Intensive Care Unit Nurses' Perceived Empowerment, Caring, Job Satisfaction, and

Intent to Leave or Intent to Stay within Central Canadian Hospitals

by

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ABSTRACT

Intensive care unit nursing shortages are an ongoing issue within the Canadian healthcare system. Empowerment and caring have been identified as significant within the Healthy Workplace Environment research found in "Magnet Status" hospitals, or hospitals that were able to recruit and retain nurses amidst a major USA nursing shortage in the 1980s. The purpose of this study was to better understand the relationships among Manitoban intensive care unit nurses' perceived empowerment, caring, job satisfaction and intent to leave or stay.

An adapted version of the Conceptual Framework for Predicting Nurse Retention provided the link between intensive care unit nurses' perceived empowerment, caring, job satisfaction and intent to leave or stay. A cross sectional design utilized socio-demographic information: age, education, and years of experience as an intensive care unit nurse; the Conditions of Workplace Empowerment Questionnaire II; the Caring Efficacy Scale; a single item job satisfaction question; and a two item intent to leave and intent to stay question (followed by open-ended questions asking why) was distributed by the College of Registered Nurses of Manitoba to 630 nurses registered as critical care nurses in the province of Manitoba. Ethical approval was obtained from the Education Nursing Research Ethics Board at the University of Manitoba. Findings indicate the majority of intensive care unit nurses who participated in this study were satisfied with their job. Multivariate analyses indicated that job satisfaction was statistically significantly associated with intent to stay.

ACKNOWLEDGEMENTS

DEDICATION

This thesis is dedicated to my husband, Duncan and our daughters, Anabelle, Sabrina, and Juliet. This study would not have been possible without their love, patience, and support.

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Chapter One: Statement of the Problem

Nursing is an essential service profession within the healthcare system. An increased

requirement for nurses is anticipated as the proportion of older adults within the general

population increases. Unfortunately since the late 1990s, there has been a history of nursing

shortages. Stone, Larson, Mooney-Kane, Smolowitz, Lin, and Dick (2009) have suggested that

the shortages of nurses are related to an aging workforce, pending retirements, problems with

recruitment and retention, and more specifically difficulty in retaining new nursing graduates in

the workplace. A viable and stable nursing workforce is needed to ensure that patients and

families are provided the best possible healthcare. This chapter identifies nursing demographics,

and specifically the intensive care unit (ICU) nursing demographics in Canada. Eight themes

were identified within Healthy Workplace Environment research (Kramer & Schmalenberg,

2008). Of those, caring and empowerment were identified as possible stimuli to retain ICU

nurses in Manitoba. The framework for the study, the Conceptual Framework for Predicting

Nurse Retention (CFPNR), taken from the work of Sawatzky and Enns (2012) and Sawatzky,

Enns, and Legare (2015) is introduced and includes research purpose and objectives.

Current Nurse Demographics in Canada

In Canada, nurses are regulated and licensed by separate colleges. There are: registered

nurses (including nurse practitioners), licensed practical nurses (also called registered practical

nurses), and registered psychiatric nurses (CIHI, 2015). Licensed practical nurses and registered

psychiatric nurses have different educational requirements and scopes of practice in comparison

to registered nurses. Only registered nurses work in Manitoba ICUs, and so this group was the

focus of this study.

In 2013, 73% of all regulated nurses eligible to practice in Canada were registered nurses, and only 58% of those registered nurses worked full time (CIHI, 2015). In 1992 there were 824 registered nurses for every 100,000 Canadians. However by 2009 there were only 785 registered nurses (CIHI, 2013) for every 100,000 Canadians. Concerns have been expressed about the shortage of nurses and the issues of turnover, yet data to support effective policies for retention are lacking (O`Brien-Pallas, Tombin Murphy, Shamian, Li & Hayes, 2010). One consequence of the nursing shortage has been mandated overtime. In 2010, 21 million hours of overtime were reported, which is the equivalent to 11,400 full time positions, at a cost of $891 million (Gormanns, Lasota, McCracken & Zitikyte, 2011). Clearly a larger workforce of registered nurses is needed.

ICU Nurse Demographics in Canada

ICUs, which are also referred to as critical care units, are environments that are dynamic, complex, and inherently stressful. In order to work in the ICU, additional training is required of registered nurses. The estimated cost to train a single Ontario critical care nurse ranged from $14,000 to $22,000 and this was dependent on duration of the program, tuition, and salary scale of the nurse (Official Languages Community Development Bureau, 2009). This study is situated in the province of Manitoba and the 24 week program (known as the Winnipeg Critical Care Nursing Education Program) offered in Winnipeg, Manitoba is a combination of classroom, lab work, and shifts mentored by experienced nurses from medical, surgical, intermediate, neonatal, and pediatric ICUs. There are costs and time requirements to become an ICU nurse, but additional training ensures that complex patient care is provided by well-prepared nurses.

O'Brien-Pallas et al. (2010) surveyed 41 hospitals across 10 provinces and reported the

highest turnover rate comes from the ICU (26.7%) **.** In Manitoba, the largest center is Winnipeg

with a population of 718,400 in 2015 (City of Winnipeg, 2016). As of September 2014, the

Winnipeg Regional Health Authority had over 31 full time permanent vacancies in 13 ICUs

across six hospitals within the city. The ICU nurse to patient ratio in an ICU is between 1:1 and

1:2 and this ratio depends on both the knowledge and skill set of the nurses and the acuity of the

patients. ICU nurses must deal with increased patient care complexity, sophisticated technology,

and declining resources (The National Union of Taiwan Nurses Association, 2006; Lai et al.,

2008).

Caring and Empowerment and ICU Nursing Shortages

In 2008, Kramer and Schmalenberg identified the qualities of a Healthy Workplace

Environment. A Healthy Workplace Environment was derived from a groundbreaking study

conducted in 1982 by the American Association of Nurses (AAN) who coined the term "Magnet

Status" hospitals (Kramer & Schmalenberg, 2008). Magnet Status hospitals were able to recruit

and retain nurses during a major nursing shortage in the USA. Kramer and Schmalenberg (2008)

developed a 37 item questionnaire that expanded upon the Nursing Work Index (developed in the

1982 study) and identified eight themes essential to quality care; calling them 'Essentials of

Magnetism within a Healthy Workplace Environment'. Together these eight themes, known as a

Healthy Workplace Environment have been empirically linked to increase recruitment, retention,

and job satisfaction among nurses (Kramer & Schmalenberg, 2008). These eight themes are: 1.

working with other nurses who are clinically competent; 2. having good nurse-physician

relationships and communication; 3. promoting nurse autonomy and accountability; 4. supportive

nurse manager and supervisor; 5. allowing control over nursing practice and practice

environment; 6. having support for education; 7. staffing adequately; and 8. having concern for

the patient. Within the Healthy Workplace Environment research two concepts have impacted

the current nursing shortage: empowerment and caring. The purpose of this study was to explore

the relationships among caring, empowerment, job satisfaction, socio-demographic factors, and

the intent to leave or intent to stay amongst ICU nurses in Manitoba.

