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Generational Differences in Empowerment, Professional Practice Environment, Incivility, Authentic Leadership, Job Satisfaction, Engagement and Intent to Leave in Acute Care Nurses

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I am submitting herewith a dissertation written by Lisa Marie Haddad entitled "Generational Differences in Empowerment, Professional Practice Environment, Incivility, Authentic Leadership, Job Satisfaction, Engagement and Intent to Leave in Acute Care Nurses." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

Kenneth D. Phillips, Major Professor

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Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)
Generational Differences in Empowerment, Professional Practice Environment, Incivility, Authentic Leadership, Job Satisfaction, Engagement and Intent to Leave in Acute Care Nurses

A Dissertation Presented for the Doctor of Philosophy Degree

University of Tennessee, Knoxville

Lisa Marie Haddad

May 2013
Dedication

I dedicate my dissertation work to my family and friends who supported me through the process. To my mom and stepdad, Connie and Glenn Halstead, who provided help, encouragement, loving pushes and unwavering belief in my ability to succeed. You have supported me through adverse situations. Mom, you have inspired me through my entire life. Thank you!

To Bud Hankins, my big brother. I have always looked up to you and admired you for who you are. Thank you for your support and for always being my friend.

To my children, Courtney, Daniel, Emily and Fletcher, who sacrificed time with me to allow me to reach my dream. I hope to inspire each of you to believe in yourself, set goals, and not let anything stop your dreams. With determination you can do anything and become anyone.

To Michael McKeehan, you provided inspiration, support and big shoulders.

To Dr. Susan Justice, Dr. Michael Bone and Dr. Robert Evans: Your belief in a stranger provided hope and a light through the darkest moments. Through a selfless act you have touched lives forever.
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Abstract

**Aim.** The aim of this study was to examine generational differences among acute care nurses on empowerment, professional practice, authentic leadership, incivility, job satisfaction, engagement and intent to leave the current job.

**Background.** Empowerment in nursing is a well-studied subject. Perceptions of professional practice environments, authentic leadership and incivility are related to empowerment. An increase in empowerment has been linked to job satisfaction and the likelihood of leaving one’s job or the profession. The nursing shortage forces attention to job satisfaction and keeping the professionals we currently have in the profession. Generational differences exist within different cohorts of nurses and can affect how they respond within their job and organization.

**Method.** Descriptive and inferential analyses of the demographic and major study variables, along with reliability assessments of the study instruments were conducted. Generational differences were determined using general linear modeling. The hypothesized structural model was tested using Structural Equation Modeling (SEM) with Proc CALIS in SAS.

**Results.** A sample of 210 nurses working in the hospital setting in the East Tennessee were included in the study. Significant associations among the variables were observed. There were no differences detected between the generational groups. The hypothesized model did not fit. After review, the final model was improved to acceptable associations among variables.

**Conclusion.** Given the current multi-generational status of nurses and the state of nursing, efforts should be made to support and assist the needs of the various generations. Providing empowering environments, with authentic leaders and a professional practice environment increases job satisfaction, and is likely to provide an environment in which the nurse will want to remain.
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Chapter 1

The purpose of this study is to examine the generational differences in nurses’ perceptions of empowerment, professional practice environment, and authentic leadership, perceptions of incivility, job satisfaction, engagement and intent to leave the organization in the acute care setting. An overview of the problem, background information, introduction to the idea, statement of the problem, purpose of the study, theoretical framework, hypotheses, conceptual and operational definitions, limitations and delimitations, assumptions and significance of the study are detailed in this chapter.

Introduction

Nurses are crucial in today’s healthcare. The United States Bureau of Labor Statistics (2010) projects that between 2010 and 2016 about 500,000 additional nurses will be needed nationally. The Health Resource and Services Administration (2006) estimate a shortage of one million nurses by the year 2020. We are in the midst of a shortage of nurses, and it is expected to worsen as Americans are living longer and the Baby Boomer population ages.

A 2004 report by The American Organization of Nurse Executives (AONE) identified vacancy rates of 10.2% and turnover rates for registered nurses in U.S. hospitals at 21.3%. Tennessee rates for vacancy and turnover are consistent with national averages (Tennessee Center for Nursing, 2012). Turnover rates for nursing are considerably higher when compared to other professions (Harris, 2007).

It is a challenge for organizations to retain nurses, especially those with specific skill sets (Perrine, 2009). Low retention rates lead to increases in organizational cost, decreases quality of patient care, and increases malpractice claims (Waldman, Kelly, Arora, & Smith, 2010). Failure to retain nurses also has a negative influence on unit productivity and work conditions, causes
staffing difficulties, and contributes to a cycle of more turnovers (Jones, 2004). Employee turnover is expensive for organizations, costing between 75% and 125% of an RN’s annual salary (Pine & Tart, 2007).

The majority of nurses are employed in the acute care setting. Rapid changes occurring within organizations, coupled with a stressful, fast-paced environment can be difficult for a nurse to handle (Waite, 2004). These changes can be challenging for any nurse, but some nurses are more prone to struggle through the process. The literature identifies inexperienced nurses, struggling with heavy workloads and responsibility, without adequate support and guidance as those most likely to leave their job and even the profession (Bratt, 2009; Duchscher, 2001; Godinez, Schweiger, Gruver, & Ryan, 1999).

Dissatisfaction in nursing can be caused by different factors. Nurses are expected to be ready to perform when they arrive in the organization. Duchscher and Cowin (2004) identify this unrealistic expectation as “hitting the ground running” when the nurse arrives on the unit. In addition to unrealistic expectations, nurse to nurse violence is identified as another reason nurses leave the profession. Hostility, hazing or uncivil behaviors are reported at various levels by nurses (Thomas, 2009).

Results from numerous studies indicate a strong relationship between empowerment and job satisfaction in nursing (Laschinger, Finegan, Shamian, & Wilk, 2004; Leiter & Laschinger, 2006; Manojlović, 2005; Park, Park, Yom, & Kim, 2006). Experienced nurses who rate themselves as having high feelings of empowerment have been shown to have increased retention rates (Laschinger, Finegan, Shamian, & Wilk, 2001a; Laschinger, Wong, & Greco, 2006; Nedd, 2006). Lack of empowerment may be one explanation for the growing shortage of nurses worldwide (Laschinger & Finegan, 2005). Employees who feel empowered are more
likely to be satisfied and to remain in their positions, while organizations that do not empower
their employees are more likely to lose them.

Nurses transition through different stages in their career. Organizations need to support
nurses through the transition stages. Not all nurses will respond to support, interventions and
education in the same way. Differences in attitudes toward work and the organization, different
value systems, and different responses to common life events can all be attributed to generational
differences (Clausing, Kurtz, Prendeville, & Walt, 2003; Kupperschmidt, 2000). To impact job
satisfaction and retention, it is necessary for healthcare organizations to understand that
generational differences exist between nurses. Understanding how generational differences
contribute to the workplace environment is crucial to retaining nurses in the profession (Leiter,
Jackson, & Shaughnessy, 2009; Leiter, Price, & Laschinger, 2010). Managers and co-workers
who do not understand generational differences can inadvertently raise tensions causing job
satisfaction and productivity to decline (Kupperschmidt, 2000).

**Background**

Generational cohorts are groups of people who share a band of birth years and have
commonly shared events that have shaped attitudes and values (Kupperschmidt, 1998; 2000).
Certain historical or environmental events affect the values, beliefs and expectations of the
generation (Strauss & Howe, 1991). Although there are overall generalizations for each cohort
individual diversity does still exist.

Current multigenerational diversity includes three generations of employees: (a) Baby
 Boomers, (b) Generation X, and (c) Millennial’s/Generation Y. There is growing generational
research showing significant differences between the cohorts in relation to their career
aspirations and expectations (Eisner, 2005; Hartung, Porfeli, & Vondracek, 2005; Lancaster &
The unique experiences of the different groups can create value differences, gender issues, tensions between cultures, problems with team building and difficulties in active participation in general (McNamara, 2005).

Baby Boomers (born between 1943 and 1960) were raised in economic growth and prosperity. They have been heavily influenced by civil rights struggles, the women’s liberation movement, the space program, the Cold War, and the Vietnam War (Clausing et al., 2003). Baby Boomers are often characterized as workaholics (Strauss & Howe, 1991) who experienced a healthy post-war economy and vibrant job market in the 1970s that fostered optimism (Lancaster & Stillman, 2005). They value loyalty and recognition from authority (Apostolidis & Polifroni, 2006; Stuenkel, de la Cuesta, & Cohen, 2005; Wieck, 2005), will challenge status quo, adapt slowly to technological advances and value creativity and risk taking (Strauss & Howe, 1991). As nurses, professionalism and autonomy are important to them (Kupperschmidt, 1998; 2000).

Generation X’ers (born between 1961 and 1979) were more likely to be raised in dual income homes or single parent homes. Sometimes referred to as the misunderstood generation, they are independent with low need for external approval or support (Lieter et al., 2010). Societal influences included Watergate, MTV, latchkey experiences, personal computers and the Internet (Clausing et al., 2003). They believe in balance in their work - home life and are motivated by money. Generation X’ers welcome diversity, are independent, confident, creative and comfortable with change and new technology (Leiter et al., 2010). As nurses, the values of work – life balance remains, while they seek professional acknowledgment for their achievements and expertise (Boychuck-Duchscher & Cowin, 2004).

Generation Y’ers (Born between 1980 – 2000) combine the work ethic of the Baby Boomers with the technological savvy of the X’ers (Clausing et al., 2003). They are self-reliant,
family-oriented, fun-seeking and hopeful. The most important influences arise from technological advances and thus the ability to communicate with anyone at any time. They learn differently, in that they have a mosaic mode of moving randomly among a series of points instead of a linear mode of thinking (Barna, 1995). Generation Y’ers prefer a team approach, desire flexible working hours, need supervision and structure in new situations, and expect a clear picture of expectations and outcomes (Clausing et al., 2003).

Understanding the differences in people and cohorts provides an opportunity for organizations to tailor resources to best meet needs and expectations of each group. According to Kanter (1993), organizational empowerment comes from support, power, opportunity, resources and access to information in a workplace. Kanter demonstrated that work environments and organizations that do not provide these things set the employees up to fail. Without support from the organization, employees have difficulty accomplishing their work or achieving organizational goals. Without information, resources and opportunities to learn, employees lack the power to change themselves or the ability to make a positive impact. Researchers have shown positive correlations between empowerment, nursing outcomes and work effectiveness, job satisfaction and increased retention (DeCicco, Laschinger, & Kerr, 2006; Laschinger & Wong, 1999; Regan, 2002). Work environments that are supportive and consistent in standard of care are valued by nurses (Leiter & Laschinger, 2006).

I became interested in generational differences in empowerment while working on several different educational projects. It was interesting that some nurses adapted to the fast-paced environment better than others despite having access to the same resources within an organization. Some nurses were able to succeed in a department or hospital after a short time, while others found it necessary to leave the unit or organization altogether. As an educator, it
became apparent that some nurses needed to be instructed differently. Some nurses / students seemed to thrive while others needed different instructional methods. It was clear after teaching several courses that age was a determining factor.

**Statement of the Problem**

Generational differences affect how nurses respond to different environments, events and resources. Researchers have explored empowerment within nursing, linking it to increased job satisfaction, and better retention of nurses. Few studies have explored generational differences existing in the perception of empowerment; and no studies could be found correlating generational differences with the variables proposed in this study. Organizations cannot begin to provide the information and skills necessary without fully understanding the diversity of different generations. This study focused on testing the different generational perceptions of empowerment, professional practice environment, incivility and authentic leadership and the impact on job satisfaction, job engagement and intent to leave the organization.

**Purpose of the Study**

The purpose of this study was to develop and test a theoretical model that was used to examine generational differences in empowerment, professional practice environment, and authentic leadership, and how generational differences are related to nurses’ perceptions of incivility, job satisfaction, engagement and intent to leave the organization. This knowledge can provide awareness for organizations, allowing them to provide resources in the most effective way in a resource constrained environment. Additionally, individual nurses can use this knowledge as a foundation to build upon, accepting responsibility for themselves to cooperatively work with others. Incorporating this information can impact the nursing profession by attempting to understand and satisfy needs of the nurse.
Specific Aims and Hypotheses

The specific aims and hypotheses are as follows:

Specific Aim I: To test the generational differences in the nurse’s perception of empowerment.

1. Nurses demonstrate differences in their perception of empowerment based on the generational cohort to which they belong.

Specific Aim II: To test the generational differences in nurse’s perception of professional practice environment.

1. Nurses will have a difference in their perception of professional practice environment based on the generational cohort to which they belong.

Specific Aim III: To test the generational differences in the nurse’s perception of authentic leadership and supervisor / co-worker incivility.

1. Nurses will have a difference in their perception of authentic leadership and incivility based on the generational cohort to which they belong.

Specific Aim IV: To test the generational differences of the nurses job satisfaction, engagement in the job and intent to leave in their current position.

1. Nurses will have a difference in their level of job satisfaction, engagement in their job and their intent to leave their current position based on the generational cohort to which they belong.

Specific Aim V: To test the relationship of the nurses perception of empowerment, professional practice environment, incivility, and how those impact job satisfaction, engagement and intent to leave one’s job and how this varies among the different generations.
1. Nurses in different generational cohorts will have different strengths of relationships in the theoretical model.

**Theoretical Framework**

The theoretical background for this study was based on two theories. The first, Rosabeth Moss Kanter’s Theory of Structural Power in Organizations was published in 1993. Kanter began her work in the 1970s and focused on empowerment in women and minorities active in business. Kanter (1993) contends that empowerment from an organization changes how a person reacts to the job. She acknowledges that even the philosophies of Adam Smith and Karl Marx were in agreement that the “job makes the person” (p. 3). Kanter developed her theory from a study of a large corporation that illustrated the relationship between employer and employee. Her examination of interactions among people in large organizations was an attempt to discover the dimensions of the relationship between a person and an organization. A main focus of her study was the treatment of women and minorities within large companies, and the quality of their work. She reviewed the positions of people within the organization, analyzing the relationships among them. The results revealed that organizational effectiveness of the individual is a result of processes in the workplace, and not a result of personality characteristics or societal norms.

Kanter (1993) theorizes that people will thrive when they are put in a situation that encourages empowerment. Kanter maintains that people are empowered to reach organizational goals if their work environments are structured in ways that provide access to information, support and resources necessary to perform their jobs, as well as access to learning opportunities. This impact of organizational structures on behavior is stronger than individual personalities (Laschinger, Shamian, & Thomson, 2001b). Personal behavior in organizations is determined by
Empowerment, defined simply, means having the ability to choose (Kuokkanen & Leino-Kilpi, 2001). Kanter (1993) describes six components of empowerment: (a) opportunity, (b) information, (c) support, (d) resources, (e) formal power, and (f) informal power. Kanter views power not as a negative trait associated with hierarchical organization, but rather as a positive one that is goal oriented and leads to efficiency. Power is not provided or prohibited by organizations or individuals; rather it is developed by generating opportunities, providing effective information and making support available at each level of the organization (Kanter, 1993; Kuokkanen & Leino-Kilpi, 2001). Kanter (1979, 1983) says there are formal and informal systems within the organization from which power can be derived. Both are keys to access factors such as opportunity, information, support and resources, thus allowing a person to accomplish job-related activities successfully.

Although Kanter’s original work was done in the area of business, it has been successfully linked to healthcare and nursing. Using Kanter’s theory as a framework, nurses’ job satisfaction has been linked to empowerment. Starting in the early 1990’s, Laschinger developed a research program linking empowerment, work environments, nurses’ health and wellbeing and the role leadership plays (Personal Communication, January 20, 2011). Laschinger has been involved in numerous studies and published many articles involving empowerment and job satisfaction (Laschinger, nd). Laschinger et al. (2006) studied the impact of staff nurse empowerment as it relates to how a person fits in a job, work engagement and burnout. Laschinger, Wong, McMahon, and Kaufmann (1999) reported that nurses experienced increased structural empowerment and higher job satisfaction when management encouraged autonomy.
and facilitated decision-making. Laschinger and Finegan (2005) used Kanter’s theory of empowerment in designing an intervention to build trust and respect in the workplace, which increased job satisfaction and retention. Zurmehly, Martin, and Fitzpatrick (2009) linked retention to empowerment using Kanter’s theory as a framework. Nurse empowerment has been shown to have a positive effect on patient outcomes, work effectiveness, job satisfaction and retention rates (DeCicco et al., 2006; Laschinger & Wong, 1999).

The second theoretical framework is the Generational Theory. It was originally developed by Strauss and Howe (1991) in their comprehensive historical picture of the generations of the United States of America. Generational cohorts are defined as those who share birth years and experiences that ultimately influence their personalities and generational characteristics (Kupperschmidt, 2000). These are generalized experiences for the cohorts, and therefore, individual differences do exist. Due to these influences of the cohort experience, the group tends to have similar characteristics such as the way they spend their money; attitudes toward authority and organizations; opinions on what they want, need and expect from work; and attitudes toward marriage and family responsibilities (Kupperschmidt, 2000; Strauss & Howe, 1991). Because of the differences in responses to outside stimuli, it is imperative that organizations not only understand these differences, but provide appropriate input to these groups.

Based on the theoretical frameworks of Kanter (1993) and Strauss and Howe (1991) the following hypothesized relationships among the variables were developed and are summarized in Figure 1. Hypothesized relationships were based on findings in the literature. Some of the relationships could be multi-directional. In an effort to keep the model simpler unidirectional relationships were utilized.
Independent Variables | Moderating Variables | Dependent Variables
---|---|---
Generational Differences - Baby Boomers - Gen X - Gen Y | Professional Practice Environment | Job Satisfaction
Empowerment | Incivility | Engagement
Authentic Leadership | Intent to Leave

Figure 1. Theoretical Model

**Conceptual Definitions of Terms**

**Generational Cohort:** Groups of subjects banded together by birth years. For the purpose of this study three generational groups were considered: Baby Boomers, Generation X’ers and Generation Y’ers.

**Empowerment:** A major concept for this study is empowerment. Empowerment comes from the Latin word *potere*, meaning to have the ability to choose (Kuokkanen & Leino-Kilpi, 2001). Kanter (1993) defined empowerment as the ability to mobilize resources to accomplish goals. Synonyms for empowerment include: to make possible, to commission, to permit, to invest with power, to authorize, and to facilitate (Empowerment, 2011). For the purpose of this study empowerment was measured structurally, by nurses’ perception of the identified resources.
within the organization. Kanter has identified six conditions that interact to form structural empowerment: (a) opportunity, (b) information, (c) support, (d) resources, (e) formal, and (f) informal power. These make up the different sub-scales of the Conditions of Work Effectiveness Questionnaire-II developed by Laschinger et al. (2001a).

**Opportunity:** Kanter (1993) defines opportunity as employees’ expectations, and future prospects to challenging and meaningful work. Faulkner and Laschinger (2008), building off Kanter’s theory, defined opportunity as something found within organizations and characterized by the possibility of learning and advancing within the job.

**Information:** Kanter (1993) defines information as the corner stone for empowerment in the workplace. Lack of valid information can hamper effective behavior within the organization, preventing employees from meeting organization goals. Faulkner and Laschinger (2008) stated that information is getting the expertise and technical knowledge required to work effectively within the organization. Information can take the form of formal, being structured from within the organization; or informal, being structured around the organization.

**Support:** Kanter (1993) defines support as contact, communication and feedback from management, co-workers, and subordinates. It provides a feeling of acceptance in the organization. The support of others within the organization builds and promotes behaviors that foster cooperation, rather than competition. Faulkner and Laschinger (2008) say support includes feedback and helpfulness from colleagues, managers and subordinates.

**Resources:** Kanter (1993) defines resources as the availability of time, materials, supplies, money, and personnel to complete a job effectively and to meet the organizational goals. Faulkner and Laschinger (2008) say resources are the time and necessary materials to do the job.
**Power:** Kanter (1993) defines power as formal and informal, and suggests a combination of both is necessary for an employee to perform. Employees who have access to these types of power are more likely to be motivated and committed, and to accomplish their work in meaningful ways.

