequate to assure the effective functioning of the group.					
34. It is important for a group to understand its level of empowerment.					
35. The group actively prepares for the effects of changing health care trends.					
36. The group anticipates changing health care trends in relation to the organization's ability to achieve desired outcomes.					

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APPENDIX C

FACULTY COVER LETTER

THE UNIVERSITY OF
SOUTHERN MISSISSIPPI

Dear Nursing Faculty Member:

I am a doctoral candidate in the college of nursing at The University of Southern Mississippi pursuing a PhD in nursing with a focus on leadership. I am requesting your participation in a study title "Group Empowerment Capacity and Capability in Schools of Nursing". This study is surveying full time faculty members in American Association of Colleges of Nursing (AACN) schools offering baccalaureate and higher degree programs. Your school was selected using a stratified random sample for participation in a confidential, online survey in hopes of identifying levels of group empowerment capacity and capability in schools of nursing.

Your participation in this project is voluntary. You may choose not to respond to any part of the study. The survey should take approximately 15 to 20 minutes to complete and includes a demographic data sheet. You will be asked to complete the survey via Qualtrics online surveys.

The collected data will be reported in aggregate form and will not identify you or your organization. Strict confidentiality will be maintained. The findings could be useful for administrators to identify levels of group empowerment capacity and capability within schools of nursing. These findings also have the potential to increase levels of faculty group empowerment. I understand how valuable your time is, and greatly appreciate your support with this project.

If you have any questions, please contact Louanne Friend at (985)859-6024 or mary.friend@eagles.usm.edu. My faculty advisor is Dr. Katherine Nugent who may be reached at (601)266-6485 or Katherine. Nugent @ usm.edu. This project has been reviewed by The University of Southern Mississippi Human Subjects Review Committee which ensures that research projects involving humans follow federal regulations. Any questions or concerns about rights as a research participant should be directed to the Chair of the Institutional Review Board at (601) 266-6820. Participation in this study is completely voluntary and participants may withdraw at any time without penalty, prejudice or loss of benefits. Return of the completed survey will signify your consent. Upon completion of this survey you will be given the option to submit your email address to become eligible to win one of four I- Pods and/or to receive a copy of the survey findings. To begin the survey, click on the link embedded below and you will automatically start the questionnaire.

Sincerely,

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Mary Louanne Friend
The University of Southern Mississippi
Doctoral Student
747 Libby Lane
Mandeville, LA 70471

Click here to take survey

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APPENDIX D

ADMINISTRATOR LETTER

THE UNIVERSITY OF
SOUTHERN MISSISSIPPI

118 College Drive #0000 | Hattiesburg, MS 39406-0001
Phone: 601-266-5454 | Fax: 601-266-5711 | e-mail:mary.friend@eagles.usm.edu | www.usm.edu

Dear Dean/ Director/Chairperson:
I am a doctoral candidate in the college of nursing at The University of Southern Mississippi pursuing a PhD in nursing with a focus on leadership. I am writing to request that you and your faculty participate in my study titled "Group Empowerment Capacity and Capability in Schools of Nursing".
This study is based on the Sieloff Theory of Group Empowerment within Organizations© and is designed to assist any group within any organization to estimate levels of group empowerment, where empowerment is defined as the group's ability to achieve outcomes.
I am very excited about this project as it is the first time the theory, and its related instrument, The Sieloff-King Assessment of Group Empowerment(SKAGEO©)will be utilized in nursing education. The study findings could be useful in assisting schools of nursing by not only identifying levels of group empowerment, but also leadership competencies associated with group empowerment.
I plan to conduct an online anonymous survey using Qualtrics survey software. My study sample includes faculty and deans in schools of nursing offering baccalaureate and graduate programs and identified as having membership in the AACN within the United States. Your school was selected as part of a stratified random sample representing each of the four regions of AACN nursing programs in the United States. The collected data will be reported in aggregate form and will not identify you, your organization, or faculty. I understand that many organizations will honor the USM IRB approval for this study; however, if your school requires its own IRB approval, please kindly direct me to the appropriate contact person.
If you agree to participate in this study, I kindly ask that you provide me via email with the contact information for a gatekeeper that I may contact to distribute surveys to your faculty members. The link to the administrator portion of the survey will be mailed to you in 24 hours via Qualtrics for your convenience.
The anticipated time period for data collection is April and May 2013. I understand how valuable your time is, and greatly appreciate your help with my research project. Thank you in advance for your support. If you have any further questions, please do not hesitate to contact me at (985)859-6024, or by email at mary.friend@eagles.usm.edu. My faculty advisor is Dr. Katherine Nugent who may be reached at 601-266- 6846, or by email at Katherine. Nugent @ usm.edu. I look forward to hearing from you.
Sincerely,

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Mary Louanne Friend, MN, RN
Doctoral Student
The University of Southern Mississippi
747 Libby Lane
Mandeville, LA 70471
mary.friend@usm.edu

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APPENDIX E

SCORING GRID REPRESENTING THE MINIMUM AND MAXIMUM SCORES AND RANGES FOR EACH SUBSCALE AND TOTAL SCALE SCORE

SUBSCALE/ TOTAL SCALE	MINIMUM SCALE	MAXIMUM SCALE	HIGH E RANGE	MEDIUM E RANGE	LOW E RANGE
Group Leader's Outcome Attainment Competency	4	20	20-15	14-9	8-4
Communication Competency	3	15	15-11	10-7	6-3
Controlling the Effects of Environmental Forces	7	35	35-26	25-16	15-7
Goals/Outcomes Competency	4	20	20-15	14-9	8-4
Position	4	20	20-15	14-9	8-4
Outcome Attainment Perspective	5	25	25-19	18-12	11-5
Resources	6	30	30-22	21-19	13-6
Role	3	15	15-11	10-7	6-3
Total Outcome Attainment Capacity or EC	20	100	100-67	66-34	33-20
Total SKAGEO© or E	36	180	180-132	131-84	83-36

* EC= Empowerment Capacity, E = Empowerment

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