Empowerment is identified on a continuum and is universally found within all individuals

in their workplace environment (Spreitzer, 1995). Empowerment derives from two sources: an

organizational atmosphere and a psychological belief. Empowerment provides resources through

opportunity, support and information; and promotes an autonomous ability to set and act on

goals and objectives within the scope of the nurses' values and beliefs bounded by legal scope of

practice. Expanding upon the work of Laschinger et al. (2001) and for this purpose of this study

empowerment was defined as a combination of organizational and psychological factors. An

individual's accessibility to resources results in higher motivation to succeed within their

organization. Research has demonstrated a link between empowerment and six of the

previously identified Magnet Hospital themes as follows: 2. having good nurse-physician

relationships and communication; 3. promoting nurse autonomy and accountability; 4. having a

supportive nurse manager and supervisor; 5. allowing nurses' control over nursing practice and

practice environment; 7. staffing adequately; and 8. having concern for the patient (Aiken,

Clarke, Sloane, Sochalski, & Silber, 2002; Aiken, Smith, & Lake, 1994; Armstrong &

Laschinger, 2006; Armstrong, Laschinger, & Wong, 2009; Laschinger, Almost, & Tuer-Hodes,

2003).

The concept of caring is comprehensive and truly defines nursing. Caring is viewed on a philosophical level as being responsible for providing caring connections with others (Watson, 2005). Expanding upon Watson's (2005) work and for the purpose of this study caring was defined as a complex phenomenon that occurs between two people and is meant to be therapeutic. Caring has a philosophical basis, but requires a good deal of self reflection, a thoughtful identification of issues and context, and selection of appropriate behavior and all of it stems from an concern for others before one acts on it. Action begets reflection and so on as one learns to care professionally. The concept of caring is linked to the eighth Essential of Magnetism: having concern for the patient. ICU nurses provide care to very ill patients, some of whom may not be conscious or aware of the care being provided. The caring connection between ICU nurses and their patients is somewhat unique in these circumstances. ICU nurses rely on verbal and nonverbal communication provided by the patients and their loved ones during care. The patient's labile condition can challenge the ICU nurses' ability to pick up on subtle cues that indicate a rapid decline.

Increased access to a caring environment (Amendolair, 2012) and an empowering atmosphere enhances job satisfaction (Laschinger, Nosko, Wilk, & Finegan, 2014; Wong & Laschinger, 2012). The correlation between nurses' job satisfaction and intent to leave has been explored extensively. The nursing research, outlined later on in chapter two, suggests the more satisfied nurses were with their jobs the less likely they were to leave their current position (Baernholdt & Mark, 2009; Doran, Duffield, Rizk, Nahm, & Chu, 2014; Faller, Gates, Georges, & Connelly, 2011; Ganz & Toren, 2014; Sawatzky & Enns, 2012; Sawatzky et al., 2015; Stewart et al., 2011).

Conceptual Framework

This study was conducted under a modified version of the Conceptual Framework for Predicting Nurse Retention (CFPNR). The CFPNR is based upon previous empirical research on nurse retention (Larabee, Tanney, Ostrow, Withrow, Hobbs, & Burant, 2003; O`Brien-Pallas et al., 2001; Price & Mueller, 1981; Tzeng, 2002). Most recently published research by Sawatzky and Enns (2012) and Sawatzky et al. (2015) has informed this study. The premise of the CFPNR is that "influencing factors" such as organizational climate may be related to the "intermediary factors" such as job satisfaction, and both the influencing factors and intermediary factors may influence the primary outcome, that is intent to leave or intent to stay (Sawatzky & Enns, 2012; Sawatzky et al., 2015).

See Figure 1 for the complete CFPNR.

Figure 1

Conceptual Framework for Predicting Nurse Retention

Influencing Factor   Intermediary Factor   Outcome

Empowerment   Job Satisfaction   Intent to Leave/
Caring   Intent to Stay
Socio-demographic
        Age
        Education
        Years of Experience
        as an ICU nurse
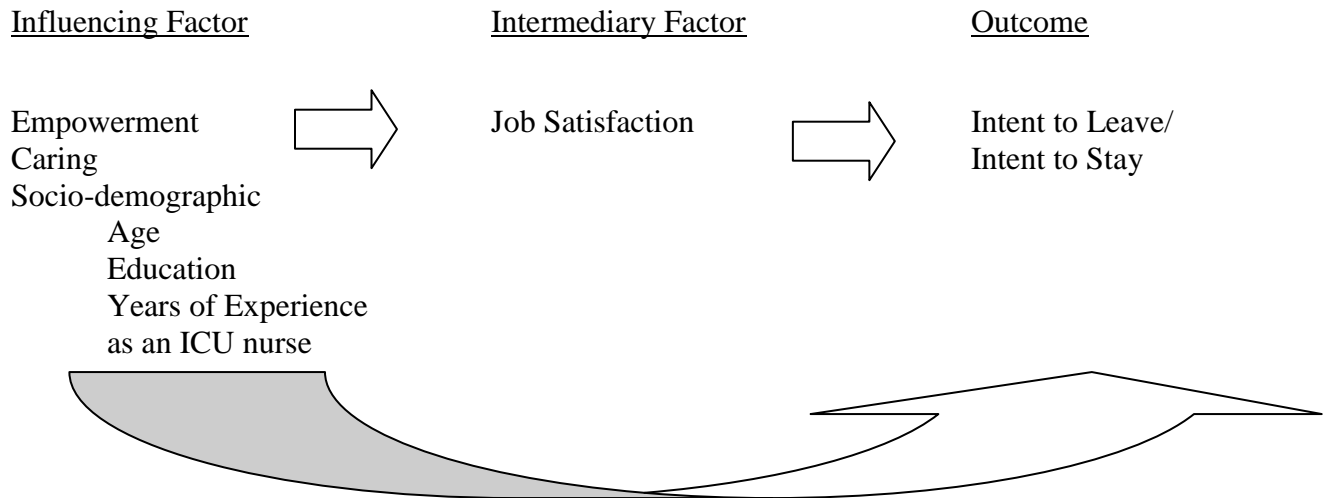
 More information on the conceptual framework is provided in Chapter Two.

Although this study was informed by Sawatzky and Enns' (2012) framework, the influencing and intermediary factors are not the same. The purpose of this study was to explore the relationships among caring, empowerment, job satisfaction, socio-demographic factors, and the intent to leave or intent to stay amongst ICU nurses in Manitoba. There were four research objectives:

1. To compare the reasons why ICU nurses intend to leave or intend to stay,

2. To explore the relationships among empowerment, caring, socio demographic factors, and job satisfaction,

3. To examine the relationship between job satisfaction and intent to leave or intent to stay, and

4. To examine the overall relationships among empowerment, caring, socio-demographic factors, job satisfaction, and intent to leave or intent to stay.

Chapter Two: Conceptual Model and Literature Review

While the relationships among empowerment, caring, job satisfaction, and intent to leave or

intent to stay have been studied within nursing generally, less attention has focused on these

relationships for ICU nurses. Throughout Chapter Two, the Conceptual Framework for

Predicting Nurse Retention (CFPNR) is described, and linked to the objectives of this study. The

literature on empowerment, caring, job satisfaction, intent to leave and intent to stay is reviewed

and analyzed in relation to this study.

The CFPNR model used for this study posits an intermediary relationship (job satisfaction)

between influencing factors (empowerment, caring, and socio-demographic factors) and the

outcome of intent to leave or intent to stay. The objectives are guided by the model.