Faulkner and Laschinger (2008) define formal power as coming from within the organization. It is visible and essential for the organization to achieve its goals. Informal power is defined as peer relationships and alliances within the organization, and it facilitates the accomplishment of organizational goals. It is a combination of these concepts that make up empowerment (Faulkner & Laschinger, 2008). For the purpose of this study, empowerment is defined as ability to use the resources available to meet goals.

**Professional Practice Environment:** The environment in which the subject is employed as a nurse is the practice environment. It is defined in two ways, the type of unit they work in and broad categories of hospital characteristics.

**Incivility:** Workplace incivility is defined as low-intensity deviant behavior with ambiguous intent to harm the target, and in violation of workplace norms for mutual respect. These include behaviors such as rudeness, discourteousness, and general lack of respect for others (Anderson & Pearson, 1999).

**Authentic Leadership:** Authentic leadership is defined as behaviors demonstrated by those in management positions that promote positive work attitudes ultimately influencing work behaviors and outcomes (Avolio, Gardner, Walumbwa, Luthans, & May, 2004).

**Job Satisfaction:** This refers to the fulfillment and happiness that an employee feels towards their job. Satisfied employees are more likely to remain in their position. Cox, Teasley, Parsons, Carroll, and Ward-Smith (2006) determined that nurses satisfied with the opportunity
for growth, the variety of challenges, and access to information, support and resources were less likely to leave the nursing profession. Laschinger et al. (2004) have linked a strong relationship between job satisfaction and structural empowerment within nursing.

**Engagement in Job:** Defined as tenacious and persistent positive work-related state of mind, characterized by dedication, attention to, and supported by high levels of enthusiasm (Schaufeli & Bakker, 2004a).

**Intent to Leave:** For the purpose of the study intent to leave was defined as turnover intention, “the perception of the estimated likelihood of leaving an organization” (Price & Mueller, 1981, p. 546).

**Operational Definition of Terms**

**Generational Cohort:** For the purpose of this study, Baby Boomers had birth years between 1943 and 1960. Generation X’ers had birth years between 1961 and 1980. Generation Y’ers had birth years between 1981 and 2000. The cusp years (1959 – 1960 and 1978- 1979) were eliminated in data collection. This allowed for a clearer contrast between the generations.

**Structural empowerment in the organization** was measured by the 19-item total score on the Conditions of Work Effectiveness Questionnaire II (CWEQ-II) (Laschinger et al., 2001a) (Appendix A). This tool measures the following components of empowerment: a) opportunity, b) information, c) support, d) resources, and e) power (Appendix A).

**Professional Practice Environment** the perception of professional practice environment was measured using The Practice Environment Scale of the Nursing Work Index (Lake, 2002) (Appendix B).

**Incivility** was measured as negative, hurtful, dehumanizing or derogatory behaviors experienced by the participant as they related to their immediate supervisor and co-workers. The
Workplace Incivility (supervisor and co-worker) was used to measure incivility (Cortina, Magley, Williams, and Langhout, 2001) (Appendix C).

_**Authentic leadership**_ was measured using The Authentic Leadership Questionnaire (Avolio, Gardner, and Walumbwa, 2007) (Appendix D).

_**Job satisfaction**_ was measured using four questions adapted from Hackman and Oldham’s (1975) Diagnostic Survey (Appendix E).

_**Engagement**_ in one’s job was measured using Utrecht Work Engagement Scale (UWES) short version (Schaufeli & Bakker, 2004b) (Appendix F).

_**Intent-to-Leave the organization**_ was measured using four items from the Turnover Intentions measure (Kelloway, Gottlieb, and Barham, 1999) (Appendix G).

_**Demographic Data**_ included the following: year born, highest nursing education, gender, marital status, race / ethnicity, other degrees held, unit and job hired for, full time, part time or as needed scheduling, shift hired for, how long worked in current job, and current organization, and how long expected to remain in current job and with current organization.

**Assumptions**

Nurses have experienced empowerment at some level. Nurses will display traits that associated with their particular generational cohort. Nurses will answer openly and honestly, reporting their thoughts and feelings correctly on the chosen tools. Participants will honestly report any intent to leave their position. There could be variability in terms of age and interactive effects with years of experience which the generational division may not capture.

**Limitations**

There were some notable limitations involved with this study. There could have been challenges in recruitment, as only nurses who felt empowered may have agreed to participate and
complete the survey. More nurses may have responded to the survey from one generational cohort than another. Nurses may have worried that their job could be influenced if they did not fill out the questionnaire a certain way. To adapt for this, disclaimers were included in an information letter ensuring the participants that the answers cannot be traced back to them by confidentiality and de-identification of survey as soon as it is returned. There may have been confounding variables that could not be controlled in this study design. One year intent to remain in one’s current job may not be a predictor of long term retention. There may have been a larger number of participants from one unit or hospital, making the scores less representative of the entire group. A sample more representative of the population would allow for more generalization. A longitudinal study that re-tests over time would help to determine if responses change.

**Delimitations**

Delimitations for the study included only the recruitment of nurses who are employed at an acute care facility in the southeast where the study was done. Only registered nurses were included. Nurses who work outside of the hospital setting were not included.

**Significance of the Study to Health Sciences and Nursing**

Nursing is in a crisis and that crisis is likely increase. Job satisfaction is key to improving retention within nursing. Generational Theory coupled with Kanter’s theory (1977) provides a framework to view employee empowerment and the generational differences associated with it. Using these theories allowed the researcher to view employees’ perceptions and thoughts and to link them to retention rates, satisfaction rates, and intention to leave. Empowerment is both structural and psychological, and both parts must be studied to reveal the whole impact that empowerment has on employees. Nurses who view their environment as empowering are more
likely to provide high quality of care and to experience greater satisfaction with their jobs, which will retain nurses and allow for future development in nursing (Ning, Zhong, Libo, & Qiujie, 2009).

Summary

With the knowledge gained from this study, generational cohorts can better understand the differences that other groups bring to the nursing profession. Organizations can better guide and shield the different generations to retain the nurses we have. The Baby Boomers are the “experience” of the nursing profession, and they are the ones to train the newer generations. Baby Boomers need not only to have their needs met, but also have to understand the younger generations and how to best interact with them.
Chapter 2

Review of the Literature

This chapter is divided into sections which include methods used to search the professional literature and the review of the relevant literature divided into themes: generational differences, empowerment, empowerment as it relates to nursing, Kanter’s theory, professional practice environment, incivility, authentic leadership, job satisfaction, engagement in the job, and intent to leave the job in the next year. An explanation of how the model fit together, definitions of concepts and gaps in literature will be identified.

Method of Literature Search and Databases Used

Databases used for this literature search were CINAHL, PubMed, and PsycINFO. Key terms used in the literature search were generational differences, generational theory empowerment, and empowerment in nursing, professional practice environment, authentic leadership, incivility, job satisfaction, engagement, intent to leave the job and turnover intention. Publication dates ranged from 2000 – 2013. Studies prior to 2000 were selected to provide background information in the areas of empowerment and generational differences and for their classic contributions. There is a vast amount of literature on empowerment and nursing empowerment, as well as job satisfaction and generational differences, and incivility. Information on intent to leave a job position, professional practice environment and engagement in one’s job was not as copious. Only journal articles that were printed in English were selected.

Literature Review

Nearly 70% of nurses are employed in acute care setting (HRSA, 2002). It is essential to create an atmosphere within organizations where nurses can have a voice and develop the skills necessary to move into the professional role. An environment that will empower and motivate nurses is necessary to rejuvenate and sustain the nursing workforce (Askildsen, Baltagi, &
Researchers are finding that workplace relationships and responses may be influenced by generational differences (Boychuck-Duchscher & Cowin, 2004).

Factors such as years of experience and the age of the nurse in the acute care setting can affect how they transition from novice to experienced nurse, and react differently to the workplace environment. The transition period for nurses in the past held little value, and the difficulties they experienced were treated as a sort of rite of passage. Duchscher and Myrick (2008) categorized experiences that may cause nurses to change jobs or to leave the profession into themes including (a) horizontal and vertical violence, (b) reduced levels of self-confidence, (c) inappropriate use and underutilization of nurses, and (d) lack of an organizational culture to support the transition. Duchscher and Myrick identified implicit and explicit factors that may contribute to the dissatisfaction and distress among nurses entering the acute care settings. These include things such as moral distress, job dissatisfaction, career disillusionment, poor staffing level, and internal conflict. Through a review of literature, they explored the ideological, structural, and relational aspects that continue to surface in the work environments of nurses. They provided a detailed framework to use as a guide for increasing empowerment, awareness, and providing enhancing strategies in the workplace. Details regarding the qualities of the studies were not discussed in the review.

Nursing shortages force organizations to examine this transition period, to identify breakdowns in the process, and to create an atmosphere where nurses can transition into a professional role. Generational differences in values affect organizational relationships and organizational commitment (Leiter et al., 2010). Each generational cohort responds differently, and therefore, organizations must not only acknowledge this, but also tailor opportunities,
information, support, resources, and power to meet the needs of different groups. Generational differences are more than just a difference in years. How each group responds to things such as education, technology, and task make it necessary for an organization to acknowledge and support these differences.

Duchscher (2008) identified stages nurses go through as the transition from novice to experienced. Each stage incorporates different needs and expectations of a nurse. According to Duchscher, new nurses lack practice expertise and confidence. To achieve this, new nurses go through a series of stages. In the initial 12-month period, there are three main stages identified: doing, being, and knowing. The first stage, doing, encompasses the first three to four months and is marked by intensity, fluctuation of emotions, discovery, learning and performance by the nurse. Often, this phase includes the realization that the profession is not what they thought it would be. The second phase, being, comes during the next four to five months of the first year and is marked by rapid advancement in thinking, knowledge level and skill competency. Some participants identified this stage as the most difficult. The excitement regarding their completion of school, coupled with the initial shock of their first job, has been a drain on their resources, both personally and professionally. Many nurses sought validation in their knowledge and skills during this stage. The third phase, knowing, comes during months 9 to 12 of practice. During this stage, nurses begin to reach a level of confidence and comfort in their daily duties. They begin to feel they are colleagues with the rest of the nursing staff. These stages were developed after analyzing four qualitative studies spanning 10 years (Duchscher, 2001; 2003; 2007; 2008). These stages suggest that a longer orientation and support period for nurses is warranted to provide them the skills necessary to transition successfully into the professional role. This study did not look at these stages relating them to the different generational cohorts.
Generational Differences

A major part of any nursing succession plan needs to include an understanding of what each generation can offer, what they require, and how to meet those needs in the workplace (McNamara, 2005). In the past few years, researchers have begun to focus more on the differences of each generational cohort. Managing multiple generations can prove to be difficult without a clear understanding of the differences of each group.

Hahn (2011) defined generational cohorts and presented two multigenerational scenarios. Using five imperatives, strategies for effectively managing multigenerational staff were suggested. The imperatives were as follows: (a) accommodate employee differences, (b) create workplace choices, (c) operate from a sophisticated management style, (d) respect competence and (e) initiate and nourish retention. Communication and respect were found to be the underlying key strategies to understanding and bridging the generational gap. Additionally, managers can effectively bring strength and cohesiveness to nursing teams by embracing and respecting generational differences.

Dealing with different generations is not solely the responsibility of management. In 2006, Kupperschmidt addressed the difficulties faced by nurses as they work side-by-side with different generational cohorts and challenged individual nurses with the responsibility of learning to work cooperatively with peers in cohorts other than their own. Kupperschmidt describes the different generations, presents examples of conflict between the generations and how to deal with the conflict, while defining the strengths different cohorts possess. In summary, it is an individual nurse’s professional responsibility to understand the differences and create environments that have a minimum of multigenerational disrespect and conflict.
Looking more specifically at variances in generational cohorts, Leiter et al. (2009) identified clear differences in Baby Boomers and Generation X’ers and their evaluation of work life, workplace relationships, and social environments. Using a questionnaire they surveyed 2,436 nurses in the acute care setting. With a response rate of 27.38%, (n=667), respondents were assigned to two groups: Group one, Generation X (n=255), birth years 1963 – 1980; Group two, Baby Boomers (n=193), birth years 1943 – 1958. Nurses with birth years 1958 – 1963 were excluded due to the cusp of the two generations, thus allowing for a more clear generation experience (Lancaster & Stillman, 2005). The results confirmed that there are generational differences in professional values and personal distress. Generation X’ers felt work life was less consistent with their personal and professional values, more distressing, experienced more symptoms of job burnout, and they were more likely to change their job (Leiter et al., 2009). Such results pose a challenge to recruitment and retention strategies for management and organizations. Generation X’ers are the future of nursing experience, as the Baby Boomers continue to age and retire.

Leiter et al. (2010) looked at generational differences in distress, attitudes and incivility among nurses. Their objectives were to replicate the findings of the previous study where Generation X nurses reported higher levels of distress than Baby Boomers (Leiter et al., 2009) and to test whether Generation X nurses reported more negative social environments at work. Leiter et al. (2010) surveyed 1,600 Canadian nurses from 41 units at five hospitals. With a response rate of 45% (n=729), respondents were divided into two groups: Generational X’ers, birth year 1963 – 1981 and Baby Boomers, birth year 1943 – 1958. Respondents with birth year 1959 – 1962 were not considered in the result to clarify the contrast between the two groups. Results supported previous findings that Generation X’ers experienced more distress in hospital
environments. Perhaps more important were the findings that Generation X’ers experienced greater incivility from coworkers and supervisors than Baby Boomers.

Generational differences in nursing must be identified and embraced. Baby Boomers have a unique knowledge, experience, and leadership that is essential to be passed on. They cannot be viewed as simply the old workers who need to retire, but instead, must be respected and put in a position where others look up to them for knowledge (Kupperschmidt, 2000). Generation X’ers and Y’ers typically have a deeper knowledge and comfort in use of technology (Stuenkel et al., 2005). Some nurses may be classified by age in one cohort, but could be considered a better fit in another group based on knowledge (Smola & Sutton, 2002). Understanding these differences provide each generation the ability for empathy towards other groups.

**Empowerment**

Empowerment is a broad term that means different things within different disciplines. The term surfaced in the 1920s but was not widely used until the 1970s. The common ideology of empowerment refers to increasing the power of a low power group so that it is more equal to the high power group (Empowerment, 1998). Empowerment is the interpersonal process of providing the proper tools, resources and environment to build, develop and increase the ability and effectiveness of others to set and reach individual goals (Hawk, 1992). Empowerment can be viewed as either a process or an outcome.

Empowerment gained popularity in the 1970s and 1980s. Originally, it was used in a wide variety of causes, such as the women’s movement, gay rights (Minkler & Cox, 1980), the black power movement (Davis, 1988; Minkler & Cox, 1980), AIDS patients (Haney, 1988; Kirp & Epstein, 1989), students (Bode, 1989; Fagan, 1989), teachers (Fagan, 1989), and employees
(Kanter, 1977). Empowerment has become well studied in various disciplines such as education, philosophy, social work, business and nursing.

From an educational perspective, Freire (1985) sees empowerment as an emergence from poverty and oppression, focusing learning on a radical social change, mobilization and organization of the suppressed to obtain power. Hawk (1992) links the philosophic support for the empowerment of learners to the works of Dewey, Lewin, Rogers, and Freire. Lee and Johnson-Bailey (2004) view empowerment through a feminist pedagogy, citing the mobilization of resources to produce change and empower women.

Empowerment can be viewed as a process or an outcome. Looking broadly, it is a process by which people, organizations and communities gain power (Rappaport, 1984). Narrowing the view, empowerment as an outcome reflects a quality or properties a nurse has, allowing for influence over their environment (Reynolds, 1971). The focus of empowerment as an outcome is more on solutions than problems. Empowerment has not traditionally been studied with generational differences in mind. This becomes more important as the population ages, employees continue to work into later years in life, and generational cohorts continue to develop vastly different ideals. This study is relevant in assuring that organizations can meet the needs of each generation.

From a community perspective there are numerous definitions and applications of empowerment. Rappaport (1984) discusses empowerment at the community level as people uniting to accomplish common goals. Two basic assumptions can be found in the literature in regard to empowerment and the community. First, it is assumed that every person has the potential to become empowered (Rappaport, 1985). Zimmerman (1990) describes a decision-making processes between individuals and their environment as psychological empowerment.
Second, it is assumed that empowered communities are developed from empowered individuals working together to achieve a mutual goal for that community (Ellis-Stoll, 1998).

If empowerment in the community emerges from the individual, than how does the individual gain the skills to be empowered? In the cognitive psychology literature, empowerment means to enable to act (Conger & Kanungo, 1988). Zimmerman (1995) described psychological empowerment at the individual level as a link between a sense of personal control and efficacy and a willingness to change and take action. This personal efficacy view of empowerment has been adopted by others as well. For example, Shea and Howell (1992) define empowerment as a process enabling individuals to understand the relationship between their actions and outcomes, allowing individuals the power to achieve the outcomes they desire.

Thomas and Velthouse (1990) view empowerment as an intrinsic motivation made up of four cognitions: meaning, competence, self-determination and impact. These reflect a person’s orientation to their work. Spreitzer (1996) built on this, defining the four cognitions as follows:

Meaning is the fit between the requirements of a work role and a person’s beliefs values and behaviors (p. 484); Competence is the self-efficacy related to work,” the belief in one’s capability to perform work activities with skill” (p. 484); Self-determination is a “sense of choice in initiating and regulating actions” (p. 484); Impact is “the degree to which a person can influence strategic, administrative or operating outcomes at work” (p. 484). For Spreitzer, empowerment comes from within the person, and is manifested in decision-making.

Motivation regarding empowerment can be found throughout the literature, but what seems to be lacking is the explanation of what factors motivate individuals to change their behaviors successfully, and determination of the time required for behavioral change. Regan
(2002) suggests empowerment is the belief or motivational state found within the individual. Knowledge and skill are necessary, but are not sufficient to bring out change. Viewed through the lens of self-efficacy theory (Bandura, 1997), human behavior is a continuous interaction between behavior, cognitive and environmental influences (Donaldson, 2004). When individuals with low self-efficacy encounter difficult situations, they tend to doubt their abilities, decreasing their efforts or giving up all together. On the contrary, individuals with high self-efficacy will exert greater effort bringing about the desired changes. Empowering an individual increases their self-efficacy.

Empowerment can be examined from an organizational level as well. As a psychological construct, empowerment can be seen as different from work autonomy. Merriam-Webster defines autonomy as self-directing freedom (Autonomy, 2010). Autonomy can be attributable to the design of the job, allowing the person to be in charge of how they go about their work, and how they use personal initiative to complete their work (Hackman & Oldham, 1980). Sabistion and Laschinger (1995) hypothesize job autonomy is a determinant of empowerment. Highly autonomous jobs encourage empowerment, allowing the individual a choice in job related activities, although autonomy alone is not reflective of empowerment.

Deming (1986) saw empowerment as a core value in the Total Quality Improvement Management Theory. He proposed that empowerment delegates authority and responsibility to lower levels of hierarchy, improving productivity and adding benefits for the organization rather than the individual. However, Boggs, Carr, Fletcher, and Clarke (2005) cautioned against empowerment programs that result in decision-making power and freedom without a shared authority and support for autonomy or access to resources. Programs such as these promoted an unwillingness to share what was viewed as a finite amount of power by high level leaders.
In business, Kanter (1979) viewed empowerment as access to information, support, resources and opportunities within the work setting. Empowerment is developed or supported from within the organization; it is external to the person (Kanter, 1993). She describes six components of empowerment: (a) opportunity, (b) information, (c) support, (d) resources, (e) formal power, and (f) informal power. Kanter’s theory maintains that people are empowered to reach organizational goals if their work environments provide access to information, support and resources necessary to perform their jobs, as well as access to learning opportunities. Personal behavior in organizations is determined by the work environment and conditions related to the operation of the organization, not by individual personality traits (Kanter, 1977).