1. To compare the reasons why ICU nurses intend to leave or intend to stay.

2. To explore the relationships among empowerment, caring, socio demographic factors,
    and job satisfaction.

3. To examine the relationship between job satisfaction and intent to leave or intent to stay.

4. To examine the overall relationships among empowerment, caring, socio-demographic
    factors, job satisfaction, and intent to leave or intent to stay.

Conceptual Framework

This study has been informed by the work of Sawatzky and Enns, (2012) who developed

the CFPNR to identify key factors that affect nurse's intent to leave. According to Sawatsky and

Enns (2012), "the influencing factors may predict intention to leave either directly or indirectly

by their impact on the intermediary factors". Sawatzky and Enn's (2012) stated "intermediary

factors may intercede with the influencing factors in the decision to stay or leave one's current

job, or they may have a direct impact on the decision to stay or leave one's current position". The

goal of the CFPNR is to identify retention strategies tailored to each type of nursing practice.

Sawatzky and Enns' (2012) CFPNR is described in Figure 2.

Figure 2

Sawatzky and Enns' (2012) Conceptual Framework for Predicting Nurse Retention

Influencing Factors   Intermediary Factors   Outcome

Organizational Climate   Job Satisfaction   Intention to Leave
        Professional Practice   Engagement
        Staffing & resources   Professional quality of life
        Nursing management   Compassion Satisfaction
        Nurse / MD collaboration   Compassion Fatigue
        Nurse competence   Burnout
        Control / responsibility   Caring
        Positive scheduling climate
Person Factors
        Demographics

Sawatzky and Enns' (2012) CFPNR is similar to this study including the intermediary

factor of job satisfaction and the outcome of intent to leave. However, with this study, the

influencing factors are different. Empowerment and caring are identified as influencing factors

within this study. ICU nursing is dependent on the resources available to empower the nurse

providing care, and fosters an environment where a more intense bond between the patient and nurse may develop.

Intent to Leave and Intent to Stay

Definition of Intent to Leave and Intent to Stay

Intent to leave is generally viewed as the movement of staff out of an organization, or repositioning within the same organization. A groundbreaking study by Fishbein & Ajzen (1975) sought to explain factors that predict actual turnover, suggesting that behavioral intention is the primary antecedent to actual behavior. Both the behavioral and the cognitive processes of turnover intentions are important predictors of actual turnover. Coomber and Barriball (2007) found intent to leave is considered an outcome of affective variables, such as job satisfaction; whereas actual turnover may be meditated by other variables such as age or tenure. A total of 19 studies discussing intent to leave and three studies discussing intent to stay were reviewed for this study. Both intent to leave and intent to stay were predominately tested utilizing a dichotomous measure. Intent to stay research within nursing is quite limited, and in two of the three articles reviewed no definition for intent to stay was provided. For the purpose of this study intent to stay will be defined as a desire to remain working within the ICU.

Intent to Leave and Job Satisfaction Research

In 2005 a study on critical care nursing was conducted in Ontario (Fisher, Baumann, Hunsberger, Blythe, & Fitzpatrick, 2007). This study attempted to identify how current nursing standards of practice in each program affected job satisfaction and intent to leave at the 12 provincially sited ICUs. The Critical Care Steering Committee formed the Ontario Critical Care

Expert Panel which recognized that successful recruitment and retention of ICU nurses is

essential to provide quality patient care. The task groups brought together critical care nurse

leaders from across the 12 ICU's in the province to conduct a survey to determine the status and

adherence to nursing standards. The standards of practice included: 1. incorporating professional

behavior and ethics into practice; 2. providing opportunities to maintain nursing competency in

critical care; 3. understanding the importance of critical care unit structure and interdisciplinary

teamwork in relation to risk management; 4. providing the ability to implement caring

communication in therapeutic and professional relationships; and 5. providing the ability to

incorporate knowledge, clinical skills integration and critical thinking.

Findings from the study concluded that ICU nurses appreciated the comprehensiveness of

the standards and described them as all-encompassing. A particular strength was the inclusion of

competencies such as "professional behavior / ethics", "continuing competence" and "research"

which emphasized the importance of developing rather than maintaining skills outside the

clinical base. ICU nurses noted the importance of these skills in critical care practice and how

they would continue to challenge nurses to think outside their scope. The ICU nurses noted some

limitations in the standards. The standards did not explain how the various structures available

within the healthcare system are able to provide opportunities for continuing education and

competency.

Fisher et al. (2007) also asked ICU nurses what would keep them in their jobs and

increase job satisfaction. ICU nurses responded that the things that needed to be done included

enhancing an ICU nurses' role in: 1. implementing patient safety content; 2. planning for disaster

and pandemic emergency preparedness; 3. emphasizing the criteria for both the patient and

patients' family as the patient; 4. providing clinical leadership opportunities; and 5. utilizing

clinical and health services research.

Fisher et al. (2007) identified nurse's perceived challenges to job satisfaction that

included: 1. nurses' inability to take time off for educational purposes due to limited financial

support; 2. limited access to the computer / online educational systems that are required for

nurses to take online courses; 3. limited replacement for nurses during educational leaves of

absence; 4. nurses' refusal to upgrade to meet the new standards of practice; 5. new graduates

lacking the experience needed to work in ICUs; and 6. current shortage of mentors / preceptors

to bridge the gap between theory and practice in the clinical teaching environment. Fisher et

al's., (2007) findings suggested that job satisfaction had an inverse relationship with intent to

leave. The findings also indicated that ICU nurses wanted to be educationally challenged but

lacked the financial support and appropriate mentors to facilitate ongoing educational

opportunities.

Stewart et al. (2011) surveyed rural Canadian nurses using a questionnaire based upon

empirical and conceptual issues identified in previous research in Australia, Canada, and the

USA. They also used a single item intent to leave question "Do you plan to leave your present

nursing position?" The results reported that nurses were more likely to have had intentions to

leave their nursing position within the next 12 months if they were male, reported higher

perceived stress, did not have dependent children or relatives, had higher education, were

employed by their primary agency for a shorter time, had greater dissatisfaction with job

scheduling, had lower satisfaction with their autonomy in the workplace, were required to be on

call, performed advanced decisions or practice, and worked in remote settings. These findings

identified additional elements that impacted intent to leave. In comparison to Fisher et al's.

(2007) study, Stewart et al. (2011) reported that intent to leave had an inverse relationship to

more years of experience, lower number of dependents, increased education and gender (male).

Sawatzky and Enns (2012) surveyed emergency room nurses throughout Manitoba

utilizing the Perceived Nurse Working Environment scale (Choi, Bakken, Larson, Du, & Stone,

2004) , a single item Likert scale job satisfaction scale (1= not at all satisfied to 5= very

satisfied), the Engagement Composite Questionnaire (Hewitt Associates, 2008), the Professional

Quality of Life Scale (Stamm, 2005), and Price and Mueller's (1981) single item "Do you intend

to leave your current position in the coming year?" and reported predictors of nurse perceived

intentions to leave included older age, lower compassion satisfaction (which is the pleasure you

derive from doing well at work), higher professional practice scores, and lower income.

In a later study, Sawatzky et al. (2015) surveyed critical care (CC) nurses throughout

Manitoba using the Perceived Nurse Working Environment scale (Choi, et al., 2004), McCloskey

Mueller Satisfaction Scale (Mueller & McCloskey, 1990), a single item question related to

autonomy, the Nursing Expertise Self-Report Scale (Garland, 1996), personal factors, a single

item Likert scale job satisfaction scale (1= not at all satisfied to 5= very satisfied), the

Engagement Composite Questionnaire (Hewitt Associates, 2008), the Professional Quality of

Life Scale (Stamm, 2005), and Price and Mueller's (1981) single item "Do you intend to leave

your current position in the coming year?" Caring was measured through compassion fatigue,

compassion satisfaction, and a qualitative component. Sawatzky et al. (2015) reported

organizational climate factors: professional practice, supportive management, good physician /

nurse collaboration, nurse competence, control / responsibility, autonomy, engagement,

compassion satisfaction had a statistically significant inverse relationship with intent to leave

both nursing and CC. Compassion fatigue and burnout had a statistically significant direct

correlation with intent to leave nursing and CC, which is similar to the findings reported by

Sawatzky and Enns' 2012 study.

Doran et al. (2014) used the Practice Environment Scale of the Nursing Work Index

(Lake, 2002), the four item Likert scale job satisfaction questionnaire (Laschinger & Havens,

1996), a single item "Do you intend to leave your current job within the next year?" Doran et al.

(2014) reported advanced practice nurses (nurses with postgraduate specialist education) in

Ontario had higher job satisfaction but it did not reflect in their intent to leave in comparison to

staff nurses who reported lower job satisfaction and higher intent to leave. These findings were

interesting as the job satisfaction score did not greatly impact the desired intent to leave between

the two groups, which contradicts with Coomber and Barriball (2007) and Sawatsky and Enns

(2012) who reported job dissatisfaction was the primary predictor of intent to leave.

Han, Trinkoff, and Gurses (2015) utilized the Job Content Questionnaire (Karasek,

1985), 12 items assessing physical demands (Trinkoff, Lipscomb, Geiger-Brown, Storr, &

Brady, 2003), three items from the Nursing Work Index-Revised (Lake, 2002), six items from

Job Content Questionnaire (Karasek, 1985), single item work schedule measure, single item

week burden measure, single item job satisfaction question, and a single item intent to leave

question amongst 1641 registered nurses in Illinois and North Carolina. Han et al. (2015)

reported 75% of nurses were satisfied with their job and 90% did not intend to leave their

position. Of those who intended to leave, most were male and had higher education. These

findings are similar to the Stewart et al.'s (2011) findings that identified male nurses and nurses

with higher education reported greater job dissatisfaction. Han et al. (2015) also reported a

direct association between job dissatisfaction and nurses in jobs with high psychological

demands, low autonomy, worked long hours, and limited support from supervisors or peers.

Baernholdt and Mark (2009) surveyed rural and urban medical/ surgical units across the

USA utilizing Zohar's (1980) Safety Climate scale; Minick and Harvey's (2003) Expertise scale;

Minick and Harvey's (2003) Commitment to Care scale; Mark and Hagenmueller (1994)

Decentralization scale; Gerber's (1990) Autonomy scale; Gittell, Fairfield, and Beirbaum's

(2000) Relational Coordination scale; and Hinshaw and Atwood's (1984) Job Satisfaction scale.

Baernholdt and Mark (2009) based turnover rates of nurses on actual termination that occurred

during a six month period. They reported rural / urban location was not significantly associated

with nurse job satisfaction or actual turnover rates. Instead, availability of support services,

commitment to care (how responsible the nurses felt to provide care) and autonomy had a direct

association with nurses' job satisfaction, and a direct association was reported between increased

work complexity, increased unit vacancy rates, and increased intent to leave. It is interesting to

note this study did not report an association between job satisfaction and intent to leave.

Faller et al. (2011) surveyed travel nurses employed by a large healthcare staffing

company using the Copenhagen Burnout Inventory (Kristensen, Borritz, Villadsen, &

Christensen, 2005), the Job Satisfaction statement "Overall I am satisfied with my current job",

nurse assessed quality of care statement "On the last shift you worked, was the quality of patient

care on the unit (a) below the standard of care, (b) adequate, (c) above the standard of care", and

a three item intent to leave questionnaire (Tsui & O`Reilly, 1989) and reported a direct

association with increased job satisfaction and hospital held Magnet Status designation.

However, there was an inverse relationship between job satisfaction and nurses who were specialized in critical care. They also found a direct association was established between younger nurses' and nurse perceived levels of stress associated with changing jobs. Similar to Baernholdt and Mark (2009), this study also did not report an association between job satisfaction and intent to leave.

Ganz and Toren, (2014) used the unpublished Job Satisfaction Questionnaire of the Hadasseh Medical Organization and the question "I intend to leave my workplace in the next 12 months" measured on a scale 1 (do not intend at all) to 5 (definitely intend) and found most respondents were Jewish, married women born in Israel with an average experience of 22 years, and worked in either general ICUs or medicine units. This study's significant findings include overall high levels of job satisfaction (mean 3.8/5) and low levels of intent to leave (8.8%).

Roulin, Mayor, and Bangerter (2014) surveyed French speaking nurses working in Switzerland utilizing the Extended Satisfaction with Life Scale (Alfonso, Allison, Rader, & Gorman, 1996), the Survey Work-Home Interaction-Nijmegen (Geurts, 2000), the Maslach Burnout Inventory (Maslach & Jackson, 1981), the Team Diagnostic Survey (Wageman, Hackman, & Lehman, 2005), the Revised Nursing Work Index (Aiken & Patrician, 2000), and the intent to leave question "How often do you think about leaving your current position?" and reported both group cohesion and unit effectiveness were directly associated to job satisfaction, and had an inverse relationship to intent to leave.

Tao, Ellenbecker, Wang, & Lee (2015) used a qualitative study in four Shanghai ICU's and found three themes of job dissatisfaction and high intent to leave and three themes of job satisfaction and low intent to leave. The three themes of job dissatisfaction and high intent to

leave were stress from excessive workload demands, stress from ICU work environment, and

lack of respect and recognition. Three themes of job satisfaction and low intent to leave were the

positive relationships with co-workers, internal recognition of work and accomplishments, and

professional opportunities to strengthen skills. Roulin et al. (2014) also reported a direct

association between unit effectiveness, work complexity, and perceived job satisfaction.

     Liu, While, Li, & Ye (2013) used the Mueller-McCloskey Satisfaction Scale (Mueller &

McCloskey, 1990), the Maslach Burnout Inventory (Malasch & Jackson, 1986), the Practice

Environment Scale of the Nursing Work Index (Lake, 2002), the Simplified Coping Style

Questionnaire (Jie, 1998), and the Social Support Rating Scale (Xiao, 1994) on 215 nurses

working in 12 cardiac critical care units in Shanghai. Most of the respondents (58%) were

satisfied with their job. A direct association between praise or recognition received by co-

workers, positive relationship with co-workers, less than 5 years or between 10-19 years of work

experience and job satisfaction was reported within this study. Job dissatisfaction was directly

associated with the extrinsic rewards provided, limited professional opportunities, limited control

or responsibility, poor family / work balance, poor scheduling, and negative interactions. A high

percentage (80%) of respondents reported low levels of personal accomplishment, and high

levels of emotional exhaustion (52%). It is interesting to note, that over 80% of respondents did

report a positive practice environment, and this is likely due to their reported positive

relationships with managers, good quality of care, and good nurse-physician relations. It is also

statistically significant to report that despite 28% of respondents reporting their intent to stay,

and 12% of respondents intending to leave, the majority (approximately 60%) did not report their

intention to stay or leave. No association between job satisfaction and intent to leave was

reported.