Empowerment Related to Nursing

Nursing literature offers many definitions of empowerment similar to those in other disciplines, focusing on the outcomes of nurses, empowering the patient. In 1992, Laschinger began a research program to investigate the impact of nursing work environments on nurses' empowerment for professional practice, their health and well-being, and leadership roles in creating empowering work conditions (Laschinger, n.d.). Laschinger and other faculty of University of Western Ontario have tested Kanter’s theory extensively in more than 15 studies, each study supporting the theory within the nursing profession (Laschinger et al., 2001a).

Several concept analyses of empowerment examine its attributes, characteristics and uses. Attempting to clarify the meaning of empowerment, and explore potential applications to nursing, McCarthy and Freeman (2008) examined characteristics and uses of the concept of empowerment within diverse disciplines. They were able to expand the view of empowerment based on empirical references. They concluded their study with the identification of three
classifications of empowerment within nursing: community advocacy, patient care, and empowerment of nurses.

Examining the attributes, characteristics and uses of empowerment within the discipline of nursing, Gibson (1991) identified characteristics of the concept, providing a definition for empowerment. Empowerment defined through this concept analysis is a process of helping people to assert control over factors affecting their lives. Researchers concluded by suggesting nurses need to shift their thinking, allowing empowerment to emerge within the profession, shifting to a role of facilitator and resource instead of service provider.

Rodwell (1996) and Ellis-Stoll (1998) explored empowerment using the methods advocated by Walker and Avant, analyzed empowerment concepts, provided definitions, defined attributes, discussed consequences and antecedents of empowerment, and discussed borderline and contrary cases. Rodwell defined empowerment as a process whereby groups or individuals are enabled to change a situation, given skills, resources, opportunities and authority. Ellis-Stoll defined empowerment as an active learning and adaptive process for the purpose of changing poor behaviors. Both authors viewed the transfer of power, in relationship to empowerment, as a necessity for transformation to take place. Positive self-esteem and recognition of self-worth was also needed. One must value others in order to value oneself (Chavasse, 1992). Therefore, nurses cannot empower unless they themselves are empowered (Rodwell, 1996).

The history of nursing, with an emphasis on self-sacrifice, charitable work and obedience when following orders from physicians, provides the roots of lack of empowerment within the nursing profession (Winstead-Fry, 1977). Nurses, in general, have been viewed by society as being in a powerless position, with poor performance and high levels of attrition and dissatisfaction within the profession. Studies trace this back to the early 1960s, when Corwin
first identified the discrepancies between a professional and bureaucratic role within nursing. In the 1970s, nurses were identified in the literature as lower on the hierarchical structure compared to other healthcare providers, identifying a phenomena that continues to this day, with many nurses experiencing “reality shock” in their first job (Kramer, 1974).

Prescott and Dennis (1985) conducted a study with 250 nurses from 15 different hospitals. Their findings suggest nurses place a low value on exertion of power that could affect organization change. Additionally, lack of support and resources lead to powerlessness, apathy and indifference within for nurses.

In the late 1980s, studies began using Kanter’s theory within nursing. Chandler (1991) linked staff nurses’ identification of support, opportunity and information as important factors to work effectiveness and empowerment. Chandler (1986) also developed the first tool to measure nurses’ perception of empowerment, the Conditions of Work Effectiveness Questionnaire, using Kanter’s concepts with the nursing work environment. Laschinger later developed the Conditions of Work Effectiveness II, which has been used with much success in measuring the empowerment of nurses and was described in detail in chapter one (Laschinger et al., 2001a).

Others researchers have examined empowerment in nursing as well. Gorman and Clark (1986) identified barriers to nursing practice, testing the effectiveness that empowering strategies had in improving nursing practice. This included things such as educational and structural solutions for the problems of powerlessness experienced by nurses in the hospital setting, providing tools necessary for analytic and interpersonal skills they needed to develop and implement plans for change. Structurally, it established new lines of communication between staff nurses and nurse administrators, giving the nurses more control over working conditions and allowing more access to needed resources. This laid the ground work for some quality
training programs. They were able to show that nurses can be prepared to function more effectively and that organizations can promote behaviors allowing for an increase in feelings of empowerment.

**Generational Differences and Empowerment**

Despite the extensive research done on empowerment, little is found in the literature to demonstrate the effects of generational differences in empowerment. Empowerment should focus more on solutions than on problems (Gibson, 1991). It should address people’s strengths, rights, and abilities rather than deficits and needs (Kieffer, 1984). Understanding how the different generations respond is a necessity to understanding the different resources that may be needed.

**Professional Practice Environment**

In the early 1980s researchers began to be interested in practice environments, looking specifically at characteristics that allowed some organizations to retain nurses despite the national shortage. The American Academy of Nursing interviewed nurse executives and staff from 41 of the original 46 Magnet hospitals finding that their practice environments emphasized decentralized decision making, autonomy, good relationships between nursing and physicians, flexible scheduling and adequate staffing (McClure, Poulin, Sovie, & Wandelt, 1983).

In 1989, Kramer and Hafner used the findings from the American Academy of Nursing interviews to develop the Nurse Work Index (NWI). Defined as a perception of the environment conducive to quality nursing care, it was an all-inclusive, 65-item list that used the characteristics from the Magnet hospitals, as well as 25 years of literature on job satisfaction and work value instruments. Factors included areas of administration, professional practice, and professional development. From this group, the initial 13 forces of magnetism were developed (Laschinger,
Validity for the NWI was supported by testing in 16 Magnet hospitals and 8 non-Magnet hospitals (Kramer & Hafner, 1989).

In 2000 Aiken and Patrician revised the NWI to measure the characteristics of professional nursing practice environments that included areas such as nurse autonomy, control over practice and relationships with physicians. Aiken and Patrician selected 56 of the original 65-items they believed best characterized an environment that was supportive of nursing. Lake (2002) used this as a foundation to describe a supportive professional practice environment, further developing the scale into five different components: (a) adequate staffing, (b) strong nursing leadership, (c) staff involved in the decision making process, (d) a nursing model of care, and (e) effective collaboration between nursing and medicine.

To validate her findings, Lake (2007) examined seven instruments used in 54 different studies to evaluate their usefulness in measuring nursing practice environments. The results of this extensive review of literature was that the Practice Environment Scale of the Nursing Work Index (PES-NWI) developed by Lake was the most useful instrument to evaluate the nursing practice environment. The second conclusion of this review was that future research should focus on generating evidence about the effect of the practice environment on patient outcomes.

Professional practice environment was studied by Laschinger, Finegan, and Wilk (2009a), linking the relationship of the professional practice environment, workplace civility, and empowerment in the new graduate population. Using a sub-set of data collected in an earlier study, they surveyed new graduate nurses (n=271). New graduate nurses perceived their work environment to have moderate levels of overall Magnet hospital characteristics (Laschinger et al., 2009a), which is similar to the results in Lake (2002) study involving Magnet hospitals. These results support the importance of the professional practice environment especially in the
new graduate population. Practice environment is directly related to feelings of autonomy and empowerment in the nurse. Organizations with a higher satisfaction in the practice environment have greater job satisfaction and are able to retain nurses.

**Incivility**

Unhealthy work environments are characterized by uncivil behaviors, affecting relationships among staff members in the workplace (Cho, Laschinger, Wong, 2006). Although few empirical studies exist in the literature, anecdotal reports of uncivil behavior in health care settings have increased (Laschinger, Leiter, Day, & Gilin, 2009b). Defined as “low intensity, deviant behavior with an ambiguous intent to harm, and in violation of the workplace norms for mutual respect” (p. 457), uncivil behaviors include rudeness, discourtesy and lack of respect for others (Anderson and Person, 1999). Continued over time, and directed at one individual, uncivil behaviors increase to bullying levels.

Findings from a decade of studies suggest that uncivil behavior is far more damaging than most managers imagine (Porath & Pearson, 2009). Some behaviors become so common and accepted that they are no longer questioned. According to Porath and Pearson the recipients of this poor behavior become angry, frustrated and even vengeful, causing job satisfaction and performance to decline. Farrell (1997) associated uncivil relationships among nurses with errors, accidents and decreased performance.

Incivility in the workplace is not limited to co-workers. The relationship of workplace empowerment, manager and coworker incivility and burnout to job satisfaction, organizational commitment and turnover intent was studied by Laschinger et al. (2009b). Incivility from supervisors to nurses was found in 67.5% of nurses surveyed. Supervisor incivility, empowerment and cynicism were the best predictors of job dissatisfaction and low
organizational commitment. Authentic leadership may be one key strategy to decrease uncivil behavior by peers and supervisors. A characteristic of authentic leadership such as protectiveness would shield the nurse from uncivil behaviors.

**Authentic Leadership**

Shirey (2006) identified the need for quality leadership in healthcare, basing it on the complex, uncertain and changing trends. Authentic leaders are described as being genuine, trustworthy, reliable, and believable (George, 2003; Luthans & Avolio, 2003). Nurses must be guided in the development of their professional practice by authentic leaders, who in part are protecting them from uncivil (lacking manners) behaviors of others. In a survey of several thousand managers and employees from a diverse range of companies, Porath and Pearson (2009) found that employees who were the target of uncivil behaviors were 48% more likely to decrease their work effort, and 78% felt their commitment to the organization declined. Perceptions of workplace incivility (rude and discourteous behavior) are significantly related to the level of support they sensed from their supervisor, and these perceptions related to their feelings of occupational stress and their turnover intentions (Dion, 2006).

A model examining the relationship between authentic leadership and follower outcomes was developed by Avolio et al. (2004). The relationship was demonstrated by linking the amount of personal identification the follower has with the leader, the social connection with the work group, and the trust in the leader. The model was tested by Walumbwa, Avolio, Gardner, Wernsing, and Peterson (2008) demonstrating a positive relationship between authentic leadership and job satisfaction.

Authentic leadership, organizational culture and healthy work environments were studied by Shirey (2006). Using a qualitative descriptive study approach, interviews of 21 nurse
managers in three acute care hospitals were conducted. Differences in organizational culture were apparent in the results. Nurse managers described personal satisfaction in their positions within positive organizational cultures. This suggests that organizational culture and leadership matter, since creating and sustaining a healthy work environment can be facilitated by a positive organizational culture.

The relationship between authentic leadership, staff nurses’ trust in their manager, work engagement, voice behavior (ability to speak up) and the perceived quality of care on the unit were linked in a model created by Wong, Laschinger, and Cummings (2010). According to their hypothesis, staff nurses’ perception of authentic leadership is based on personal identification, social identification and trust in the manager, which all influence work engagement, voice behavior and the quality of care provided. A random sample of 280 direct care nurses (response rate of 48%), working in areas of Ontario was surveyed. Study findings suggested that authentic leadership and work outcomes are mediated by personal identification with the manager and social identification with the work unit, as well as trust in the manager and work engagement. This model also supported the authentic leadership theory developed by Avolio et al. (2004). Authentic leaders who support and work towards development of unconditional trust in the work environment will create a climate where nurses are more engaged in their work, more comfortable to speak up about concerns and more likely to offer suggestions for change (Wong et al., 2010). Nurses report that organizations supportive of empowerment qualities often have many authentic leadership components as well.

**Job Satisfaction**

Job satisfaction is the fulfillment and happiness that the employee feels towards their job. Job satisfaction can be affected by influences in the work setting. A report by the Institute of
Medicine (IOM) (2004) found that a positive work environment can improve patient safety in hospital settings. Job satisfaction has been inversely linked in the literature to nurses’ intent to leave both the current job and the profession (Coomber & Barriball, 2007). Positive work environments are influenced by managers and leaders within an organization, by colleagues and by the organization itself.

Feelings of empowerment have been associated to higher job satisfaction as well. Lautizi, Laschinger, and Ravazzolo (2009) studied empowerment, job satisfaction and job stress in an exploratory study of Italian mental health nurses. The sample consisted of 77 nurses (return rate of 64%) who provided nursing services in different mental health agencies in Italy. Study results supported prior findings that job satisfaction is an important element of nursing, despite it being relatively low in this population. Italian mental health nurses related job satisfaction to the amount of opportunity for growth, such as advancement in their work environments, and the amount of support they receive. Despite cultural differences, job satisfaction has been positively linked to opportunity for advancement in many different countries.

Coomber and Barriball (2007) studied job satisfaction and the likelihood of an employee leaving. After reviewing nine articles, researchers determined that stress and leadership issues have the greatest influence on dissatisfaction and turnover. A worker’s education level and pay were also associated with job satisfaction, but less strongly.

Giallonardo, Wong, and Iwasiw (2010) also looked at leadership qualities, using them as a predictor of work engagement and job satisfaction in the new graduate population. Using a predictive survey design, they tested a model with 170 new nurses. Study results suggested that job satisfaction was linked to authentic leadership and work engagement. New graduates who
were paired with preceptors who demonstrated high levels of authentic leadership, had increased levels of satisfaction and were more engaged in their work.

Ning et al. (2009) used Kanter’s Empowerment Theory to find relationships among structural empowerment, job satisfaction and demographics. A cross-sectional design with a sample of 598 nurses revealed job dissatisfaction. This was found to be highest when nurses lacked compensation, professional promotion, low amount of work responsibility, poor work environments, and heavy workloads.

Cai and Zhou (2009) completed a similar study in China. They looked at structural empowerment, job satisfaction, and turnover intention among nurses. Questionnaires completed by staff nurses from two acute care hospitals (n=189) showed that structural empowerment and job satisfaction were related to turnover intention.

Researchers in Finland also studied empowerment, job satisfaction and organizational commitment. Kuokkanen, Leino-Kilpi, and Katajisto (2003) studied nurses in critical care (n=121), long-term care (n=151), and public health (n=144). Their findings showed that job satisfaction, commitment to the job, and level of professional activity correlated strongly with empowerment.

Using Kanter’s theory in nurse educators, Sarmiento, Laschinger, and Iwasiw (2004) linked job satisfaction to empowerment and burnout. With a sample of 89 college nurse educator professors, researchers tested a theoretical model to examine the relationships. Participants reported moderate levels of empowerment in the workplace, as well as moderate levels of burnout and job satisfaction. Regression analysis indicated higher levels of empowerment were associated with lower levels of burnout and greater work satisfaction.
Job satisfaction and intent to remain in current job among new nurses with baccalaureate degrees were examined by Roberts, Jones, and Lynn (2004). Respondents (n=123) who reported greater job satisfaction were more likely to stay in their current position. This suggests that job satisfaction plays an important role in intent to stay, and therefore, the focus of administrators needs to be on increasing job satisfaction.

**Engagement in Job**

Engagement in one’s job is defined as by Schaufeli and Bakker (2004a) as a positive and fulfilling sense, characterized by vigor, dedication to and absorption in work. Similar to empowerment, engagement develops from access to job resources, supportive management, and developmental opportunities (Schaufeli & Bakker, 2004a). Laschinger, Wilk, Cho, and Greco (2009c) examined the relationship of empowerment, engagement and effectiveness and compared the differences between new graduates and experienced nurses. The sample was obtained from two different studies. The first study was of new graduates (n=282). The second study was a representative sample of acute care nurses (n=311). A survey questionnaire was used. Using structural path analysis, the researchers developed a model. Results supported the hypothesis that work engagement plays a mediating role between empowerment and perceived effectiveness in both groups, with stronger results in the more experienced group.

**Intention of Nurses to Leave Current Position**

Intent to leave is the “perception of the estimated likelihood of leaving an organization” (Price & Muller, 1981, p 546). Laschinger and Finegan (2005) used empowerment interventions to build trust and respect within the workplace. Using a non-experimental predictive design, 273 questionnaire responses were analyzed. Findings showed that structural empowerment had a
direct effect on organizational trust, and organizational commitment. Nurses who scored high in job satisfaction had higher organizational commitment.

Beecroft, Dorey, and Wenten (2008) researched turnover intention among new graduate nurses. They attempted to determine the relationship of new nurses’ intent to leave their position with variables such as individual characteristics, work environment and organizational factors. Respondents (n=889) were new nurse graduates working in pediatrics in a residency program. Using a single-item scale, Hinshaw and Atwood (1982) measured participants’ intent to remain in their facility for the next year. Scores ranged from (1) not at all; to (7) I surely do. Data were collected over a seven-year period. Higher scores in work environment and organizational characteristics contributed to the likelihood that nurses would not leave their current position. New graduate nurses who were satisfied with their jobs and pay felt increased commitment to the organization and their intent to leave decreased (Beecroft, Dorey, & Wenten, 2008).

**Gap in Literature**

Research findings support linking job satisfaction to empowerment, and job satisfaction to increased retention rates. There is no lack of literature discussing the difficulties nurses experience as they transition into their professional role. The leadership role has been studied as well as the professional practice environment. A gap found in the literature is framed by the questions of how generational differences affect empowerment, authentic leadership, and engagement in the job and how those variables affect job satisfaction and intent to stay. If differences can be identified on these variables, then programs can be tailored better to meet the needs of different generational cohorts, thereby increasing job satisfaction, and as a result of that, impacting retention of nursing staff.
Hypothesized Study Model

Based on the review of literature and the gaps that were identified, the current study was designed to provide a comprehensive and integrated examination of the relationship among the identified variables. Moderating mechanisms were added to the model to show what affects the strength of the relationship between the independent and dependent variables. The hypothesized model compares the relationship of the generational effects on empowerment, and the nurses’ perception of the professional practice environment, incivility, authentic leadership and how these affect job satisfaction, engagement and intent to remain in the job. It was hypothesized that generational differences affect the relationship among empowerment and job satisfaction, engagement in job and intent to remain in the current job.

Summary

Empowerment has been linked to job satisfaction, which is linked to increase in intent to stay in both the current job and the nursing profession overall. Nurses experiencing uncivil behaviors in a non-professional environment are less likely to remain in their current position. Generational differences exist within the nursing profession. Research needs to focus on defining the differences and providing managers and organizations the tools necessary to empower nurses, increasing their job satisfaction and desire to remain in their job.
Chapter 3

Method

This chapter is a discussion of the specific methods and procedures that were utilized to carry out the study. It includes a statistical explanation of theorized model, design, setting, population and sample of the study. A description of the operational definitions of variables including psychometric properties to support the validity and reliability of the measures are provided. The procedure (recruitment, distribution and collection of surveys), plan for data analysis and explanation of how human subjects were protected is also provided.

Model

The hypothesized theoretical model was discussed in Chapter 1. The statistical model follows:

Figure 2 Statistical Model: Generational Differences In Nurses
The hypothesized model as shown predicts that empowerment is positively related to the professional practice environment and that in a professional practice environment incivility decreases. Generational differences are not connected to the other variables as the model. The model will be examined three different times, using only the data from the respondents in that cohort. It is hypothesized that empowerment positively influences authentic leadership which also decreases incivility. Authentic leadership and a professional practice environment are related to increased job satisfaction, which will increase engagement and decrease nurses’ intention to leave their current position. What is not clear at this time is how these factors vary between different generational cohorts. The relationships among the variables as described represent findings in the literature. Some of the relationships could be multi-directional. In an effort to keep the model simpler unidirectional relationships were utilized.

**Design**

The purpose of this study was to develop and test a theoretical model to examine generational differences in empowerment, professional practice environment, and authentic leadership, and how they affect the nurses’ perceptions of incivility, job satisfaction, engagement and intent to stay in the organization. The model was tested, and then the different generational groups compared. A survey tool was designed utilizing the tools described previously: (a) Conditions of Work Effectiveness Questionnaire-II (Laschinger et al., 2001a), (b) The Practice Environment Scale of the Nursing Work Index (Lake, 2002), (c) Workplace Incivility Scale (Cortina et al., 2001), (d) The Authentic Leadership Questionnaire (Avolio et al., 2007), (e) Job Diagnostic Survey (Hackman & Oldham, 1975), (f) Short Version of Utrecht Work Engagement Scale (Schaufeli & Bakker, 2004b), and (g) Turnover Intention Scale (Kelloway et al., 1999). These tools have been used successfully in studies. Support for internal and external validity of
the instruments is discussed later. This study combined the different tools into a survey booklet. Collection of data utilizing tools that are validated and reliably in the literature, allowed for a generalization from the sample to a larger population.