Summary

It is interesting to note that although job satisfaction and intent to leave were researched in all the studies mentioned above, not all studies reported an association between job satisfaction and intent to leave. The majority of the research reported that job satisfaction had an inverse relationship with intent to leave (Fisher et al., 2007; Stewart et al., 2011; Ganz & Toren, 2014. However, three additional studies did not report a correlation between job satisfaction and intent to leave (Baernholdt & Mark, 2009; Faller et al., 2011; Liu et al., 2013). This suggests a presumed inverse correlation between job satisfaction and intent to leave existed.

Intent to Leave and Empowerment Research

Zurmehly, Martin, and Fitzpatrick (2009) used a web based survey to collect data from Western Ohio nurses that was comprised of questions from the CWEQ-II (Laschinger et al., 2001), four items from the RN Vermont Intent to Leave Survey (Rambur, Palumbo, McIntosh & Mongeon, 2003), a single item question rating job satisfaction, and five intent to leave questions adopted from McCarthy's (2002) study. Zurmehly et al. (2009) reported nurses had an inverse relationship between intent to leave and empowerment. Nurses with high intention to leave their current position reported organizational factors such as poor relationships with supervisors or management, job stress, poor co-worker relations, decreased salary benefits, and poor job assignment. Nurses between 50 and 60 years of age and nurses with baccalaureate degrees or higher reported an inverse relationship with intent to leave and perceived empowerment. It seems likely that older or more experienced nurses feel committed to their position and to the organization. This is important because these older nurses are essential to support a culture that nurtures new nurses.

Hauck, Griffin, and Fitzpatrick (2011) reported an inverse relationship between North

Eastern USA ICU nurse's perception of access to workplace empowerment structures and their

stated intent to leave their current position when utilizing the CWEQ II (Laschinger et al., 2001)

and the Anticipated Turnover Scale (Hinshaw, Atwood, Gerber, & Erickson, 1985). Hauck et al.

(2011) reported perceived empowerment had a positive correlation to autonomy, job satisfaction,

organizational commitment, and an inverse relationship with intent to leave. This fits with

Zurmehly et al. (2009) who reported an inverse relationship between intent to leave and

perceived empowerment.

Oyeleye, Hanson, O`Connor, and Dunn (2013) surveyed acute care Midwest USA nurses

using Malasch's Burnout Inventory scale (Maslach & Jackson, 1981), the Uncivil Workplace

Behaviours questionnaire (Martin & Hine, 2005), the Workplace Incivility Scale (Cortina &

Magley, 2009), a four item turnover intention scale, and Spreitzer's (1995) Psychological

Empowerment Scale. Oyeleye et al. (2013) reported statistically significant relationships

between stress and incivility (disrespect within the workplace), stress and burnout, burnout and

incivility, and burnout and turnover intention. Turnover intention and incivility were

significantly directly related, but psychological empowerment scores did not correlate with any

of the variables tested. Overall, turnover intention was found to be low, and was directly

associated to incivility and burnout.

Fitzpatrick, Campo, and Gacki-Smith (2014) used a web based survey of nurses with

Emergency Nurse Association membership asking the nurses their current type of Board of

Certification for Emergency Nursing (BCEN), the CWEQ-II (Laschinger et al., 2001), the

Anticipated Turnover Scale (Hinshaw et al., 1985), and four items specific to their intent to

leave. The results reported no significant difference between gender and BCEN certified nurses and their intent to leave their position and / or nursing. BCEN certified nurse's had higher informal power scores compared to those who did not have BCEN certification. Female nurses scored significantly higher on the empowerment subscale of opportunity.

Summary

Overall, the majority of the research reported an inverse relationship between empowerment and intention to leave (Zurmehly et al., 2009; Hauck et al., 2001). However three studies did not report a relationship between empowerment and intent to leave (Zurmehly et al., 2009; Oyeleye et al., 2013 & Fitzpatrick et al., 2014). These relationships would have been helpful in understanding if and how empowerment affected nurse's intent to leave. Job stress, burnout, and poor co-worker relationships were directly associated to turnover intentions amongst ICU nurses (Oyeleye et al., 2013; Zurmehly et al., 2009; Tao et al., 2015; Faller et al., 2011). A direct association was established among older age, higher education, autonomy, job satisfaction, increased organizational commitment, female gender and empowerment (Ganz & Toren, 2014; Doran et al., 2014; Stewart et al., 2011). To date, there is no research solely on intent to stay and empowerment.

Intent to Stay Research

Nowrouzi et al. (2016) used single item intent to stay question to survey 459 nurses working in all specialties across North Eastern Ontario, Canada. Nowrouzi et al. (2016) reported nurses between 37 and 48 years were almost three times as likely to stay in their current position. Significant factors in intent to stay include working less than 31 hours per week, and working

between zero and one hour of overtime per week. No definition of intent to stay was provided within this research. This is unfortunate as research exploring intent to stay within nursing is limited.

Intent to Leave and Intent to Stay Research within the ICU

Research reports multiple reasons ICU nurses intend to leave their current positions. Stone et al. (2009) used a single report item "Do you plan to leave your current position in the coming year?" and reported over 17% of US ICU nurses indicated "yes". Reasons for ICU nurse stated intent to leave included working conditions (52%), positive career move (22%), personal or family reasons (11%), retirement (3%), and no reason given (12%).

Campbell (2013) used a nine item intent to stay instrument, the JAREL Spiritual Well-being scale (French, Lenton, Walters, & Eyles, 2000), and a 57 item expanded nursing stress scale (Hungelmann, Kenkel-Rossi, Klassen, & Stollenwerk, 1996) amongst 80 Ohio cardiovascular, surgical and medical ICU nurses. Intent to stay was defined as intent to stay working in the ICU, and the study reported a neutral response to the intent to stay questions. Campbell (2013) reported no correlation between intent to stay and stress or spirituality.

Stone, Mooney-Kane, Larson, Pastor, Zwaziger, and Dick (2006) reported 15% of US ICU nurses indicated intent to leave within the year. Based on Choi et al.'s (2004) Perceived Nurse Work Environment and the single item "Do you plan to leave your current position in the coming year?" strong evidence reports that occupational climate (organizational features such as norms and selecting leadership) and the labor market have significant roles in determining intent

to leave. Stone et al. (2009) also reported that poor working conditions were correlated to intent

to leave.