A cross-sectional, randomized non-experimental design was used to test the hypothesized model. This design was used to determine whether generational differences are related to perceptions of empowerment, job satisfaction, engagement and intent to remain. Randomized sampling was used. Additional data were collected to describe the sample and determine the generalizability of this sample to a larger population of nurses who work in acute care hospitals.

**Setting**

The study was conducted in the southeast region of Tennessee. Nurses in this region work in many different capacities. For the purpose of this study, focus was on nurses working in the acute care setting. These organizations include a range from very small rural facilities to large academic medical centers.

**Population**

A list of registered nurses licensed in the State of Tennessee is kept at the state level. A list of these nurses in 16 east Tennessee counties was obtained through the Board of Nursing. Advanced Practiced Nurses and nurses who were not currently practicing were removed from the list. The final list contained 11,610 nurses licensed in 16 counties in east Tennessee.

**Sample**

A single-stage sampling of the population was done. A random sample was pulled from the population. The sample size was based on the use of multilevel structural equation modeling for statistical analysis. A minimum sample size of 200 is required for statistical analysis using structural equation modeling (Kline, 2011). For multi-leveling, Maas and Hox (2005) suggest a
sample size greater than 50 at the group level. Missing data, reliability of the variables and the strength of the relationships among the variables also influence the sample size that is needed. For this study, I attempted to get 75 participants in each of the three generational groups for a total of 225 nurses. To obtain this sample size, a survey was sent to every 10\textsuperscript{th} nurse on the original population list. A total of 1100 surveys were sent out. If a survey was returned as undeliverable by the postal service, it was resent to the next potential participant on the list. Attempting to get 75 surveys per group allowed extra for those birth years that were excluded and those surveys that were not filled out completely or not returned.

Nurses were excluded if they were unwilling to participate, did not fill out the survey at least 80\%, or had a birth year that fell between 1959 - 1962 or 1979 – 1982 or before 1944. Removing birth years on the cusp of generations allowed for better clarification between the generational cohorts. This resulted in the following nurses being removed from the respondents: four nurses prior to 1959, 20 on the cusp of 1959 – 1962 and 17 on the cusp of 1979 – 1982.

Instrumentation

Independent Variables

Generational Differences: For the purpose of generational analysis, generational differences were measured by asking the birth year of the participant. For this study generational cohorts were divided into the following groups: Baby Boomers, birth years 1943 – 1960, Generational X’ers, birth years 1961 – 1980, Generational Y’ers, birth year 1981 or after. Participants with birth years on the cusp (1959 – 1962 or 1979 – 1982) were not included to better clarify differences between generations. Participants with birth years before 1943 were not included since this group would be too small, given that most have retired.
**Empowerment:** Structural empowerment in the organization was measured using Conditions of Work Effectiveness Questionnaire II (CWEQ-II) (Laschinger et al., 2001a) (Appendix A). Appropriate permission to use the Conditions of Work Effectiveness Questionnaire II was obtained (Appendix I).

This tool was developed by Laschinger et al. (2001a) as a modification of the original Conditions of Work Effectiveness by Chandler (1986). The questionnaire contains 19 items to measure the six elements linked to structural empowerment as identified above. Additionally, two questions at the end measure global empowerment and are not added to the sum of the scale, but are instead used to provide evidence of construct validity (Laschinger et al., 2009a). The conceptual background for this measurement tool is Kanter’s Theory of Organizational Behavior (1993). Each part of this tool is linked directly to one of the six elements of structural empowerment and measures the nurses’ perception of that element. This tool rates the questions on a five-point, Likert-type scale of “strongly disagree” to “strongly agree”, with higher scores indicating greater structural empowerment (Faulkner & Laschinger, 2008).

Laschinger et al. (2001a) measure empowerment concepts in the following way (Appendix B): *Opportunity* is measured by three questions that relate to the amount of challenge and the ability to gain new knowledge and skills within the work place. *Information* is measured by three questions that rate the current state of the hospital, values of top management and goals for top management. *Support* is measured by three questions that are based on feedback for things the nurse does well or could improve upon, and helpful hints or problem solving they may receive. *Access to resources* is measured by three questions about whether the nurse has enough time to complete paperwork and to accomplish job requirements and whether additional help is available when needed. * Formal power* is measured by three questions about rewards the nurse
may receive, flexibility they feel in their job, and work-related visibility within the institution. Informal power is measured by four questions about collaborating on patient care with physicians, whether they are sought out by peers for help, whether they are sought out by managers for help and whether the nurse seeks ideas from professionals other than physicians.

Reliability and Validity. The CQE-W-II has been tested thoroughly in nursing, and is consistent in reliability and validity (Laschinger et al., 2009b). Reliability for this tool is demonstrated through Cronbach’s alphas. Subscales scores range from 0.78 - 0.93 (Manojlovich & Laschinger, 2002), 0.71 – 0.85 for subscales, and 0.80 for total scale (Faulkner & Laschinger, 2008). Cronbach’s alpha for the current study was determined in this sample once data collection was complete.

The construct validity of the CWEQ-II has been substantiated by Laschinger et al. (2001b) with the following results: confirmatory factor analysis that showed a good fit with the hypothesized factor structure: chi squared = 279, degrees of freedom = 129, comparative fit index = .992, incremental fit index = .992, root mean square error of approximation = .054. The CWEQ-II contains a two-item measure of global empowerment that is strongly correlated with the CWEQ-II (r = 0.66, p = 0.01) as a construct validity check (Faulkner & Laschinger, 2008).

Limitations with this tool include a response bias that is known to be a concern when using self-reported questionnaires (Polit & Hungler, 1991). Laschinger et al. (2001b) acknowledge the self-reporting aspect of the tool to be a weakness. Nurses who respond to the survey may already feel more empowered, leading to bias. Nurses who respond may be more open to learn about empowerment, or may already feel more empowered than other nurses.
Moderating Variables

Professional Practice Environment: Professional Practice Environment was measured using the Practice Environment Scale of The Nursing Work Index (NWI-PES) (Lake, 2002) (Appendix B). Permission to use the NWI-PES was not necessary as the tool is public domain; however, notification of intent to use was made with acknowledgment from the developer (Appendix J). This tool was developed by Lake and consists of 31 items rated on a four-point Likert-type scale ranging from one (strongly agree) to four (strongly disagree). Scores are calculated by summing and averaging the items. Higher scores reflect a supportive practice environment. Lake (2002) describes values above 2.5 as meaning general agreement, while values below 2.5 indicate disagreement with the characteristics measured.

The tool is divided into five subscales reflecting Lake’s (2002) five-factor professional practice environment characteristics. The subscales are as follows: (a) nurse participation in hospital affairs, (b) nurse foundations for quality of care, (c) nurse manager ability, leadership and support of nurses, (d) staffing and resource adequacy and (e) collegial nurse-physician relationships. In a review of 37 research studies using the NWI-PES (Warshawsky & Havens, 2011) the staffing and resource adequacy subscale most often scored lowest; however, most researchers report significant associations between scale scores and multiple nurse, patient and organizational outcomes.

Reliability and Validity. The NWI-PES has been tested in the nursing literature. Reliability for the tool is through Cronbach’s alpha, established by acceptable ranges from 0.65 to 0.85 (Armstrong & Laschinger, 2006; Klopper, Coetzee, Pretorius, & Bester, 2012; Lake, 2002; Laschinger et al., 2009a; Leiter & Laschinger, 2006; Sermeus et al., 2011). Cronbach’s alpha for the current study was determined in this sample once data collection was complete.
Sub-scales have shown a high predictive validity for workforce stability issues and quality of care in hospitals (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Bruyneel, Van den Heede, Diya, Aiken, & Sermeus, 2009; Sermeus et al., 2011). The construct validity of the NWI-PES was tested by Lake (2002); Leiter and Laschinger (2006) sustained a good fit by a confirmatory factor analysis.

Limitations with this tool include a response bias that is known to be a concern when using self-reported questionnaires (Polit & Hungler, 1991). Laschinger et al. (2001b) acknowledge the self-reporting aspect of the tool to be a weakness. Nurses who respond to the survey may feel happier in their practice environment and are, therefore, more likely to respond, leading to bias.

**Incivility:** Incivility was measured using the Workplace Incivility Scale (WIS) (Cortina et al., 2001) (Appendix C). The scale was developed from a study that examined over 1,100 public-sector employees, 71% of whom reported incivility in the workplace in the prior five years. The tool rates seven questions on a five-point Likert-type scale ranging from one (never) to five (everyday). Participants are asked to rate their supervisor and coworkers on how often they have experienced the described behaviors in the past 30 days. Behaviors include “low intensity, deviant behavior with an ambiguous intent to harm and in violation of the workplace norms for mutual respect” (p. 457), uncivil behaviors include rudeness, discourtesy and lack of respect for others (Anderson and Person, 1999). Scores are calculated by summing and averaging the items. Higher scores reflect a more uncivil environment. Appropriate permission to use the WIS was obtained (Appendix K).

**Reliability and Validity.** Internal consistency was found to be acceptable in previous studies with ranges from 0.84 – 0.89 (Cortina et al., 2001; Laschinger et al., 2009b; Smith,
Andrusyszyn, & Laschinger, 2010). Reliability coefficients for supervisor and co-worker were acceptable with ranges of 0.88 – 0.85 (Smith et al., 2010). Limitations of this tool are self-reporting tools can be a weakness due to response bias that is known to be a concern when using self-reported questionnaires (Polit & Hungler, 1991).

**Authentic Leadership:** Authentic leadership was measured using questions from the Authentic Leadership Questionnaire (ALQ) (Avolio et al., 2007) (Appendix D). It consists of 16 items divided into four leadership subscales: (a) relational transparency, (b) balanced processing, (c) self-awareness and (d) internalized moral perspective. Items are rated on a Likert-type scale, ranging from zero (not at all) to four (frequently, if not always). Subscales are summed and averaged to produce a total score between zero and four. Higher authenticity is represented with the higher scores.

**Reliability and Validity.** Validity of the four dimensions of authentic leadership is through confirmatory factor analysis (Walumbwa et al., 2008). Internal consistency has been reported reliably, as evidenced by Cronbach’s alphas, ranging from 0.70 to 0.90 (Walumbwa et al., 2008). Cronbach’s alpha for the current study was determined in this sample once data collection was complete. Acceptable alpha coefficients also were found in the literature for the four subscales of the ALQ: self-awareness (α = 0.93), transparency (α = 0.83), ethical / moral (α = 0.84), and balanced processing (α = 0.81) (Walumbwa et al., 2008). Appropriate permission to use questions from the Authentic Leadership Questionnaire was obtained (Appendix L).

**Dependent Variables**

**Job Satisfaction:** Job satisfaction was rated with four questions adapted from Hackman and Oldham’s (1975) Job Diagnostic Survey (Appendix E). Using a five-point Likert-type scale ranging from one (strongly disagree) to five (strongly agree), participant’s rate job satisfaction in
the following areas: coworkers and supervisors feeling of accomplishment from doing the job, and overall job, and supportive work environment (Hackman & Oldham, 1975; Tsui, Egan, & O’Reilly, 1992). This survey is a non-copyrighted tool that does not require approval to use (Hackman & Oldham, 1980 p. 275).

**Reliability and Validity.** Internal consistency in previous studies was 0.83 (Laschinger & Havens, 1996; Laschinger et al., 2001b) and had ranges from .56 - .88 in previous studies (Hackman & Oldham, 1975). Cronbach’s alpha for the current study was calculated once datum collection was complete. Validity of the tool was addressed by Hackman and Oldham and results suggest that the variables measured related to one another.

**Engagement in Job:** Engagement in one’s job was measured using short form of Utrecht Work Engagement Scale (UWES) (Schaufeli, Salanova, Gonzalez-Roma, and Bakker, 2002) (Appendix F). This tool measures three components of work engagement: vigor, dedication, and absorption. Each of the three components asks three questions, for a total of nine. Items are rated on a five-point Likert-type scale ranging from strongly disagree to strongly agree (Schaufeli & Bakker, 2004b). Permission to use the short version scale is not needed for non-commercial scientific research (Schaufeli et al., 2002).

**Reliability and Validity.** The original UWES had evidence of convergent and divergent validity (Schaufeli & Bakker, 2004b). Short form UWES had alpha reliabilities for the subscales that ranged from 0.87 – 0.92 (Laschinger et al., 2009c). Cronbach’s alpha ranged from 0.75 – 0.94 for the subscales and 0.89 – 0.97 for total scores (Schaufeli & Bakker, 2004b). Cronbach’s alpha for the current study was calculated once data collection was complete.

**Intention to Leave:** Intent to leave was measured using four items from the Turnover Intentions measure (Kelloway et al., 1999) (Appendix G). This scale determines if the nurses have the
intent to remain in their current position or if they have plans to leave in the next 12 month period. Items are rated on a five-point Likert-type scale ranging from one (strongly disagree) to five (strongly agree). Higher scores reflect the increased likelihood of leaving the current facility. Appropriate permission to use Turnover Intentions was obtained (Appendix M).

**Reliability and Validity.** Reliability testing of the original scale indicated that it is internally consistent (0.82), item correlations ranged from $r = 0.57$ to 0.63 (Leiter & Maslach, 2009). Cronbach’s alpha for the current study was calculated once data collection was completed.

**Procedure**

**Recruitment and Distribution:** Following dissertation proposal approval and IRB approval a modified version of the Dillman method for mail surveys was used (Dillman, Smyth, & Christian, 2009). Nurses were mailed a cover letter of explanation (Appendix N), asking them to participate in the study, providing essential information for informed consent, instructions for the participants to complete the survey booklet and an addressed, stamped envelope for return of the survey booklet. A phone number at the University of Tennessee, College of Nursing, was also provided for any of the participants to call if they had questions during the survey. Additionally the cover letter explained that those nurses who returned the surveys had the option of their name being entered into a drawing for a $100 Visa gift card.

Surveys were sent to each participant with the cover letter and a small white card for them to write their name on if they chose to be included in the drawing. When the surveys were returned, the envelope was opened, the survey placed in one pile and the small name card placed in another. For confidentiality, there was no tracking of the survey to the participant.
After two weeks, a postcard (Appendix O) reminder was sent out asking them to participate. Survey booklets were collected for a period of two months from the initial mailing. Surveys were mailed through the United States Postal Service. Surveys that were returned as not deliverable due to incorrect address were resent to the next person on the mailing list.

**Collection:** Completion and voluntary return of the postage-paid research booklet served as implied informed consent for the study. Surveys were returned to Dr. Ken Phillips in the College of Nursing at the University of Tennessee. All study information will be kept secure for three years at the in a locked cabinet in the office of research within the College of Nursing at the University of Tennessee, Knoxville.

**Protection of Human Subjects**

Permission to conduct this study was obtained from the Institutional Review Board (IRB) at University of Tennessee. Confidentiality for participants was maintained throughout the study. Data collected through surveys were not identifiable by name. Surveys were anonymous. When returned, envelopes were opened, placed in a separate pile. If the small white name card was returned, it was placed separately from the survey. All research materials will be stored in a locked file in Dr. Ken Phillips’ office in the College of Nursing at the University of Tennessee for three years. All publications of the results from the study will be reported as aggregate data.

Participants had the opportunity to ask questions before completing the survey and throughout the study by calling the phone number that was provided in the cover letter. Nurses who agreed to participate by completing the survey consented to be included in the study. All information related to the study was available to the researcher and dissertation committee only.
Data Analysis

Prior to the model being tested, missing data was accounted for. Participants were removed if more than 20% of the questions in the survey not answered, not including the demographic data. There was only one subject who did not answer over 80% of the questions and that subject was not employed in the acute care setting, and therefore removed. There were a total of 253 subjects who responded. There were four subjects who were born prior to the Baby Boomer era, and therefore, they were not counted. There were 20 subjects born in the cusp years or 1959 – 1962, and 17 subjects born in the cusp years of 1979 – 1982. Each of the cusp groups respondents were also excluded to provide a clearer differentiation between the groups. The final sample consisted of 210 subjects who were included in the study.

Descriptive and inferential analyses of the demographic and major study variables were conducted, along with reliability assessments of the study instruments using Statistical Package for the Social Science (SPSS) (version 17) and Statistical Analysis System (SAS) (version 9.3). General linear model (GLM) was used to examine the difference of generational differences within all scales and subscales. The hypothesized structural model outlined in Figure 1 was tested using Structural Equation Modeling (SEM) with Proc CALIS in SAS (SAS, 2011). There is debate in the SEM literature regarding the best index of overall fit for evaluating structural equation models (Hoyle, 1995; Kline, 2011). Hoyle (1995) recommends several criteria to evaluate the fit of the model. These include chi-squared ($\chi^2$) and the chi-square/degrees of freedom ratio ($\chi^2/d.f.$) as the omnibus fit indices (Jöreskog & Sörbom, 1989), the Comparative Fit Index (CFI) as the incremental fit indices (Bentler, 1990) and the Incremental Fit Index (IFI) (Bentler & Bonett, 1980). The Root Mean Square Error of Approximation (RMSEA) as suggested by Browne and Cudeck (1989) also was used.
The difference between the hypothesized model and the just identified version of the model is $\chi^2$ (Laschinger, Grau, Finegan, and Wilk, 2010). According to Kline (2011), low, non-statistically significantly values are desired. In large sample sizes, the null hypothesis is expected to be rejected almost every time. Due to this limitation, $\chi^2$ was used only to evaluate the relative differences in fit among competing models. Chi-squared ranges between zero and infinity, with zero indicating a perfect fit and a larger number indicating extreme lack of fit (Mulaik et al., 1989). A good model fit would provide an insignificant result at a 0.05 threshold (Barrett, 2007). Assuming no correlation among observed variables, the proportion of improvement of the hypothesized model relative to a null model is the incremental fit indices (Laschinger et al., 2010). Kline (2011) presents the generally agreed-upon critical value for the CFI and IFI as 0.90 or higher. The lack of fit between the data and the model, which is the standardized summary of the average covariance residuals is the RMSEA (Kline, 2011). Hu and Bentler (1999) describe low (between 0 and 0.06) as indicative of a good fitting model.

**Summary**

Generational differences in empowerment, professional practice environment, incivility and authentic leadership were compared. The relationship between these variables and job satisfaction, engagement and the job and intent to remain in the current position was examined. Structural equation modeling was used to analyze the datum, fitting the hypothesized model to the statistical model.
Chapter 4

Results

The study was designed to extend knowledge of generational differences in nurses’ perceptions of empowerment, professional practice environment, and authentic leadership, and their perceptions of incivility, job satisfaction, engagement and intent to leave the organization in the acute care setting. This chapter is divided into the following sections: results, descriptive statistics, generational level variables, preliminary analysis, multi-level analysis, differences related to generations, and a summary of the overall findings.

The study was intended to expand information as outlined in the following specific aims and hypotheses:

Specific Aim I: To test the generational differences in the nurse’s perception of empowerment.

1. Nurses demonstrate differences in their perception of empowerment based on the generational cohort to which they belong.

Specific Aim II: To test the generational differences in nurse’s perception of professional practice environment.

1. Nurses will have a difference in their perception of professional practice environment based on the generational cohort to which they belong.

Specific Aim III: To test the generational differences in the nurse’s perception of authentic leadership and supervisor / co-worker incivility.

1. Nurses will have a difference in their perception of authentic leadership and incivility based on the generational cohort to which they belong.

Specific Aim IV: To test the generational differences of the nurses job satisfaction, engagement in the job and intent to leave in their current position.
1. Nurses will have a difference in their level of job satisfaction, engagement in their job and their intent to leave their current position based on the generational cohort to which they belong.

Specific Aim V: To test the relationship of the nurses perception of empowerment, professional practice environment, incivility, and how those impact job satisfaction, engagement and intent to leave one’s job and how this varies among the different generations.