Blake, Leach, Robbins, Pike, and Needleman (2013) surveyed 35 PICU nurses across the

USA and reported a statistically significant relationship between authentic leadership (open and

honest leaders) and perceived intentions to leave when using the Practice Environment Scale of

the Nursing Work Index Revised (PES-NWIR) (Aiken & Patrician, 2000) and the single item

intent to leave question "Do you intend to leave your job in the next six months?" The hospital

variables: nursing hours per patient day for each unit (HPPD), Magnet Status designation, nurse

union representation, and the manager's responsibility for more than one unit reported no

statistically significant association with intentions to leave among PICU nurses. However, years

of experience as a PICU nurse had a statistically significant inverse relationship with intention to

leave. This is interesting as compared to Nowrouzi et al.'s (2015) research, intent to stay was

also directly associated to less nursing hours and more years of experience.

Lai et al. (2007) used a researcher designed, self-administered paper and pencil

questionnaire and reported that 48.5% of 130 eastern Taiwan ICU nurses had an intention to

leave their current job, and intent to leave the nursing profession. Further analysis indicated that

surgical ICU nurses were significantly more likely to intend to leave their jobs compared with

medical ICU nurses. ICU nurses who intended to leave had identified poorer sleep quality, more

depression and poorer health status. Lai et al. (2007) speculated that low levels of commitment to

their job and high levels of burnout caused a high percentage of those intending to leave. These

findings are similar to Oyeleye et al. (2013) who also reported a direct association between

burnout and intent to leave.

Van Dam, Meewis, and van der Heijden, (2012) used six items of Van Dam's (2008) turnover intention scale and reported 30% of the ICU nurses had intentions to leave. These findings are lower than Lai et al.'s (2007) research noted above. Van Dam et al. (2012) reported ICU nurse's inability to deal with night shifts, lack of opportunity, and lowered motivation were directly associated with turnover intention. ICU nurses who reported a supportive work environment were less likely to report intention to leave. These findings are similar to Blake et al. (2013) who also reported helpful leadership had an inverse relationship with intent to leave.

Summary

Overall throughout the research, ICU nurses' perceived intent to stay and intent to leave were assessed by utilizing single item questions. Reported lack of support, poor work atmosphere, limited work experience, and poor health was directly associated to ICU nurse's intent to leave (Lai et al., 2007; Blake et al., 2013; Stone et al., 2009). Intent to stay was directly associated to hours worked per week (around 31 hours), and limited overtime (zero to one) (Nowrouzi et al., 2016).

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Job Satisfaction

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Definition of Job Satisfaction

In 1911, Frederick Taylor examined ways to measure work and this inspired future research about job satisfaction (Castaneda & Scanlan, 2014). In 1934, Uhrbrock was one of the first psychologists to test job satisfaction through attitude measurement techniques assessing factory worker attitudes comparing both the nature of the job to perceived relationships with co-workers and supervisors (Latham & Budworth, 2007). Job satisfaction is a complex phenomenon

with several definitions. Job satisfaction according to Hayes, Bonner, and Pryor (2010) is defined

as intrapersonal impacted by factors such as experience, education and age; interpersonal

impacted by factors such as autonomy, co-worker / patient interactions and relationships; or

extra-personal impacted by factors such as workload, organizational structure and salary. For the

purpose of this study, job satisfaction was defined as a personal reaction to an organization based

on relationships, opportunities, and responsibilities.

Job Satisfaction and Empowerment Research

Nurse empowerment has been linked to many job related and organizational outcomes

such as job satisfaction. Utilizing both the CWEQ II (Laschinger et al., 2001) and the six item

global job satisfaction survey (Quinn & Shepard, 1974), Wong and Laschinger (2012) reported a

direct association between authentic leadership and job satisfaction for acute care nurses working

in Ontario with an average age of 43.4 years and 18.9 years of experience.

Laschinger et al. (2014) surveyed Ontario nurses in medical-surgical and critical care

units using the CWEQ-II (Laschinger et al., 2001), Lake's Practice Environment Scale (Lake,

2002), seven items from Shortell's Culture Scale (Shortell, Rousseau, Gillies, Devers & Simons,

1991), Judge's Core Self-evaluation scale (Judge, Erez, Bono, & Thoresen, 2003), Spreitzer's

(1995) Psychological Empowerment Scale, and a four item measure of job satisfaction adapted

from Hackman and Oldman's (1975) Job Diagnostic Survey and reported structural

empowerment had a positive correlation to unit support for professional practice and unit level

effectiveness. Judge's Core Self-evaluation scale which measured self-esteem, generalized self-

efficacy, emotional stability, and locus of control had a significant positive association to nurse

perceived job satisfaction. Laschinger et al. (2014) utilized the CWEQ II (Laschinger et al.,

2001) and reported a direct association between empowerment and nurse perceived job satisfaction. It is interesting to note that Wong and Laschinger's (2012) study was able to link authentic leadership to both empowerment and job satisfaction but did not establish a correlation between job satisfaction and empowerment. One may appreciate knowing if such a link exists between empowerment (i.e. having the resources and support) and job satisfaction. Although Laschinger et al. (2014) did establish a direct association between empowerment and job satisfaction; they did not analyze the relationship between self-esteem, generalized self-efficacy, emotional stability, and locus of control with empowerment.

Job Satisfaction Research within the ICU

Research has found several factors that affect job satisfaction amongst ICU nurses. Penz, Stewart, D'Arcy, and Morgan, (2008) reported that while age did not predict job satisfaction in rural Canadian ICUs, (female) gender did have a direct association to job satisfaction. Using the Index of Work Satisfaction scale (Stamps, 1997), this study also reported it was important to have available, maintained, up to date equipment and supplies to enhance perceptions of job satisfaction in rural ICUs. Satisfactions with their home community and less extensive workloads were also significant predictors of job satisfaction for rural ICU nurses.

Wu, Oliffe, Bungay, and Johnson (2014) utilized an interpretive descriptive method and reported that recognition of performance, thank-you cards, letters, hugs, cookies, gifts, mentions in patient's obituaries, and both verbal and nonverbal expressions of appreciation were directly associated to job satisfaction amongst male nurses working in British Columbian ICUs.

In Western Canadian PICU's, Mahon (2014) utilized Carspecken's (1996) five stages for critical qualitative research and identified four themes essential to nurse perceived job satisfaction. The first theme "trust and communication" referred to trusting nurse colleagues' ability to look after a patient and communicating with the use of feelings as well as medical facts. The second theme "entering the inner sanctum and recognition" was described as becoming an expert PICU nurse and this was associated with retaining PICU nurses. The third theme "education and power" referred to achieving educational milestones. The fourth and final theme "care of the dying child" stated that while death is distressing in its entirety, the support provided to family was one of the more satisfying components of the job.

Haut et al. (2006) created a 10 question five point Likert scale questionnaire on job satisfaction for surgical ICU nurses working in a Pennsylvania hospital. Haut et al. (2006) reported the constant presence of dedicated intensivists improved job satisfaction through better nurse-physician interactions and consistent team approach to care. This study also reported an inverse relationship between perceived ICU nurse's job satisfaction and employee absenteeism in a 'nurse managed special care unit' that emphasized shared governance (collaboration) and nurse autonomy.

Li and Lambert (2008a) found Chinese ICU nurses identified workload and uncertainty about treatment as negative predictors of job satisfaction. Utilizing the Demographic Data Questionnaire, the Nursing Stress Scale (Gray-Toft & Anderson, 1981), the Brief Cope questionnaire (Carver, 1997) and the Job Satisfaction Survey (Spector, 1997), and years of experience in nursing, behavioral disengagement and positive reframing (both behavioural disengagement and positive reframing are identified by Carver's Brief Cope questionnaire as

ways to cope) were reported as positive predictors of job satisfaction (Li & Lambert, 2008a).