1. Nurses in different generational cohorts will have different strengths of relationships in the theoretical model.

These specific aims were incorporated into the hypothesized study model (Figure 1) and tested using a sample of nurses from 16 east Tennessee counties.

Descriptive findings are reported for study variables for the entire sample, and also broken into the different generational cohorts. Preliminary analysis of the relationships between variables is based on a correlation matrix of key model variables. Statistical analysis of the full hypothesized model using multilevel structural equation modeling (MLSEM) is completed, along with analysis at a generational group level.

Descriptive Statistics

The final sample consisted of 210 nurses from 16 counties in East Tennessee. A total of 1500 surveys were mailed out (combined initial mailing and those who were returned and re-mailed), with a return of 253 (response rate 16.9%). Removing those who did not work in the acute care setting, with birth years before Baby Boomers (prior to 1944), and those in the cusp years (1959 – 1962 and 1979 – 1982), the final sample consisted of 210 nurses. Of those final 210 the generational groups were as follows: Baby Boomers n= 69 (32.9 %), Generation X n= 98 (46.7%), and Generation Y n=43 (20.5%) (Table 1).
Table 1: Generational Groups

<table>
<thead>
<tr>
<th>Year Born?</th>
<th>Entire Sample</th>
<th>Baby Boomers</th>
<th>Generation X</th>
<th>Generation Y</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>210</td>
<td>100</td>
<td>69</td>
<td>32.9</td>
<td>98</td>
</tr>
</tbody>
</table>

Demographic Description

The sample consisted of 87.1% females and 12.9% males. The majority was married, 72.4%, with 12.4% reporting being single, and 11.9% reporting being divorced. The age of the respondents ranged from 24 to 69 years (M = 44.8, SD = 12.1). Ethnicity of the sample was 94.8% White – non Hispanic (n=199), with only 4.4% (n=9) comprising the other groups (Hispanic n=1, 0.5%; African American n=4, 1.9%; Asian n=1, 0.5%; Native American n=1, 0.5%; other n=2, 1.0%). Of the subjects, 51% had no children living with them, 23.8% had one child living with them, 19.5% had two children living with them, and 4.8% had three or more children living with them. In the group, 49.5% had earned their Bachelors of Science in Nursing (BSN), and 32.9% earned their Associate of Science in Nursing (ASN) degree. Yearly household incomes varied greatly, ranging from $30 - 250 thousand (M = 80, SD = 34.6), with only 77% of respondents answering this question.

The types of units where the respondents work varied: 12.9% in medical surgical areas, 3.8% in telemetry, 13.3% in critical care, 11% in emergency department, 13.4% in surgical areas, and 32.4% in other areas. Within the sample, 76.7% worked full time, 13.3% worked part time, and 8.6% worked as needed. The majority worked the day shift, 62.4%, followed by 15.2% working the night shift. Respondents have worked in their current job between 1 and 30 years (M = 7.2, SD = 6.5). The demographic description of the sample is shown in Table 2.
### Table 2: Demographic Description of Sample

<table>
<thead>
<tr>
<th>Variable</th>
<th>Entire Sample</th>
<th>Baby Boomers</th>
<th>Generation X</th>
<th>Generation Y</th>
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</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td>--------------</td>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Range</td>
<td>24 – 69</td>
<td>53 – 69</td>
<td>32 – 51</td>
<td>24 – 31</td>
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<tr>
<td>Mean</td>
<td>44.8 (SD=12.1)</td>
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</tr>
<tr>
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<td>40-250</td>
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<td>32-110</td>
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<td>Mean</td>
<td>80.1 (SD=34.6)</td>
<td>92.3 (SD=41.1)</td>
<td>81.3 (SD=32.0)</td>
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<td><strong>Gender</strong></td>
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<td>Female</td>
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Note: SD = Standard Deviation
Table 2: Continued

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<th>Baby Boomers</th>
<th>Generation X</th>
<th>Generation Y</th>
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<td>n</td>
<td>%</td>
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<td>4.3</td>
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<td>2.9</td>
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</table>

The Baby Boomer group consisted of 92.8% females. Of the 69 nurses, 8.7% were single, 79.7% were married and 8.7% were divorced or widowed. The age of the Baby Boomers ranged from 53 to 69 years (M = 58.9, SD = 3.8). Race / ethnicity of the sample consisted primarily of white – non Hispanic (98.6%) with the other 1.4% Asian. In the sample, 78.3% of the subjects had no children living with them. Yearly household income ranged from $40-250 thousand (M = 80.1, SD = 41.1). Of the nurses, 43.5% reported they had obtained their BSN degree. They worked in a variety of unit types: medical surgical areas 11.6%, telemetry 2.9%, critical care 10.1%, emergency department 8.7%, surgical areas 18.8%, and other areas 33.3%.
Within the sample, 73.9% of the nurses reported they worked full time, 14.5% worked part time, and 10.1% worked as needed status. The majority, 63.8%, reported they worked the day shift, 2.9% worked evening shift, and 14.5% worked the night shift.

Generation X group had a total of 98 nurses in the sample, 83.7% of those being females. The majority, 72.4%, were married, 18.4% divorced, and 7.1% single. The age of the respondents ranged from 32 to 51 (M = 42.6, SD = 4.8). Race / ethnicity of the sample was 95.9% white – non Hispanic, with only 4.0% comprising the other groups (Hispanic n=1, 1.0%: African American n=1, 1.0%; Native American n=1, 1.0%; other n=1, 1.0%). In the sample, 27.6% of the subjects had no children living with them, 32.7% had one child living with them, and 38.8% had two or more children living with them. Yearly household income ranged from $30 - 160 thousand, (M = 81.3, SD = 32.0). Most of the degrees earned by this group were BSN degree (49%), followed by ASN degree (37.8%). The respondents reported working in a variety of clinical settings: medical surgical areas (10.2%), telemetry (4.1%), critical care (12.2%), emergency department (12.2%), surgical areas (17.3%), and other areas (33.7%). Within the sample, 75.5% nurses reported they worked full time, 16.3% worked part time, and 8.2% worked as needed. The majority (65.3%) worked the day shift, followed by 12% working the evening shift.

Generation Y respondents were 20.5% of the sample. Of those, 86.0% were female. Of the 43 nurses in this group, 30.2% were single, 60.5% were married 2.3% were divorced. The age of the respondents ranged from 24 – 31 years (M = 27.2, SD = 1.6). Race / ethnicity of the sample was 86.0% white – non Hispanic, with 9.3% comprising the other groups (African American n=3, 7.0%; Other n=1, 2.3%). The majority of the sample (60.5%) had no children living with them. Yearly household income ranged from $32 - 110 thousand (M = 61.0, SD =
The respondents worked in a variety of clinical settings: medical surgical areas (20.9%), telemetry (4.7%), critical care (20.9%), emergency department (11.6%), and other areas (27.9%). The majority of the sample (83.7%) nurses worked full time, (4.7%) nurses worked part time, and (7%) of the nurses worked as needed. Most Generation Y nurses (53.5%) worked the day shift.

**Description of Variables**

The variables for this study are Generational Cohort, Empowerment, Professional Practice Environment, Incivility, Authentic Leadership, Job Satisfaction, Engagement and Turnover Intention. The variable Empowerment was measured using the Conditions of Work Effectiveness Questionnaire-II (Laschinger et al., 2001a) (Appendix A). The 19 questions that make up this scale are answered in a Likert-type fashion with a scale ranging from 1 = Never to 5 = A Lot. The Empowerment total score is derived from summing the four subscales: Opportunity, Information, Support, Resources. The higher the score, the more indicative of perception of empowerment the nurse feels. For this study, overall Empowerment was calculated at 13.64 (SD = 0.63) (range 6 – 30), higher scores indicating higher rating of empowerment indicating that participants felt they were moderately well empowered in their work environment. The subscale, access to resources, was the lowest score (M = 2.96, SD=0.94) and opportunity the highest score (M = 3.93, SD=0.78). Cronbach’s alpha reliability for this study was calculated at .83 for total empowerment and ranged from 0.69 to 0.86 for the subscales. Table 3 is a presentation of Cronbach’s alpha for this study.

Perception of professional practice environment was measured using The Practice Environment Scale of the Nursing Work Index (Lake, 2002). (Appendix B). This scale consists of 31 Likert-type questions answered on a scale of 1 = strongly agree to 4 = strongly disagree.
(reverse coded). There are five subscales made up of varying numbers of questions. Subscales are scored as a mean of the questions within that group. The Professional Practice total score is calculated as a composite score by taking the mean of the sub-scales (possible range of 1 – 4, higher scores indicating a more professional practice environment). This is done to give equal weight to each of the subscales rather than the individual items. The total Professional Practice score for this study was calculated to be $M = 2.71$ (SD = 0.53). This is similar to Lake (2002) for non-magnet hospitals. Subscales scores for this study ranged from $M = 2.51 – 2.95$ (SD = 0.53 – 0.72). Cronbach’s alpha reliability for this study was calculated at .94 for this study and ranged from 0.79 to 0.87 for the subscales. Table 3 is a presentation for Cronbach’s alpha for this study.

Incivility was measured by the Workplace Incivility Scale (supervisor and co-worker) (Cortina et al., 2001) (Appendix C). This scale consists of 14 Likert-type questions, divided into two parts and answered regarding the subjects Immediate Supervisor and Co-Workers. Ratings for the scale are 1 = Never to 5 = Everyday. Total Incivility scores are calculated by summing the mean of the two subscales (possible range of 1 – 7, higher scores indicating greater incivility). Total Incivility for this study was calculated at $M = 1.43$ (SD = 0.57) indicating respondents reported very low incivility in their work setting. Cronbach’s alpha reliability for this study was calculated at 0.93.

Authentic Leadership was measured using The Authentic Leadership Questionnaire (Avolio et al., 2007) (Appendix D). This scale consist of 16 Likert-type questions answered on a scale of 0 = Not at all to 4 = Frequently, if not always. Subscales are summed and averaged to produce a total score between zero and four. Higher authenticity is represented with the higher scores. There are four subscales that comprise the Authentic Leadership Questionnaire. Total Authentic Leadership scores for this study were calculated at $M = 2.50$ (SD = 1.03) indicating
participants felt moderate levels of leadership in their practice. Subscales ranged from M = 2.35 to 2.69 (SD = 1.05 – 1.17). Cronbach’s alpha reliability for this study was calculated at 0.98. Table 3 is a presentation for Cronbach’s alpha for this study.

Job satisfaction was tested using four questions adapted from Hackman and Oldham’s (1975) Job Diagnostic Survey (Appendix E). The five questions are answered in a Likert-type fashion, 1 = Strongly Disagree to 5 = Strongly Agree. Scores can range from one to five, with higher scores indicate higher satisfaction with one’s job. Total job satisfaction is calculated using the mean of the scores. Total job satisfaction for this study was calculated at M = 3.48 (SD = 1.01) indicating that respondents are moderately satisfied with their job. Cronbach’s alpha Reliability for this study was calculated at 0.91.

Engagement was measured using Utrecht Work Engagement Scale (UWES) short version (Schaufeli et al., 2002) (Appendix F). The scale is comprised of nine questions answered in a Likert-type fashion, with scores ranging from 0 = Never to 5 = Always. Higher scores indicate more engagement in one’s job (scores can range from 0 – 5). Total Engagement is calculated by finding the mean. Total engagement for this study was calculated at M = 3.43 (SD = 0.83) indicating respondents are often engaged in their job. Cronbach’s alpha Reliability for this study was calculated at 0.91.

Intent to leave the organization was measured using four items from the Turnover Intentions measure (Kelloway et al., 1999) (Appendix G). Four questions rated on five-point Likert-type scale ranging from one (strongly disagree) to five (strongly agree) were used. Higher scores reflect the increased likelihood of remaining in the current facility. Turnover intention for this study was M = 2.12 (SD = 1.02) indicating low numbers of respondents who intend to leave their job within the next year. Cronbach’s alpha Reliability for this study was calculated at 0.81.
Table 3: Summary of Cronbach’s Alpha Reliability Results for Variables

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<td>- Information</td>
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Comparison of Variables

The relationship of mean and standard deviation for the entire sample is presented in Table 4.

Table 4: Mean and Standard Deviation for the Entire Sample

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<td>-Balanced Processing</td>
<td>2.69</td>
<td>1.06</td>
<td>0-4</td>
</tr>
<tr>
<td>-Self Awareness</td>
<td>2.43</td>
<td>1.09</td>
<td>0-4</td>
</tr>
<tr>
<td><strong>Job Satisfaction</strong></td>
<td>2.35</td>
<td>1.17</td>
<td>0-4</td>
</tr>
<tr>
<td><strong>Job Satisfaction</strong></td>
<td>3.48</td>
<td>1.01</td>
<td>1-5</td>
</tr>
<tr>
<td><strong>Engagement</strong></td>
<td>3.43</td>
<td>0.83</td>
<td>0-5</td>
</tr>
<tr>
<td><strong>Intent to Leave</strong></td>
<td>2.12</td>
<td>1.02</td>
<td>1-5</td>
</tr>
</tbody>
</table>
The means, standard deviations, F and $p$ values of scales and subscales by generational group are presented in Table 5. Results were analyzed by using a one-way analysis of variance (ANOVA). These results did not indicate any significant difference for scales and subscales by generational groups.

Table 5: Means, Standard Deviation, F and $p$ value of scales and subscales by Generational Group

<table>
<thead>
<tr>
<th>Variable</th>
<th>Baby Boomer n=69</th>
<th>Generation X n=98</th>
<th>Generation Y n=43</th>
<th>F</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mean</td>
<td>SD</td>
<td>mean</td>
<td>SD</td>
<td>mean</td>
</tr>
<tr>
<td><strong>Structural Empowerment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Opportunity</td>
<td>13.83</td>
<td>0.73</td>
<td>13.76</td>
<td>0.54</td>
<td>13.51</td>
</tr>
<tr>
<td>-Information</td>
<td>4.07</td>
<td>0.82</td>
<td>3.84</td>
<td>0.71</td>
<td>4.01</td>
</tr>
<tr>
<td>-Support</td>
<td>3.50</td>
<td>1.10</td>
<td>3.64</td>
<td>0.76</td>
<td>3.38</td>
</tr>
<tr>
<td>-Resources</td>
<td>3.29</td>
<td>0.89</td>
<td>3.30</td>
<td>0.77</td>
<td>3.11</td>
</tr>
<tr>
<td>-Formal Power</td>
<td>2.97</td>
<td>1.01</td>
<td>2.98</td>
<td>0.91</td>
<td>3.01</td>
</tr>
<tr>
<td>-Informal Power</td>
<td>3.13</td>
<td>1.06</td>
<td>3.15</td>
<td>0.84</td>
<td>2.83</td>
</tr>
<tr>
<td></td>
<td>3.50</td>
<td>0.78</td>
<td>3.63</td>
<td>0.69</td>
<td>3.59</td>
</tr>
<tr>
<td><strong>Prof. Practice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Nurse Participation in Hospital Affairs</td>
<td>1.68</td>
<td>0.58</td>
<td>2.79</td>
<td>0.46</td>
<td>2.73</td>
</tr>
<tr>
<td>-Nursing Foundations for Quality of Care</td>
<td>2.49</td>
<td>0.67</td>
<td>2.68</td>
<td>0.59</td>
<td>2.58</td>
</tr>
<tr>
<td>- Nurse Manager Ability, Leadership, and Support of Nurses</td>
<td>2.81</td>
<td>0.57</td>
<td>2.92</td>
<td>0.51</td>
<td>2.88</td>
</tr>
<tr>
<td>-Staffing and Resource Adequacy</td>
<td>2.75</td>
<td>0.71</td>
<td>2.77</td>
<td>0.63</td>
<td>2.67</td>
</tr>
<tr>
<td>-Collegial Nurse-Physician Relations</td>
<td>2.45</td>
<td>0.83</td>
<td>2.63</td>
<td>0.60</td>
<td>2.47</td>
</tr>
<tr>
<td><strong>Workplace Incivility</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Imm. Supervisor</td>
<td>1.40</td>
<td>0.62</td>
<td>1.38</td>
<td>0.45</td>
<td>1.45</td>
</tr>
<tr>
<td>-Co-Worker</td>
<td>1.41</td>
<td>0.64</td>
<td>1.34</td>
<td>0.53</td>
<td>1.41</td>
</tr>
<tr>
<td></td>
<td>1.40</td>
<td>0.60</td>
<td>1.43</td>
<td>0.58</td>
<td>1.49</td>
</tr>
</tbody>
</table>
Table 5: Continued

<table>
<thead>
<tr>
<th>Variable</th>
<th>Baby Boomer</th>
<th>Generation X</th>
<th>Generation Y</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mean 69</td>
<td>mean 98</td>
<td>mean 43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authentic Leadership</td>
<td>mean SD</td>
<td>mean SD</td>
<td>mean SD</td>
<td>F</td>
<td>p</td>
</tr>
<tr>
<td>-Transparency</td>
<td>2.66 1.02</td>
<td>2.55 1.00</td>
<td>2.51 0.89</td>
<td>0.37</td>
<td>0.70</td>
</tr>
<tr>
<td>-Moral / Ethical</td>
<td>2.69 1.05</td>
<td>2.53 1.03</td>
<td>2.55 0.98</td>
<td>0.54</td>
<td>0.59</td>
</tr>
<tr>
<td>-Balanced Process</td>
<td>2.90 1.08</td>
<td>2.72 1.01</td>
<td>2.63 0.90</td>
<td>1.08</td>
<td>0.34</td>
</tr>
<tr>
<td>-Self Awareness</td>
<td>2.52 1.02</td>
<td>2.51 1.08</td>
<td>2.51 0.96</td>
<td>0.00</td>
<td>0.99</td>
</tr>
<tr>
<td></td>
<td>2.47 1.17</td>
<td>2.42 1.11</td>
<td>2.35 1.04</td>
<td>0.16</td>
<td>0.86</td>
</tr>
<tr>
<td>Job Satisfaction</td>
<td>3.58 1.08</td>
<td>3.58 0.96</td>
<td>3.28 0.89</td>
<td>1.60</td>
<td>0.20</td>
</tr>
<tr>
<td>Engagement</td>
<td>3.43 0.86</td>
<td>3.50 0.81</td>
<td>3.38 0.78</td>
<td>0.35</td>
<td>0.71</td>
</tr>
<tr>
<td>Intent to Leave</td>
<td>2.05 1.02</td>
<td>2.03 0.98</td>
<td>2.17 0.99</td>
<td>0.35</td>
<td>0.71</td>
</tr>
</tbody>
</table>

Correlational Analysis

**Entire Group:** Correlations for seven factors in the model were determined using Pearson correlation. Correlation results for the variables are presented in Table 6 for the entire group. All analyses were statistically significant, some in positive and some in a negative manner ($p < 0.0001$). The results indicate a strong linear relationship between job satisfaction and intent to leave, job satisfaction and empowerment, job satisfaction and engagement in one’s job, and empowerment to authentic leadership.
Table 6: Pairwise Pearson Correlation for Seven Factors in the Model (Entire Sample)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean(SD)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Structural Empowerment</td>
<td>3.37(0.63)</td>
<td>1.00</td>
<td>0.60</td>
<td>-0.26</td>
<td>0.64</td>
<td>0.70</td>
<td>0.56</td>
<td>-0.56</td>
</tr>
<tr>
<td>2. Prof. Practice</td>
<td>2.71(0.53)</td>
<td>1.00</td>
<td>-0.16</td>
<td>0.47</td>
<td>0.56</td>
<td>0.45</td>
<td>-0.49</td>
<td></td>
</tr>
<tr>
<td>3. Workplace Incivility</td>
<td>1.44(0.61)</td>
<td>1.00</td>
<td>-0.27</td>
<td>-0.37</td>
<td>-0.21</td>
<td>0.29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Authentic Leadership</td>
<td>2.50(1.03)</td>
<td>1.00</td>
<td>0.61</td>
<td>0.39</td>
<td>-0.54</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Job Satisfaction</td>
<td>3.48(1.01)</td>
<td>1.00</td>
<td>0.63</td>
<td>-0.79</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Engagement</td>
<td>3.43(0.83)</td>
<td>1.00</td>
<td>-0.58</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Intent to Leave</td>
<td>2.12(1.02)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
<td></td>
</tr>
</tbody>
</table>

All correlations are significant at \( p < 0.0001 \)

**Baby Boomers Group:** Correlation results for seven factors in the model for the Baby Boomer group are presented in Table 7. All analyses were statistically significant at various levels, except professional practice to workplace incivility and workplace incivility to engagement in one’s job (\( p > 0.05 \)). Empowerment was strongly correlated with job satisfaction, as well as job satisfaction to intent to leave. Moderate correlation was found in empowerment to professional practice, authentic leadership to intent to leave, authentic leadership to job satisfaction, and job satisfaction to engagement in one’s job.
Table 7: Pairwise Pearson Correlation for Seven Factors in the Model (Baby Boomer Group)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean(SD)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Structural Empowerment</td>
<td>3.41(0.73)</td>
<td>1.00</td>
<td>-0.26</td>
<td>0.75</td>
<td>0.79</td>
<td>0.63</td>
<td>-0.69</td>
<td></td>
</tr>
<tr>
<td>2. Prof. Practice</td>
<td>2.68(0.58)</td>
<td>1.00</td>
<td>-0.02</td>
<td>0.40</td>
<td>0.55</td>
<td>0.41</td>
<td>-0.40</td>
<td></td>
</tr>
<tr>
<td>3. Workplace Incivility</td>
<td>1.40(0.60)</td>
<td>1.00</td>
<td>-0.35</td>
<td>-0.39</td>
<td>-0.10</td>
<td>0.38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Authentic Leadership</td>
<td>2.66(1.02)</td>
<td>1.00</td>
<td></td>
<td>0.73</td>
<td>0.51</td>
<td>-0.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Job Satisfaction</td>
<td>3.58(1.08)</td>
<td>1.00</td>
<td>0.70</td>
<td>-0.81</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Engagement</td>
<td>3.43(0.85)</td>
<td>1.00</td>
<td></td>
<td></td>
<td>-0.63</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Intent to Leave</td>
<td>2.05(1.02)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
<td></td>
</tr>
</tbody>
</table>

a: significant at $p <0.0001$  b: significant at $p <0.001$  c: significant at $p <0.05$  d: not significant

**Generation X Group:** Correlation results for seven factors in the model for Generation X group are presented in Table 8. All analyses were statistically significant at various levels with the exception of workplace incivility to professional practice and workplace incivility to engagement in one’s job ($p > 0.05$). Job satisfaction to intent to leave and structural empowerment to job satisfaction was moderately correlated in Generation X Group. Many of the correlations were poor or weak in their strength.
Table 8: Pairwise Pearson Correlation for Seven Factors in the Model (Generation X Group)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean(SD)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Structural Empowerment</td>
<td>3.42(0.54)</td>
<td>1.00</td>
<td>0.56&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-0.24&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.50&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.62&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.41&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-0.44&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>2. Prof. Practice</td>
<td>2.80(0.46)</td>
<td>1.00</td>
<td>-0.14&lt;sup&gt;d&lt;/sup&gt;</td>
<td>0.46&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.52&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.33&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-0.47&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>3. Workplace Incivility</td>
<td>1.43(0.58)</td>
<td>1.00</td>
<td>-0.30&lt;sup&gt;c&lt;/sup&gt;</td>
<td>-0.36&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-0.13&lt;sup&gt;d&lt;/sup&gt;</td>
<td>0.21&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Authentic Leadership</td>
<td>2.55(1.00)</td>
<td>1.00</td>
<td>0.48&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.21&lt;sup&gt;c&lt;/sup&gt;</td>
<td>-0.34&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Job Satisfaction</td>
<td>3.58(0.96)</td>
<td>1.00</td>
<td>0.58&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-0.72&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Engagement</td>
<td>3.50(0.81)</td>
<td>1.00</td>
<td>-0.55&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Intent to Leave</td>
<td>2.02(0.98)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
</tr>
</tbody>
</table>

a: significant at $p <0.0001$  b: significant at $p <0.001$  c: significant at $p <0.05$  d: not significant

**Generation Y Group:** Correlation results for seven factors in the model for Generation Y group are presented in Table 9. Analyses were statistically significant at various levels with the exception of the following: professional practice to workplace incivility and intent to leave to incivility, engagement to incivility, job satisfaction to incivility, leadership to incivility, and empowerment to incivility ($p > 0.05$). Empowerment was strongly correlated to professional practice environment, as was job satisfaction to intent to leave.
Table 9: Pairwise Pearson Correlation for Seven Factors in the Model (Generation Y Group)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean(SD)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Structural Empowerment</td>
<td>3.32(0.61)</td>
<td>1.00</td>
<td>0.73a</td>
<td>-0.02d</td>
<td>0.62a</td>
<td>0.51b</td>
<td>0.61a</td>
<td>-0.48b</td>
</tr>
<tr>
<td>2. Prof. Practice</td>
<td>2.73(0.51)</td>
<td>1.00</td>
<td>-0.20d</td>
<td>0.65a</td>
<td>0.67a</td>
<td>0.66a</td>
<td>-0.69a</td>
<td></td>
</tr>
<tr>
<td>3. Workplace Incivility</td>
<td>1.49(0.65)</td>
<td>1.00</td>
<td>-0.03d</td>
<td>-0.19d</td>
<td>-0.11d</td>
<td>0.26d</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Authentic Leadership</td>
<td>2.51(0.89)</td>
<td>1.00</td>
<td>0.42c</td>
<td>0.51b</td>
<td>-0.47b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Job Satisfaction</td>
<td>3.28(0.89)</td>
<td>1.00</td>
<td>0.58a</td>
<td>-0.86a</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Engagement</td>
<td>3.38(0.78)</td>
<td>1.00</td>
<td>-0.67a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Intent to Leave</td>
<td>2.17(0.99)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a: significant at p <0.0001  b: significant at p <0.001  c: significant at p <0.05  d: not significant

Model Results

Entire Group

Data were analyzed using Proc CALIS in SAS (SAS, 2011). Table 10 represents Goodness of Fit Indices for the initial model, revised models, and final model for the entire group. The results showed that the initial model had a very poor fit for all indices. To improve the model, first the path coefficients were reviewed to examine if any of the paths could be eliminated. Second, a large range of multiplier tests were used to improve the model by adding a path.
Table 10: Goodness of Fit Indices for Initial Models and Final Model for Entire Group

<table>
<thead>
<tr>
<th>Model</th>
<th>Chi square</th>
<th>Df</th>
<th>Chi/df</th>
<th>p-value</th>
<th>CFI</th>
<th>NFI</th>
<th>NNFI</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical Model</td>
<td>253.52</td>
<td>13</td>
<td>19.5</td>
<td>&lt;0.0001</td>
<td>0.72</td>
<td>0.71</td>
<td>0.54</td>
<td>0.19</td>
</tr>
<tr>
<td>Revised Model 2</td>
<td>185.23</td>
<td>12</td>
<td>15.4</td>
<td>&lt;0.0001</td>
<td>0.80</td>
<td>0.79</td>
<td>0.64</td>
<td>0.15</td>
</tr>
<tr>
<td>Revised Model 3</td>
<td>174.11</td>
<td>11</td>
<td>15.8</td>
<td>&lt;0.0001</td>
<td>0.81</td>
<td>0.80</td>
<td>0.63</td>
<td>0.13</td>
</tr>
<tr>
<td>Revised Model 4</td>
<td>139.94</td>
<td>10</td>
<td>14.0</td>
<td>&lt;0.0001</td>
<td>0.85</td>
<td>0.84</td>
<td>0.68</td>
<td>0.09</td>
</tr>
<tr>
<td>Final Model</td>
<td>140.32</td>
<td>11</td>
<td>12.8</td>
<td>&lt;0.0001</td>
<td>0.84</td>
<td>0.84</td>
<td>0.71</td>
<td>0.09</td>
</tr>
</tbody>
</table>

CFI (Comparative Fit Index) (0.90 or greater better)  
NFI (Normed Fit Index) (0.90 or greater better)  
NNFI (Non-normed Fit Index) (0.90 or greater better)  
RMSEA (Root mean Square error of approximation) (less than 0.05 is better and above 0.1 is poor)

The hypothesized model did not initially fit well with the data derived in the sample (X²=253.52, df=13, CFI=0.72, NFI=0.71, NNFI=0.54, RMSEA=0.19). There is controversy in the literature regarding which fit indices provide the best information. For this reason, it is best to look at a variety of them, attempting to find the best overall fit. Results for comparative fit index (CFI), normed fit index (NFI), and non-normed fit index (NNFI) are acceptable at 0.90 or greater. None of the results for the initial model were acceptable. Additionally, the root mean square error of approximation should be less than 0.05 with anything above a 0.1 being poor. The initial model was 0.19, a poor fit. Lower chi square with higher degrees of freedom is more desirable as well. The model was then re-run adding the link of empowerment to job satisfaction, as this relationship is well studied in the literature. This resulted in a poor fit as well (X²=185.23, df=12, CFI=0.80, NFI=0.79, NNFI=0.64, RMSEA=0.15), but the fit indices were improving, and chi square decreased. Laschinger, et el. (2009c) established a relationship between empowerment
and engagement, so a third run of the model linked empowerment to engagement in one’s job. This resulted in a similar poor fit as model 2 ($X^2=174.11$, df=11, CFI=0.81, NFI=0.80, NNFI=0.63, RMSEA=0.13). The fourth run of the model linked empowerment to intent to leave, which has been linked in the literature. This resulted in a better fit ($X^2=139.94$, df=10, CFI=0.85, NFI=0.84, NNFI=0.68, RMSEA=0.09). In this model, incivility and professional practice environment were not at a significant level. The final model eliminated this non-significant link from professional practice to incivility in the workplace, linked empowerment to job satisfaction, engagement and intent to leave, resulting in the best fit. The best fit for the final model for the entire group is summarized in Figure 3.

![Figure 3: Final Model-Entire Group](image-url)
**Baby Boomers Group**

Data were analyzed using Proc CALIS in SAS (SAS, 2011). Table 11 represents Goodness of Fit Indices for the initial model, revised models, and final model for the Baby Boomers group. The results showed that the initial model had a very poor fit for all indices. To improve the model, first the path coefficients were reviewed to examine if any of the paths could be eliminated. Second, a large range of multiplier test was used to improve the model by adding a path.

<table>
<thead>
<tr>
<th>Model</th>
<th>Chi-square</th>
<th>Df</th>
<th>Chi/df</th>
<th>p-value</th>
<th>CFI</th>
<th>NFI</th>
<th>NNFI</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical Model</td>
<td>86.25</td>
<td>13</td>
<td>6.6</td>
<td>&lt;0.0001</td>
<td>0.75</td>
<td>0.73</td>
<td>0.60</td>
<td>0.17</td>
</tr>
<tr>
<td>Revised Model 2</td>
<td>59.44</td>
<td>12</td>
<td>5.0</td>
<td>&lt;0.0001</td>
<td>0.84</td>
<td>0.81</td>
<td>0.72</td>
<td>0.14</td>
</tr>
<tr>
<td>Revised Model 3</td>
<td>58.12</td>
<td>11</td>
<td>5.3</td>
<td>&lt;0.0001</td>
<td>0.84</td>
<td>0.82</td>
<td>0.70</td>
<td>0.13</td>
</tr>
<tr>
<td>Revised Model 4</td>
<td>39.56</td>
<td>10</td>
<td>4.0</td>
<td>&lt;0.0001</td>
<td>0.90</td>
<td>0.88</td>
<td>0.79</td>
<td>0.09</td>
</tr>
<tr>
<td>Final Model</td>
<td>40.68</td>
<td>11</td>
<td>3.7</td>
<td>&lt;0.0001</td>
<td>0.90</td>
<td>0.87</td>
<td>0.81</td>
<td>0.07</td>
</tr>
</tbody>
</table>

CFI (Comparative Fit Index) (0.90 or greater better)  
NFI (Normed Fit Index) (0.90 or greater better)  
NNFI (Non-normed Fit Index) (0.90 or greater better)  
RMSEA (Root mean Square error of approximation) (less than 0.05 is better and above 0.1 is poor)

The hypothesized model did not initially fit well with the data derived in the sample \( X^2 = 86.25 \), df=13, CFI=0.75, NFI=0.73, NNFI=0.60, RMSEA=0.17). CFI, NFI, NNFI, and RMSEA were all in the poor range. As stated, empowerment has been well linked to job satisfaction in the literature. The model was re-run adding the link of empowerment to job satisfaction. This
resulted in a better fit ($X^2=59.44$, df=12, CFI=0.84, NFI=0.81, NNFI=0.72, RMSEA=0.14). In an attempt to improve the fit, a third run of the model was done. Empowerment was linked to engagement in one’s job, which produced similar results to model 2 ($X^2=58.12$, df=11, CFI=0.84, NFI=0.82, NNFI=0.70, RMSEA=0.13). The CFI, NFI, NNFI and RMSEA were all approaching acceptable levels however in an attempt to decrease chi squared the model was re-run. The fourth run of the model linked empowerment to intent to leave, which resulted in a better fit ($X^2=39.56$, df=10, CFI=0.90, NFI=0.88, NNFI=0.79, RMSEA=0.09). The link between professional practice environment and incivility was not significant due to the t-value less than 1.96. The final run of the model for the Baby Boomer group was the same as for the entire group, the removal of the link between professional practice environment and incivility, and linking empowerment to job satisfaction, empowerment to engagement in one’s job, and empowerment to intent to leave ($X^2=40.68$, df=11, CFI=0.90, NFI=0.87, NNFI=0.81, RMSEA=0.07). The best fit for the final model for the Baby Boomer group is summarized in Figure 4.
Data were analyzed using Proc CALIS in SAS (SAS, 2011). Table 12 represents Goodness of Fit Indices for the initial model, revised models, and final model. The results showed that the initial model had a very poor fit for all indices. To improve the model, first the path coefficients were
reviewed to examine if any of the paths could be eliminated. Second, a large range of multiplier test was used to improve the model by adding a path.

Table 12: Goodness of Fit Indices for Initial Models and Final Model for Generation X Group

<table>
<thead>
<tr>
<th>Model</th>
<th>Chi square</th>
<th>Df</th>
<th>Chi/df</th>
<th>p-value</th>
<th>CFI</th>
<th>NFI</th>
<th>NNFI</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical Model</td>
<td>81.56</td>
<td>13</td>
<td>6.3</td>
<td>&lt;0.0001</td>
<td>0.70</td>
<td>0.68</td>
<td>0.52</td>
<td>0.19</td>
</tr>
<tr>
<td>Revised Model 2</td>
<td>55.97</td>
<td>12</td>
<td>4.7</td>
<td>&lt;0.0001</td>
<td>0.81</td>
<td>0.78</td>
<td>0.67</td>
<td>0.14</td>
</tr>
<tr>
<td>Revised Model 3</td>
<td>55.33</td>
<td>11</td>
<td>5.03</td>
<td>&lt;0.0001</td>
<td>0.81</td>
<td>0.78</td>
<td>0.63</td>
<td>0.13</td>
</tr>
<tr>
<td>Revised Model 4</td>
<td>46.96</td>
<td>10</td>
<td>4.7</td>
<td>&lt;0.0001</td>
<td>0.84</td>
<td>0.81</td>
<td>0.66</td>
<td>0.09</td>
</tr>
<tr>
<td>Final Model</td>
<td>47.61</td>
<td>11</td>
<td>4.3</td>
<td>&lt;0.0001</td>
<td>0.84</td>
<td>0.81</td>
<td>0.70</td>
<td>0.10</td>
</tr>
</tbody>
</table>

CFI (Comparative Fit Index) (0.90 or greater better)  
NFI (Normed Fit Index) (0.90 or greater better)  
NNFI (Non-normed Fit Index) (0.90 or greater better)  
RMSEA (Root mean Square error of approximation) (less than 0.05 is better and above 0.1 is poor)

The hypothesized model did not initially fit well with the data derived in the sample (X²=81.56, df=13, CFI=0.70, NFI=0.68, NNFI=0.52, RMSEA=0.19). Similar to the initial model for the entire group and Baby Boomer group, the CFI, NFI, NNFI, and RMSEA were all in the poor range. The model was then re-run adding the link of empowerment to job satisfaction. As discussed this link is well established in the literature. This resulted in a better fit (X²=55.97, df=12, CFI=0.81, NFI=0.78, NNFI=0.67, RMSEA=0.14). Attempting to achieve the best fit possible, the model was run for a third time, linking empowerment to engagement in one’s job, which produced similar results to model 2 (X²=55.33, df=11, CFI=0.81, NFI=0.78, NNFI=0.63, RMSEA=0.13). As in the previous groups, the model was re-run for a fourth run time, linking empowerment to intent to leave, which resulted in a better fit (X²=46.96, df=10, CFI=0.84,
NFI=0.81, NNFI=0.66, RMSEA=0.09). The final run of the model for the Generation X group was empowerment linked to job satisfaction, empowerment linked to engagement in ones’ job and empowerment linked to intent to leave. Additionally, the link between professional practice and incivility was not significant and was removed. The best fit was obtained with this run of the model ($X^2=47.61$, df=11, CFI=0.84, NFI=0.81, NNFI=0.70, RMSEA=0.10). The final model for the Generation X group is summarized in Figure 5.

Figure 5: Final Model-Generation X Group
**Generation Y Group**

Data were analyzed using Proc CALIS in SAS (SAS, 2011). Table 13 represents Goodness of Fit Indices for the initial model, revised models, and final model. The results showed that the initial model had a very poor fit for all indices. To improve the model, first the path coefficients were reviewed to examine if any of the paths could be eliminated. Second, a large range of multiplier test was used to improve the model by adding a path.

Table 13: Goodness of Fit Indices For Initial Models and Final Model for Generation Y Group

<table>
<thead>
<tr>
<th>Model</th>
<th>Chi square</th>
<th>Df</th>
<th>Chi/df</th>
<th>p-value</th>
<th>CFI</th>
<th>NFI</th>
<th>NNFI</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical</td>
<td>79.43</td>
<td>13</td>
<td>6.11</td>
<td>&lt;0.0001</td>
<td>0.60</td>
<td>0.57</td>
<td>0.35</td>
<td>0.245</td>
</tr>
<tr>
<td>Revised</td>
<td>73.83</td>
<td>12</td>
<td>6.15</td>
<td>&lt;0.0001</td>
<td>0.63</td>
<td>0.60</td>
<td>0.35</td>
<td>0.21</td>
</tr>
<tr>
<td>Revised</td>
<td>64.48</td>
<td>11</td>
<td>5.7</td>
<td>&lt;0.0001</td>
<td>0.68</td>
<td>0.65</td>
<td>0.38</td>
<td>0.15</td>
</tr>
<tr>
<td>Revised</td>
<td>64.77</td>
<td>11</td>
<td>5.9</td>
<td>&lt;0.0001</td>
<td>0.68</td>
<td>0.65</td>
<td>0.38</td>
<td>0.15</td>
</tr>
<tr>
<td>Final</td>
<td>65.47</td>
<td>12</td>
<td>5.5</td>
<td>&lt;0.0001</td>
<td>0.67</td>
<td>0.65</td>
<td>0.43</td>
<td>0.15</td>
</tr>
</tbody>
</table>

CFI (Comparative Fit Index) (0.90 or greater better)  
NFI (Normed Fit Index) (0.90 or greater better)  
NNFI (Non-normed Fit Index) (0.90 or greater better)  
RMSEA (Root mean Square error of approximation) (less than 0.05 is better and above 0.1 is poor)

The hypothesized model did not initially fit well with the data derived in the sample ($X^2$=79.43, df=13, CFI=0.60, NFI=0.58, NNFI=0.35, RMSEA=0.25). The model was then re-run similar to what was done for the prior groups. In this run of the model, the link from empowerment to job satisfaction was added. This resulted in a slightly better fit ($X^2$=73.83, df=12, CFI=0.63, NFI=0.61, NNFI=0.35, RMSEA=0.21), but one that was not acceptable. In the third run of the model, empowerment was linked to engagement in one’s job, which produced similar results to
model 2 ($\chi^2=64.48$, df=11, CFI=0.69, NFI=0.78, NNFI=0.63, RMSEA=0.13). The fourth run of the model removed the link between authentic leadership and job satisfaction which resulted in about the same fit as model 3 ($\chi^2=64.77$, df=11, CFI=0.68, NFI=0.65, NNFI=0.38, RMSEA=0.14). The final run of the model for the Generation X group was empowerment linked to intent to leave, resulting in a poor fit ($\chi^2=65.47$, df=12, CFI=0.68, NFI=0.65, NNFI=0.44, RMSEA=0.10). The low sample size for generation Y group is now allowing good indices of fit.