Increased workload also had an inverse relationship with job satisfaction in Penz et al.'s (2008)

study and Li and Lambert's (2008b) study. Li and Lambert (2008b) utilized Spector's Job

Satisfaction Survey (1997) among Chinese ICU nurses and identified an inverse relationship

between increased workload, poor supervision, decreased contingent rewards, complex nature of

the work, poor communication, limited self-distraction, low levels of humor, poor acceptance,

increased levels of self-blame, denial and inability to vent. Li and Lambert (2008b) suggested

developing more autonomy and enhancing opportunities to work collaborative with physicians in

the care of patients could improve a Chinese ICU nurses' self-worth and subsequently their job

satisfaction.

Chaboyer et al. (2013) sampled 10 Australian ICUs and found positive teamwork climate,

job satisfaction and stress recognition were directly associated to staff perceived ability to

provide optimal patient care. Chaboyer et al. (2013) utilized the ICU version of the Safety

Attitude Questionnaire (SAQ) (Thomas, Sexton, & Helmreich, 2003), and the refined Flight

Management Attitude Questionnaire to obtain their findings. Galletta, Portoghese, Coppola,

Finco, and Campagna (2014) utilized a self-reported paper questionnaire based on validated

scales derived from psycho-social literature and reported ICU nurses working in four Italian

urban hospitals had moderate to high levels of perceived quality of practice, job satisfaction and

team commitment. This study also found a direct association between safe and efficient teams

and job satisfaction.

Myhren, Ekeberg, and Stokland (2013) used the Job Satisfaction Scale (Warr, Cook, &

Wall, 1979), a modified version of the Cooper's job stress questionnaire (Sutherland & Cooper,

1992), the Maslach Burnout Inventory (Maslach, Schaufeli, & Leiter, 2001) and a basic character

inventory developed by the authors in Norwegian medicine, general, and coronary ICUs. Myhren

et al. (2013) reported significantly higher job satisfaction in the medical ICU compared to the

general and coronary ICUs. They also reported an inverse association between job satisfaction

and job stress, depersonalization, and emotional exhaustion.

Summary

Multiple factors within research have been identified to influence nurse perceived job

satisfaction. In three separate studies, increased workload had an inverse relationship with

perceived job satisfaction (Penz et al., 2008; Li & Lambert, 2008a; Li & Lambert, 2008b). The

research also reported a positive influence on ICU nurses' perceived job satisfaction based on

access to resources, autonomy, and support (Li & Lambert, 2008b). Nurse perceived job

satisfaction also had a direct association between positive relationships with physicians, and

trusting colleagues to provide support (Haut et al., 2006; Mahon, 2014). It is not only important

to identify variables that influence job satisfaction but it is essential to foster an environment that

nurtures a positive workplace environment.

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Empowerment

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Definition of Empowerment

Kanter (1977) was one of the first to explore empowerment within organizations even

though power has been discussed in nursing literature since the 1970s (Kalisch & Kalisch, 1978).

Kanter (1993) believed that empowerment was defined by the organization and its environment.

The organization provided the two forms of power: formal and informal. Formal power refers to

the ability to mobilize resources, information, and support within the organization and is derived

from jobs that are considered central to the organization. Formal power gives individuals

flexibility and creativity through discretion in decision making by having a sought after level of

prestige. Informal power is developed from relationships within and outside of an organization

and provides social connections and information channels beneficial to the organization.

Together these two forms of power influence the levels of nurse productivity and organizational

empowerment.

Kanter's (1993) Theory of Empowerment also explains four structural ways (ways to build

power) to obtain power within an organization: access to opportunity, access to information,

access to support, and access to resources (See Figure 2.1). Access to opportunity refers to the

probability of future advancement. Access to information refers to the accessibility of

knowledge. Access to support refers to available social support within an organization. Access to

resources refers to accessible supplies or money within an organization. (Kanter, 1993). The

premise behind Kanter's Theory of Empowerment suggests structural empowerment can be

provided formally or informally when opportunity, information, support, and resources, are

present therefore increasing job satisfaction and decreasing intent to leave. Laschinger et al.'s

(2001) CWEQ II is a 21 item questionnaire that measures the four structural ways to obtain

power and the two forms of power.

Figure 2.1

<u>Rosabeth Kanter's (1977, 1993) Theory of Empowerment</u>

<u>Two forms of power:</u>

1. Formal → Power by title

2. Informal → Power by Association

<u>Ways to obtain empowerment through power:</u>

1. Access to opportunity

2. Access to information

3. Access to support

4. Access to resources

Chandler (1986) expanded upon Kanter's (1977) Theory of Empowerment and was the

first nursing researcher to examine nurses' perceptions of empowerment within their current

workplace. Chandler's (1986) research study combined Roger's (1970) nursing model and

Kanter's (1977) organizational theory by exploring the relationship between a nurse's behavior

within a scientific and artistic perspective to see how it affected their organizational future.

Thomas and Velthouse (1990) stated that empowerment could not be captured by a single

concept. Spreitzer (1995) viewed empowerment as developed from ones psychological state, and

Conger and Kanungo (1988) viewed empowerment as a phenomenon that was psychological in

nature. Laschinger et al. (2001) felt empowerment was a combination of both organizational and

psychological backgrounds, and organizational empowerment is what motivates an individual's

psychological perception.

An individual's desire to achieve professional goals has been identified within Healthy

Workplace Environment, and is the foundation for the concept of empowerment (Kramer &

Schmalenberg, 2008). Kramer and Schmalenberg (2008) concluded that Healthy Workplace

Environments empower their employees. Healthy Workplace Environments provide policies,

procedures, and systems to allow employees to meet personal and professional goals within their

organization (Disch, 2002). Research by Blake et al. (2013) suggests Healthy Workplace

Environments influenced pediatric ICU nurses intent to stay by encouraging strong nurse

leadership.

Empowerment Research within the ICU

Nurses have the potential to be empowered within an organization. Empowerment can

provide several benefits within an organization. Armellino, Griffin, and Fitzpatrick (2010) used

the CWEQ II to measure empowerment (Laschinger et al., 2001), demographic data, and the

Hospital Survey on Patient Safety Culture (Sorra & Nieva, 2004a) and reported that nurses who

worked in adult critical care units perceived themselves to be moderately empowered. Age and

years of experience as a critical care nurse and at the hospital had an inverse relationship with

perceived opportunity identified within the CWEQ II (Laschinger et al., 2001). Also, critical care

nurses without patient safety culture certification perceived a higher level of structural

empowerment than those who had certification. Knowledge of patient safety culture was directly

associated to perceptions of empowerment with Armellino, Griffin & Fitzpatrick's (2010) study.

Utilizing the CWEQ-II (Laschinger et al., 2001), self-reported national certification, and

two yes/no intent to leave questions, Fitzpatrick , Campo, Graham, and Lavandero (2010)

reported that ICU nurses surveyed across the U.S.A. had an inverse relationship between

empowerment and intent to leave. Fitzpatrick et al. (2010) reported that participants with

graduate degrees scored higher on all the CWEQ-II's (Laschinger et al., 2001) subscales except

the resource subscale. The empowerment scores were also correlated to race: the highest scores

reported among Asians, followed by Caucasians, African Americans, Hispanics, and other.