Figure 6: Final Model-Generation Y Group
Summary of Overall Findings

A model hypothesizing the effect of generational differences related to empowerment, professional practice environment, incivility in the workplace, authentic leadership and their relationships to job satisfaction, engagement in one’s job and intent to leave was tested using SEM. Model fit indices and path coefficients provided support for the majority of theorized relationships among variables in the model to some extent. No generational differences were detected in the model. Nurses who felt more empowered, rated their professional practice as high, felt little to no incivility in their work environment, and felt like their leaders were authentic had higher levels of job satisfaction, were more engaged in their job and had less intent to leave.
Chapter 5

Discussion

This chapter provides a discussion of the findings, a summary of the study, application to theory, the significance of contribution to the science of nursing and recommendations for future research. This study was done to examine nurses' perceptions of empowerment, professional practice environment, authentic leadership and incivility related to job satisfaction, engagement in one’s job and intent to leave the acute care setting and how generational differences are related to these variables. The intention of the study was to generate knowledge related to generational differences in acute care nurses. Nurses are a vital part of the healthcare system. Retention of nurses is essential for organizations. It is costly for organizations to hire and train new nurses. Keeping nurses satisfied in their position and engaged in their job are important factors in their remaining with the organization and in healthcare. A cross-sectional design was used to test the hypothesized relationships between the variables. Data were collected from a sample of 210 nurses working in the hospital setting who returned a self-report survey.

Discussion of the Findings

The majority of studies examining nursing empowerment have not focused on generational differences and how those differences affect job satisfaction and retention of nurses. All the variables have been studied in the literature, but no studies could be found that linked the variables as in the hypothesized model. Generational studies are found in the literature indicating that differences exist among the cohorts, but there is a lack of information how those differences affect nurses. Nurses working in an organization are exposed to similar factors, yet their perception of empowerment, authentic leadership and incivility can be vastly different.
I did not detect differences in the selected variables among the generational groups in this study. The results confirm a model that gives important roles to empowerment, professional values and authentic leadership within nursing. The analysis confirms that perception of empowerment is strongly related to job satisfaction, engagement and intent to leave.

Sample:

The sample for this study was randomly selected from all registered nurses employed in the acute care setting in the east Tennessee area. The demographic data indicated that the sample was similar in age, gender and ethnicity when compared to the national data provided by National Sample of Registered Nurses Survey (Heath Resources and Services Administration (HRSA), 2008). The participants in this study were primarily female. There were 12.9% males, slightly higher than the 8.8% reported by Kovner et al. (2007), but similar to the 13 – 18% range found by Seldomridge and DiBartolo (2007), and 9.6% reported by HRSA (2008). The percentage of males being slightly higher to national averages can be attributed to the increase in males in the nursing profession. According to the United States Census Bureau, males in Nursing have tripled in the past 40 years, from 2.6% the 1970s to 9.6% in 2011 (US Census Bureau, 2013). East Tennessee has a large number of nursing schools in the area, and there are more males entering the nursing profession now than in the past.

Minorities represented only 2 – 6 % of the sample. Although this is not consistent with the nationally reported minority rates of 18.2% (HRSA, 2008), this is not that unusual for the demographic area that was sampled. The rural East Tennessee area is not as ethnically diverse as some larger, more urban areas of the United States. The mean age for the current study was 44.8 years (SD = 12.1), similar to the national average of 46 years (HRSA, 2008) for all nurses. For the current study, 72.4% reported being married, similar to national rates of 74% (HRSA, 2008).
Consistent with national average of 58.6% (HRSA, 2008), the majority of the sample (57.1%) had a bachelor’s degree in nursing or higher (HRSA, 2008). Generational groups within the study were similar in demographics to the sample as a whole.

**Generational Groups:**

For this study, 210 nurses were included in the sample. Of those, 69 were Baby Boomers (birth years 1943 – 1960), 98 were Generation X (birth years 1961 – 1981), and only 43 were Generation Y (born after 1981). This is consistent with prior findings supporting Generation X as the largest cohort in the current workforce (McNeese-Smith & Crook, 2003; Stuenkel et al., 2005). It is also consistent with other generational studies that had low enrollment of Generation Y nurses. Leiter et al. (2010) conducted a study of generational differences in distress, attitudes and incivility within nursing. Their sample consisted of 522 Canadian nurses. They removed the Generation Y cohort from their sample due to few response rates (n=35).

The current study was sampled by mail through the United States postal service. Generation Y cohort is more familiar with technological advances and, in fact, have grown up using computers. They are known as the “Internet” generation (Stanley, 2010). The delivery of the surveys through the postal service may have contributed to a low response rate from the Generation Y cohort in the current study. Use of online surveys could produce more participants in the Generation Y cohort. A study of Generation Y that incorporated both online and mailed surveys could add to the understanding about this response rate.

No significant differences were detected in the variables selected for the current study among generational groups. This is in contrast to the findings of Leiter et al. (2009; 2010) that revealed differences between generational groups. Leiter et al. (2010) found generational differences in distress, attitudes and incivility among nurses. Generation X nurses had more
symptoms of burnout, and were more inclined to change jobs when compared to Baby Boomers. Leiter et al. (2009) found differences between Baby Boomers and Generation X’ers when they compared the variables of burnout, turnover intention, control, value congruence and knowledge sharing. They found that, as compared to Baby Boomers, Generation X nurses experienced greater incivility from both coworkers and supervisors.

The current study included participants from a large variety of organization types spanning 16 counties. Both the size of the organization (rural to level one trauma) and the organizational characteristics can change the levels of perceived empowerment, authentic leadership, incivility, and job satisfaction. Only one local hospital that employed nurses in the sample is Magnet designated. Those nurses may have a different perception of the variables simply because of the differences in organizational cultures seen in Magnet organizations. Characteristics of the work environment in Magnet organizations are perceived to be better in empowering the nurse, providing a professional practice setting with authentic leadership (Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2007).

**Empowerment**

Empowerment within this study was measured by using the Conditions of Work Effectiveness Questionnaire-II (Laschinger et al., 2001a) (Appendix A). Empowerment for the study was calculated at $M = 13.64$ (SD = 0.63). Laschinger classifies scores of 10 – 14 as moderate level of empowerment. These findings are consistent with other studies using the same tool (Laschinger, 1996; Laschinger et al., 2009; Sarmiento et al., 2004). Empowerment scores are categorized into low, moderate or high levels. Scores are dependent on nurses’ perception and organizations’ ability to provide opportunity, information, support and resources that the nurses require. The higher the score, the more indicative of perception of empowerment the
nurse feels. Total empowerment is calculated from the four subscales: opportunity, information, support and resources. The access to resources subscale was the lowest score (M = 2.96, SD=0.94). This subscale is made up of questions related to time to accomplish paperwork, job requirements and back-up help when needed. Low rating is consistent with nurses reporting not enough time to complete their work. Access to resources has been the weakest empowerment factors as reported in a series of studies examining empowerment in the workplace from 1992 – 2008 (Laschinger, 2004; DeCicco et al., 2008).

The highest subscale for the current study was opportunity (M = 3.93, SD=0.78). This subscale has questions such as challenging work, gaining new skills and knowledge and use of own skills. Many hospitals in the East Tennessee area offer education reimbursement to nurses. Nurses are able to challenge themselves in their job, seeking new opportunities and growth. The results for this study are consistent with findings in the literature. Access to opportunity has been the strongest factors in a series of studies examining empowerment in the workplace that Laschinger (2004) has done in her research.

Cronbach’s alpha reliability for this study was calculated at .83 for total empowerment and ranged from 0.69 to 0.86 for the subscales. This is comparable to other reports in the literature, citing total scale scores 0.80, subscales 0.71 – 0.85 (Faulkner & Laschinger, 2008) and subscales ranging from 0.78 – 0.93 (Manojlovich & Laschinger, 2002).

**Perception of Professional Practice**

Perception of professional practice environment for this study was measured using The Practice Environment Scale of the Nursing Work Index (Lake, 2002). (Appendix B). This tool consists of five subscales that ask about different involvement in the nursing practice: nurse participation in hospital affairs, nursing foundations for quality of care, nurse manager ability,
staff and resources and nurse-physician relationship. Scores for this study were $M = 2.71$ (SD = 0.53) and ranges of $M = 2.51$ (SD = 0.71) to $M = 2.95$ (SD = 0.63) for the subscales. This is slightly higher than findings by Laschinger et al. (2009a). Their study was based on new graduate nurses only, linking burnout to professional practice environment, workplace civility and empowerment. The new graduate nurse population could have accounted for their slightly lower scores. The means in the current study were also slightly higher than those obtained by Laschinger and Leiter (2006) linking nursing work environments to patient safety outcomes. Armstrong and Laschinger (2006) looked at Magnet hospital characteristics and patient safety culture and found slightly lower results for the overall score than the current study. Nurses in the sample reported higher perceptions of professional practice environments. One of the largest nursing organizations in the sample has achieved Magnet Status. As mentioned, organizations that have achieved Magnet designation often have higher levels of perception of empowerment and professional practice environments (Ulrich et al., 2007).

Reliability for the Perception of Professional Practice for current study was 0.94 total score and 0.79 – 0.88 for the subscales, indicating the current study had good - excellent reliability. Cronbach’s alpha reliability for previous studies ranges form 0.65 – 0.84 (Armstrong & Laschinger, 2006; Lake, 2002; Laschinger & Leiter, 2006; Laschinger et al., 2009a).

**Incivility**

Incivility was measured by the Workplace Incivility Scale (supervisor and co-worker) (Cortina, et al., 2001) (Appendix C). The scale is divided into two sections, one for supervisor and one for co-worker. Scores for the current study were low ($M = 1.43$, SD = 0.57). This is considerably lower than other findings in the literature. Laschinger et al. (2009a) reported values that were more midlevel ($M = 3.67$, SD = 0.88). Their sample consisted only of new graduate
nurses, which could account for some of the difference. Nurses who have been in practice longer are less likely to tolerate incivility. New graduate nurses want to fit in, and are more often targeted by uncivil behaviors. Laschinger et al. (2009b) described results similar to the current study, even suggesting less incivility ($M = 0.66$, $SD = 0.89$ supervisor) ($M = 0.81$, $SD = 0.82$ coworker). Like their study, the current study results had varying amounts of incivility reported, with most nurses reporting some form of incivility from time to time. It seems consistent between both studies that only a small percentage reported incivility at high levels on a consistent base. As noted by Laschinger et al., (2009b) this is contrary to the numerous anecdotal reports that can be found in the literature reporting high levels of incivility in health care settings. Smith et al., (2010) also found incivility means consistent with the current study ($M = 1.69$, $SD = 0.53$ coworker, and $M = 1.50$, $SD = 0.56$ supervisor). This further suggests that incivility may be not as prevalent or consistent as previously thought.

Internal consistency was calculated for the current study using Cronbach’s alpha. An alpha of 0.93 is consistent with values previously reported in the literature (Cortina et al., 2001; Laschinger et al., 2009b; Smith et al., 2010).

**Authentic Leadership**

Authentic Leadership was measured using The Authentic Leadership Questionnaire (Avolio et al., 2007) (Appendix D). The tool consists of four subscales: transparency of the leader, moral and ethical beliefs of the leader, balanced processing and self-awareness. Scores for this study were calculated at $M = 2.50$ ($SD = 1.03$) indicating nurses felt moderate levels of authentic leadership in their practice. Subscales ranged from $M = 2.35$ to $2.69$ ($SD = 1.05 – 1.17$). Similar results were found ($M 2.35$, $SD = 0.99$) by Wong et al., (2010) when they researched authentic leadership and nurses’ voice behavior and perceptions of care quality.
Authentic leadership has not been well studied in healthcare. Nurse managers play a key role in work environments, but there is limited knowledge on how nurse leaders influence nurse attitudes and outcomes (Wong et al., 2010). Leadership has the ability to affect staff nurses by increasing resources, capability, information and opportunities (Leiter & Laschinger, 2006). The current study indicated moderate levels, but what remains unclear is what affects those scores and how the leader impacts feelings of empowerment, and professional practice environments.

Cronbach’s alpha reliability for this study was calculated at 0.98. This is also similar to the Wong et al. (2010) study where they reported reliability value of 0.97.

**Job Satisfaction**

Job satisfaction was tested using four questions adapted from Hackman and Oldham’s (1975) Job Diagnostic Survey (Appendix E). Total job satisfaction for this study was calculated at $M = 3.48$ (SD = 1.01) indicating that respondents are moderately satisfied with their job. This is similar to the Sarmiento, et al. (2004) study looking at nurse educators’ workplace empowerment, burnout, and job satisfaction: testing Kanters’ theory. Nurse educators were only somewhat satisfied with their jobs ($M = 3.33$, SD = 0.85). Italian mental health nurses were surveyed and reported their job satisfaction levels $M = 2.39$ (SD = 0.83) (Lautizi et al., 2009). Within Laschinger’s work, the link between empowerment and job satisfaction has been well established. In Sarmiento et al. (2004) and Lautizi et al. (2009) empowerment scores were relatively low, indicative of low job satisfaction scores. Current empowerment scores for this study were moderate, with a moderate job satisfaction score.

Cronbach’s alpha for this study was calculated at 0.91. This is higher than is found in the literature 0.83 (Laschinger & Haven, 1996), 0.82 (Sarmiento et al., 2004), 0.67 (Lautizi et al., 2009).
Engagement

Engagement was measured using Utrecht Work Engagement Scale (UWES) short version (Schaufeli et al., 2002) (Appendix F). Total engagement for this study was calculated at M = 3.43 (SD = 0.83) indicating respondents are often engaged in their job. Laschinger et al. (2009c) used the UWES linking empowerment, engagement and perceived effectiveness in nursing work environments. Scores for their study were similar to this current study, ranging from M = 3.7 (SD = 0.87) to M = 4.8 (SD = 0.85). This suggests that moderately empowered nurses are often engaged in their job.

Cronbach’s alpha reliability for this study was calculated at 0.91. This is consistent with the literature where the reliability ranges from 0.87 – 0.92 (Laschinger et al., 2009c).

Intent to Leave

Intent to leave the organization was measured using four items from the Turnover Intentions measure (Kelloway et al., 1999) (Appendix G). Turnover intention for this study was M = 2.12 (SD = 1.02) indicating low numbers of respondents intend to leave their job within the next year. Laschinger (2012) found similar results in her study (M = 2.72, SD = 1.26), linking job and career satisfaction to turnover intentions of newly graduated nurses. Nurses that are satisfied in their job are less likely to leave their job (Sarmiento et al., 2004).

Cronbach’s alpha for this study was calculated at 0.81. This is consistent with another study in the literature (0.87) (Laschinger, 2012).

Specific Aims and Hypotheses

Research questions one through four explored the generational differences in the nurses’ perception of empowerment, professional practice environments, authentic leadership, supervisor and co-worker incivility, job satisfaction, engagement in their job and their intent to remain in
their current position. The hypotheses were stated “nurses would have a difference in empowerment, professional practice environment, authentic leadership, incivility, job satisfaction, engagement and turnover intention related to generational differences”. If this was found, it would indicate that depending on the generational cohort that nurses belonged to, they would have different relationships among the variables. The hypotheses were rejected and the null hypotheses were accepted. For the current study, there were no significant generational differences detected. There were significant correlations between the variables depending on which generational cohort was being tested. Hypothesis 5 was testing of the relationship between the variables.

The framework for empowerment as identified by Kanter (1993) is the relation of the six conditions that interact to form empowerment: opportunity, information, support, resources, formal and informal power. These factors influence behaviors and responses to the work environment. It is the nurses’ perception of these six areas that lead to feelings of empowerment. As empowerment increases, (more opportunity, information, support, and access to resources) the nurses’ job satisfaction increases. In the current study, nurses expressed moderate feelings of empowerment and moderate satisfaction in their job. This is consistent with studies in the literature. Numerous studies have linked empowerment to job satisfaction in multiple areas of nursing (Lautizi, Laschinger, & Ravazzolo, 2009). The results add to this knowledge by demonstrating the positive link between empowerment and job satisfaction ($r = .70$). In studies where empowerment is stronger, job satisfaction is also found to be stronger.

Job satisfaction is strongly correlated as a significant predictor of nurses’ intentions to leave their workplace ($r = -0.79$). As nurses are more empowered, their job satisfaction increases,
and therefore they are less likely to want to leave their job. This finding supports the evidence in the literature as well.

Weak relationships were found among incivility and all other variables. This is consistent with findings in other studies that suggest that incivility, although present, may not be as much a problem as thought. Laschinger et al. (2009a) found similar findings in their new graduate population, reporting that a wide variation of levels were reported, with only 16.5% agreeing with the statement of “a lot” of conflict among nurses on the unit. Smith et al. (2010) reported that a large percent of nurses report some degree of incivility, overall low-levels of incivility were reported low (M = 1.50, SD = 0.56). This does not suggest that episodes of incivility do not occur, however, it may not be as widespread and consistent as previously thought, or it is minimized and not defined as uncivil behaviors.

Variables had similar correlational values for the Baby Boomer group. Empowerment to job satisfaction \( (r = 0.79) \) and job satisfaction to turnover \( (r = -0.81) \) both had a stronger correlation than in the entire group, further supporting the discussion above. Additionally in this group, empowerment was strongly correlated to authentic leadership \( (r = 0.75) \). This builds on the Wong et al. (2010) study. Authentic leaders can guide and build healthier work environments which in turn are linked to empowering environments.

Within the Baby Boomer group, incivility was found to not be a significantly associated with engagement and professional practice. Means and standard deviations for this group related to incivility were not found to be different from the other generational cohorts. This further supports that incivility may not be as prevalent as a problem, or nurses are not willing to report uncivil acts.
Generation X was the largest of the cohorts, and had similar correlations to the entire sample and Baby Boomer group. The differences within this cohort were the correlations were not as strong. The strongest correlation was job satisfaction to turnover intention. Incivility was found to not be significant to professional practice or to engagement in one’s job.

Generation Y was the smallest of the cohorts in this study, with only 43 respondents. The relationships between incivility and other variables were not significant. In the past, newer nurses have reported difficult transitions as they begin nursing. The current study results do not support this, all cohorts reported low incivility. This could be due to social desirability bias in answering this type of survey. This occurs when respondents answer the way they think they should to be viewed favorably by others (Nederhof, 1985).

The relationship between job satisfaction and turnover intention was strongly correlated in this group as well. This further validates the relationship between higher job satisfaction and lower turnover intentions (Laschinger et al., 2009b).

**Testing the Model**

A model was derived from a review of the literature which integrated Generational Theory and Theory of Structural Power in Organizations combined with practice experience relevant to the variables. For all groups the initial theorized models did not produce acceptable Goodness of Fit Indices. To improve the model path coefficients were reviewed to determine if paths could be eliminated and multiplier test were used to improve the model by adding paths.

In the final model for the entire group, Baby Boomer, and Generation X all showed an empowering practice environment, with low levels of incivility and high levels of leadership were significant predictors of job satisfaction. All models provided a satisfactory Goodness of Fit. Empowerment was also strongly linked with professional practice environment. The link
between professional practice environment and incivility was not significant \( (t < 1.96) \) and the path was removed. Empowerment was also significantly linked directly to job satisfaction, engagement and turnover intention. This is consistent with findings in the literature. Empowerment has been linked both directly and indirectly to job satisfaction and commitment (Laschinger et al., 2009b).

The hypothesized model for Generation Y was a poor fit, and subsequent models did not produce an acceptable Goodness of Fit. This may be a result of the low numbers of respondents in this group. There were not sufficient numbers to adequately run the model, therefore the results were inappropriate.

**Limitations**

Potential participants may be missing from the sample due to inaccurate mailing addresses. Response bias may be present in self-report questionnaires (Polit & Beck, 2008). Low response rates, especially for the Generation Y group limit the amount of generalization the results can have. It may not be reasonable to assume that the respondents who returned the survey were typical of the overall sample. Despite these limitations, the final sample was adequate to provide a representation of the nurses in the east Tennessee area. Support for the theoretical predictions offsets the limitations to generalizability to some extent (Laschinger et al., 2001b).

Nurses in this study reported low levels of incivility. It is possible that the measurement used was not sensitive to the full phenomena of incivility. It is also possible that the definition of incivility was not clear to the nurses who were surveyed. Nurses may be reluctant to report uncivil behaviors, fearing retaliation.
Structural equation modeling is a statistical technique that allows data to be analyzed from a cross-sectional design for the purpose of theory testing. The downside to this analysis is it only allows for a theory-driven relationship as specified in the model (Grapentine, 2000). The relationships for the current study were based on theoretical and empirical support, but there is not a way to determine the cause of the relationships.

**Implications**

The results offer strong support for Kanter’s theory. To increase perceptions of structural empowerment, authentic leadership and professional practice environment, administrators and organizations need to find ways to create work environments that support nurses. Work environments that are characterized by strong empowerment factors, authentic leadership and a professional practice environment create a practice setting that promotes job satisfaction and decreased the likelihood that the nurse will leave.

To increase the perception of empowerment, organizations can incorporate the four subscales into the organizational culture. Nurses in this study perceived the empowerment subscale access opportunity as the highest level. Management can continue be flexible to allow nurses to pursue opportunities for professional development. Opportunities such as tuition reimbursement, ability to move to new positions within organizations and train for new experiences will continue to meet the needs of the nurse allowing them to feel opportunity within their career.

Nurses perceived access to resources as the lowest empowerment subscale. Access to resources includes things such as availability of time, materials, supplies and personnel to complete the job effectively. Since this is the lowest score, focusing efforts to ensure that staff have time to complete their work, and adequate supplies and personnel to be successful.
Administration should ensure adequate resources are available to nurses allowing them the necessary tools to be successful and when appropriate educate the staff why they may not have what they perceive as necessary.

Information needs to move in both directions, and can be accomplished through staff meetings, council meetings and information boards to post necessary information. Basing changes on evidence based practice, allowing the nurse to be involved in those changes.

Authentic leadership can be supported within the organizations by educating leaders on positive and appropriate leadership training. That alone does not ensure a successful, authentic leader, but can provide information on the necessary skills and how to develop them. An evaluation of leaders within the organization on a yearly base ensures that staff will have input and a voice in how the leaders are treating the people they supervise or lead. Using evaluation as an intervention may raise awareness of the attributes of authentic leadership and promote positive change.

Professional practice environment is closely linked to empowerment and authentic leadership. Keeping the staff informed, educated, and allowing them to have input are all ways to encourage empowerment and increase job satisfaction. Policy changes supporting an empowering environment, with authentic leadership need to be done.

From the literature, we know that generational differences do exist. Determining what the differences are within nursing and how organizations can address those differences will provide the nurses with the resources they need. Ensuring that Generation Y is trained in a more technical manor may work better for them. Baby Boomers may need to be oriented and trained in a different way to be more successful. Organizations may need to provide extra time and training
to older generations when they train them in technological things such as an electronic medical record.

**Future Research**

Findings from the current sample are encouraging and suggest that further research is warranted. The next steps in understanding if generational differences in work environments within nursing exist include expansion of the study to validation or refute the findings. This could be accomplished by replication of this study, using a more geographically diverse sample and selection of other variables that may produce different findings. Purposeful selection of each generation may help to ensure that adequate sampling is achieved. A longitudinal design could be beneficial to further validate the model and examine changes over time. Future research is needed on all variables to better understand how they interact within different generations. Subsequent research could also bring in other variables, looking for generational differences in their relationship.

Research could be expanded to include nurses outside of the acute care setting such as the community or home care setting. Additional studies could include healthcare providers of different disciplines. Comparison could then be made between nursing and the other disciplinary professionals.

The study could be replicated using one organization to better analyze the leadership and empowerment categories that are specific to that organization. Studies could also sample from multiple organizations that have mutual commonalities such as those that have achieved Magnet status. Comparison could then be done between the different categories.

Generational research needs to be conducted in such a way that all cohorts are familiar and comfortable in the use of the survey design. The study could be replicated using email
delivery or an online program allowing the nurse to complete the survey online. This may increase the response rate of the Generation Y cohort.

**Summary**

The results for the present study provide support for the use of Kanter’s (1977, 1993) theory in the sample population. Environments that empower nurses to practice with a high professional standard and that are free from uncivil behaviors can lead to increased job satisfaction and engagement and lower levels of turnover intention. Administrations at all levels must give careful consideration ensuring empowering work environments to retain scarce resources.
List of References


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Appendices
Appendix A

CONDITIONS OF WORK EFFECTIVENESS QUESTIONNAIRE - II

HOW MUCH OF EACH KIND OF OPPORTUNITY DO YOU HAVE IN YOUR PRESENT JOB?

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Some</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Challenging work</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. The chance to gain new skills and knowledge on the job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Tasks that use all of your own skills and knowledge.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

HOW MUCH ACCESS TO INFORMATION DO YOU HAVE IN YOUR PRESENT JOB?

<table>
<thead>
<tr>
<th></th>
<th>No Knowledge</th>
<th>Some Knowledge</th>
<th>Know A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The current state of the hospital.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. The values of top management.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. The goals of top management.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

HOW MUCH ACCESS TO SUPPORT DO YOU HAVE IN YOUR PRESENT JOB?

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Some</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Specific information about things you do well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Specific comments about things you could improve.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Helpful hints or problem solving advice.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

HOW MUCH ACCESS TO RESOURCES DO YOU HAVE IN YOUR PRESENT JOB?

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Some</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Time available to do necessary paperwork.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Time available to accomplish job requirements.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Acquiring temporary help when needed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

IN MY WORK SETTING/JOB:

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The rewards for innovation on the job are</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. The amount of flexibility in my job is</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. The amount of visibility of my work-related activities</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
within the institution is

HOW MUCH OPPORTUNITY DO YOU HAVE FOR THESE ACTIVITIES IN YOUR PRESENT JOB?

1. Collaborating on patient care with physicians.
   None  1  2  3  4  5

2. Being sought out by peers for help with problems
   1  2  3  4  5

3. Being sought out by managers for help with problems
   1  2  3  4  5

4. Seeking out ideas from professionals other than physicians, e.g., Physiotherapists, Occupational Therapists, Dieticians.
   1  2  3  4  5

1. Overall, my current work environment empowers me to accomplish my work in an effective manner.
   Strongly Disagree  Strongly Agree
   1  2  3  4  5

2. Overall, I consider my workplace to be an empowering environment.
   1  2  3  4  5
## The Practice Environment Scale of the Nursing Work Index

For each item, please indicate the extent to which you agree that the item is PRESENT IN YOUR CURRENT JOB. Indicate your degree of agreement by circling the appropriate number.

<table>
<thead>
<tr>
<th></th>
<th>Adequate support services allow me to spend time with my patients.</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adequate support services allow me to spend time with my patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Physicians and nurses have good working relationships</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>A supervisory staff that is supportive of the nurses.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>Active staff development or continuing education programs for nurses</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Career development/clinical ladder opportunity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>Opportunity for staff nurses to participate in policy decisions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>Supervisors use mistakes as learning opportunities, not criticism.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>Enough time and opportunity to discuss patient care problems with other nurses</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>Enough registered nurses to provide quality patient care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10</td>
<td>A nurse manager who is a good manager and leader.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>A chief nursing officer who is highly visible and accessible to staff</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12</td>
<td>Enough staff to get the work done</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13</td>
<td>Praise and recognition for a job well done.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14</td>
<td>High standards of nursing care are expected by the administration</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15</td>
<td>A chief nursing officer equal in power and authority to other top-level hospital executives</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16</td>
<td>A lot of team work between nurses and physicians.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17</td>
<td>Opportunities for advancement.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18</td>
<td>A clear philosophy of nursing that pervades the patient care environment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19</td>
<td>Working with nurses who are clinically competent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Scale</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>A nurse manager who backs up the nursing staff in decision making, even if the conflict is with a physician.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Administration that listens and responds to employee concerns.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>An active quality assurance program.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Staff nurses are involved in the internal governance of the hospital (e.g., practice and policy committees).</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Collaboration (joint practice) between nurses and physicians.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>A preceptor program for newly hired RNs</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Nursing care is based on a nursing, rather than a medical, model.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Staff nurses have the opportunity to serve on hospital and nursing committees.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Nursing administrators consult with staff on daily problems and procedures</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Written, up-to-date nursing care plans for all patients.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Patient care assignments that foster continuity of care, i.e., the same nurse cares for the patient from one day to the next.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Use of nursing diagnoses.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appendix C

**Workplace Incivility Scale**

In the past month how often have you experienced these behaviors at your work?

1=Never  2=About once a month  3= Once or twice a week  4= Several times a week  5= Everyday

**Your Immediate Supervisor:**

<table>
<thead>
<tr>
<th>Behavior</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Put you down or was condescending to you in some way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Paid little attention to a statement you made or showed little interest in your opinion.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Made demeaning, rude or derogatory remarks about you.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Addressed you in unprofessional terms, either publicly or privately.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>5. Ignored or excluded you from professional camaraderie.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Doubted your judgment in a matter over which you have responsibility.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7. Made unwanted attempts to draw you into a discussion of personal matters.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Your Co-Workers**

<table>
<thead>
<tr>
<th>Behavior</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Put you down or were condescending to you in some way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Paid little attention to a statement you made or showed little interest in your opinion.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Made demeaning, rude or derogatory remarks about you.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Addressed you in unprofessional terms, either publicly or privately.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Ignored or excluded you from professional camaraderie.</td>
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<tr>
<td>6. Doubted your judgment in a matter over which you have responsibility.</td>
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<tr>
<td>7. Made unwanted attempts to draw you into a discussion of personal matters.</td>
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<td></td>
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</tr>
</tbody>
</table>
Appendix D

**Authentic Leadership Questionnaire**

Only sample items can be listed here: The entire scale cannot be listed.

Judge how frequently each of the following statements relate to your leader’s style as you perceive it.

<table>
<thead>
<tr>
<th>My Leader….</th>
<th>Not at all.....sometimes.....Frequently or always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Says exactly what her or she means</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>2. Admits mistakes when they are made</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>3. Tells you the hard truth</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>
Appendix E

**Five Questions from Job Diagnostic Survey**

1= Strongly Agree   2=Disagree   3= Hard to Decide   4= Agree   5=Strongly Agree

1. I feel very satisfied with my job.  
   1  2  3  4  5

2. I feel that my coworkers are satisfied with their jobs.  
   1  2  3  4  5

3. I feel I would be happy to work here until I retire.  
   1  2  3  4  5

4. I feel that the health care facility provides a supportive work environment in which to work.  
   1  2  3  4  5

5. Overall, my current work environment empowers me to accomplish my work in an effective manner  
   1  2  3  4  5
Appendix F

Short Version of Utrecht Work Engagement Scale

0=Never 1=Almost Never 2=Rarely 3=Sometimes 4=Often 5=Very Often 6= Always

1. At my work, I feel bursting with energy. 1 2 3 4 5 6
2. At my job, I feel strong and vigorous. 1 2 3 4 5 6
3. I am enthusiastic about my job. 1 2 3 4 5 6
4. My job inspires me. 1 2 3 4 5 6
5. When I get up in the morning, I feel like going to work. 1 2 3 4 5 6
6. I feel happy when I am working intensely. 1 2 3 4 5 6
7. I am proud of the work I do. 1 2 3 4 5 6
8. I am immersed in my work. 1 2 3 4 5 6
9. I get carried away when I work. 1 2 3 4 5 6
Appendix G

**Turnover Intention Scale**

1= Strongly Disagree   2= Disagree   3= Hard to Decide   4= Agree   5= Strongly Agree

1. I plan on leaving my job within the next year.  
   1 2 3 4 5

2. I have been actively looking for other jobs.  
   1 2 3 4 5

3. I want to remain in my job.  
   1 2 3 4 5
Appendix H

Permission to Use Conditions of Work Effectiveness Questionnaire-II

NURSING WORK EMPOWERMENT SCALE

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

Questionnaires Requested:
- Conditions of Work Effectiveness-I (includes JAS and ORS):
- Conditions of Work Effectiveness-II (includes JAS-II and ORS-II): Yes
- Job Activity Scale (JAS) only:
- Organizational Relationship Scale (ORS) only:
- Organizational Development Opinionnaire or Manager Activity Scale:
- Other Instruments:

Please complete the following information:
Date: April 17, 2010
Name: Lisa Haddad
Title: RN, BSN, MS
University/Organization: University of Tennessee Medical Center,
University of Tennessee, Knoxville, College of Nursing
Address: 1924 Alcoa Highway, Box 104, Knoxville, Tn. 37920
Phone: 865-228-1303
E-mail: lhaddad@utmck.edu

Description of Study: Correlation study looking at patient falls and nurse empowerment

Permission is hereby granted to copy and use the Nursing Work Empowerment Scale.
Date: April 19, 2010
Signature:

Dr. Heather K. Spence Laschinger, Professor
School of Nursing, University of Western Ontario
London, Ontario, Canada N6A 5C1
Tel: 519-661-4065 Fax: 519-661-3410
E-mail: hkl@uwo.ca
Appendix I

Permission to Use Practice Environment Scale / Nursing Work Index

Dear Lisa:

Thank you for your inquiry. I am replying on behalf of Dr. Lake. Enclosed, please find the instrument, scoring instructions, an article containing PES-NWI scores for ANCC Magnet hospitals from 1998 in Table 1, and a Warshawsky & Haven article you may find useful.

Dr. Lake’s permission is not needed as the instrument is in the public domain due to its endorsement by the National Quality Forum in 2004 and re-endorsement in 2009: http://www.qualityforum.org/Projects/n-r/Nursing-Sensitive_Care_Measure_Maintenance/Nursing_Sensitive_Care_/ However, if you prefer to have Dr. Lake’s permission, this email serves as her permission.

Please direct any reply to Dr. Lake at elake@nursing.upenn.edu. If you need anything else, feel free to write to us again.

Sincerely,

Andrea Barol
Administrative Coordinator
Center for Health Outcomes and Policy Research
University of Pennsylvania School of Nursing
378 Fagin Hall
Philadelphia, PA 19104
215-898-4727
Appendix J

**Permission to Use Workplace Incivility Scale**

Hi Lisa,

You’re welcome to use my Workplace Incivility Scale. You can get it from the articles its published in, downloadable from my lab website below.

Best,

Lilia Cortina

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Lilia M Cortina, PhD
Associate Professor & Area Chair, Psychology & Women’s Studies
University of Michigan

Web: [http://www.lsa.umich.edu/psych/lilia-cortina-lab/](http://www.lsa.umich.edu/psych/lilia-cortina-lab/)
Appendix K

Permission to Use Authentic Leadership Scale

www.mindgarden.com

To whom it may concern,

This letter is to grant permission for the above named person to use the following copyright material;

Instrument: Authentic Leadership Questionnaire (ALQ)

Authors: Bruce J. Avolio, William L. Gardner, and Fred O. Walumbwa

Copyright: “Copyright © 2007 Authentic Leadership Questionnaire (ALQ) by Bruce J. Avolio, William L. Gardner, and Fred O. Walumbwa. All rights reserved in all medium.”

for his/her thesis research.

Three sample items from this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any other published material.

Sincerely,

Robert Most
Mind Garden, Inc.
www.mindgarden.com
Appendix L

Permission to Use Turnover Intention Scale

RE: Use of Turnover Intention Tool

Kevin Kelloway [Kevin.Kelloway@SMU.CA]

Sent: Thursday, May 10, 2012 9:40AM

To: Haddad, Lisa M

Yes please feel free to use the measure
E. Kevin Kelloway, Ph.D.
Canada Research Chair in Occupational Health Psychology
Director, CN Centre for Occupational Health and Safety
Saint Mary's University
(902) 491 - 8616
kevin.kelloway@smu.ca
http://ohpsychology.ca

From: Haddad, Lisa M [LHaddad@mc.utmck.edu]
Sent: May 9, 2012 2:57 PM
To: Kevin Kelloway
Subject: Use of Turnover Intention Tool

Hi,
I am a PhD student at the University of Tennessee. I am conducting my dissertation and would like to use four items from the turnover intention tool that I have found in the literature. I am contacting you to see if I need permission to use the information. Thank you for your time. Lisa

Lisa Haddad, MS BSN RN
Nursing Research Coordinator
University of Tennessee Medical Center
Knoxville, Tn. 37920
865-305-9335
Appendix M

Cover Letter

Dear Nurse:

Enclosed you will find a survey and an envelope addressed to the investigator, and a small white card.

The purpose of this study is to provide researchers an understanding of how generational differences affect empowerment and other variables within nursing. Information gathered in this study will help nurses, educators, managers and organizations as they strive to combat nursing shortages.

The questionnaire will take approximately 20 - 30 minutes for you to complete. There are some important points to remember:

1. Participation is entirely voluntary. There is no penalty for not participating, or for beginning the survey and deciding that you no longer want to participate. You will have no adverse consequences from the research personal or from anyone involved in the study.
2. Your answers to the survey are completely anonymous. Your name or any other identifying information will not be traceable to you. You will only be identified by the small white card if you chose to return it. Your name will not be linked to the survey in any way. Results will be reported in group results not individual.
3. You must be employed in a hospital setting for your results to be included.
4. By completing and returning the survey, and the small white card with your name, you will be included in a drawing for a $100.00 Visa Gift Card. The purpose of the card is only to enter your name in the drawing.

The surveys have no right or wrong answer, mark the answer that best expresses your feelings. By completing the survey and returning it in the envelope provided, you are agreeing to participate in the study. You can request results for this study by contacting the investigator listed below.

Thank you for your interest. Any questions can be directed to the researcher. Contact information is listed below.

Sincerely,

Lisa Haddad
865-974-7603
Appendix N  

Reminder Card

Dear Nurse,

Recently you were invited to participate in a research study. The title of the study was Experiences of Nurses in the Workplace. If you have already returned your survey thank you. If you have not returned it please consider this opportunity as a chance to help our profession grow.

If you need more information or need another survey you can contact the researcher, Lisa Haddad at 865-974-7603.

Thank You

Lisa Haddad
VITA

Lisa Marie Haddad has been a nurse since 1994. She graduated from University of Tennessee, Chattanooga with Bachelors in Science, Nursing degree. Her career started in the Cardio Vascular Intensive Care Unit. Upon moving to Florida in 1995, she transferred to the Emergency Department. She remained in that focus until 2001, when she began educating others within nursing. She taught in the hospital setting as a nurse educator, and then at University of South Florida, Tampa as adjunct faculty. She began her PhD program while teaching.

Subsequent to relocation to East Tennessee, she transferred to the PhD program at the University of Tennessee, Knoxville. While completing her program, she worked at the University of Tennessee Medical Center as their Nursing Research Coordinator.