When comparing gender, women reported a higher total empowerment score and higher score on

the subscales of opportunity, information, formal power and informal power.

Browning (2013) utilized the Moral Distress Scale (Corley, 1995) and the Psychological

Empowerment Instrument (Spreitzer, 1995) amongst U.S. American Association of College

Nursing (AACN) ICU nurses and reported the empowerment item, "I really care about what I do

on my job" scored highest and the empowerment item "I have a great deal of control over what

happens in my department" scored the lowest. Increased hours worked per week, age, and ICU

experience were positively correlated to self-perceived empowerment. A moderate positive

correlation was found between empowerment and End-of-Life Nursing Education Consortium

(ELNEC) trained ICU nurses suggesting educational opportunities enhance empowerment

perceptions. Ganz et al. (2012) used the CWEQ-II (Laschinger et al., 2001), a demographic/work

characteristic questionnaire, and the Moral Distress Scale (Corley, Elswick, Gorman & Clor,

2001) and reported Israeli ICU nurses had moderate levels of structural empowerment, low

levels of moral distress frequency, and moderately high levels of moral distress intensity.

Wahlin, Ek, and Idvall (2010) conducted a phenomenological approach to research

empowerment as experienced by four ICU nurses and four ICU doctors in Southern Sweden.

They reported seven themes: "feelings of doing good"; "nourishing encounters"; "challenge,

variety, speed and excitement"; "knowledge and skill"; "self-esteem and self-confidence";

"teamwork", and "good atmosphere and organization".

"Feelings of doing good" referred to feeling empowered when nurses were able to

provide the best possible care for their patients. "Nourishing encounters" referred to positive

relationship with patients and next of kin. "Challenge, variety, speed, and excitement" referred to

saving a patient from a life threatening condition in a fast paced environment. "Knowledge and

skills" referred to continuous individual development through education and experience. "Self-

esteem and self-confidence" referred to feeling both valuable and useful and derived from next

of kin appreciation of care provided regardless of patient outcome. "Teamwork" referred to

working together toward the same goal in critical situations. "Good atmosphere and

organization" referred to allowing openness to discuss feelings and share humor without fear of

being judged. Together these seven themes were identified as experiences that increased strength

and, and perceptions of empowerment.

Summary

Overall, the research reported ICU nurses were moderately empowered (Armellino et al.,

2010; Ganz et al., 2012). Experience, education, gender, and race had a direct association to

perceptions of empowerment (Wahlin et al., 2010; Browning, 2013; Fitzpatrick et al., 2010). As

Ganz et al. (2012) reported in this study, the impact of empowerment is beneficial in establishing

a good atmosphere to foster teamwork and self confidence.

Job Satisfaction, Intent to Leave and Empowerment Research within the ICU

Job satisfaction, intent to leave, and empowerment within the ICU has been explored within the USA and Finland but not previously within Canada. Hauck et al. (2011) reported empowerment had an inverse relationship between intent to leave identifying an inverse relationship between North Eastern USA ICU nurses perception utilizing the CWEQ-II (Laschinger et al., 2001) and the Anticipated Turnover Scale (Hinshaw et al., 1985). This study reported that high empowerment scores were related to the hospital's partnerships with universities and community colleges that provide baccalaureate, master and doctoral level courses, the Critical Care Fellowship Program, and the Clinical Ladder Program for nursing (a program that recognizes and rewards nurses financially for hospital and community contributions). ICU nurses who reported perceived empowerment had a positive correlation to perceived autonomy, organizational commitment and job satisfaction. While Hauck et al. (2011) did not identify a relationship between empowerment and job satisfaction, they encouraged others to explore the possibility within ICU nursing.

Suominen, Leino-Kilpi, Merja, Doran, and Puuka, (2001) explored empowerment through Irvine, Leatt, Evans, and Baker's (1999) Empowerment Questionnaire in the context of Finnish ICU nurses and reported it had three subscales: behavioral, verbal and outcome. These three components of empowerment allowed employees to gain control over their work environment, and put those decisions into practice. Within the area of the behavioral empowerment subscale, ICU nurses reported trusting their own abilities to work in group settings and learn new organizational skills. These findings are similar to Hauck et al. (2011) who reported ICU nurses perceived empowerment as positively associated to autonomy. Within the

verbal empowerment subscale, ICU nurses had the most confidence in their ability to

communicate their views to co-workers and to participate in decisions that concerned their work,

and were less confident in their ability to state their opinions in group meetings or explain their

views on work problems to managers outside their own department. Within the area of the

outcome empowerment subscale, ICU nurses had most confidence in their abilities to change the

way they worked and to help co-workers make improvements at work. They were less confident

in their abilities to help people from different departments to determine the root causes of their

problems or make a difference to the efficiency of the hospital.

The experience of behavioral, verbal and outcome empowerment was directly associated

with age. Stronger verbal and outcome empowerment occurred with age. Increased behavioral,

verbal, and outcome empowerment was also directly associated with years of ICU nursing

experience. This research suggests that feelings of empowerment occur over time and with

experience as an ICU nurse. The type of ICU showed no statistically significant associations

with any areas of empowerment. Increased behavioral, verbal and outcome empowerment were

directly associated to motivated nurses, job satisfaction, and respect for job autonomy. The single

strongest area of empowerment was behavioral empowerment. Verbal empowerment was

directly associated to positive teamwork and multi-professional co-operation within ICU nursing.

One may infer that empowerment may exist amongst thoughts and through speech, but the

benefit of a positive workplace environment is captured by demonstrating empowerment within

an organization.

Summary

Research reported education, situational control, years of experience as an ICU nurse, and support have a direct association to ICU nurse perceived empowerment (Fitzpatrick et al., 2010; Browning, 2013; Ganz et al., 2012; Hauck et al., 2011). Several factors influenced ICU nurse's perception of empowerment and predominately nurse researchers have utilized the CWEQ II (Laschinger et al., 2001). The CWEQ II was created based on Kanter's (1993) Theory of Empowerment and includes questions to measure the four structural ways to obtain two forms of power: formal and informal.

Caring

Definition of Caring

Within nursing, there are currently three grand theories of caring: Leininger's Caring: A central focus of nursing and health services (1980); Orem's Self-Care Deficit (1991); and Watson's Philosophy and Science of Caring (1988). Leininger's (1980) was the founder of transcultural nursing, and believed that universal care was required to promote health and well-being. Orem's (1991) self-care deficit emphasized the importance of maintaining one's own well-being, with interventions considered to act on behalf of others by guiding, providing, supporting, and teaching when the individual is incapable or limited in their abilities. Watson (1988) focused on the humanistic aspects of nursing by creating a balance between a scientific and caring perspective. These three perspectives provide different aspects of the concept of caring.

Brilowski and Wendler (2005) identified five elements within the concept of caring: 'relationship', 'action', 'attitude', 'acceptance', and 'variability'. The 'relationship' refers to the ability to establish a trusting atmosphere, identifying areas of concern, and motivated to provide assistance. 'Action' refers to doing for or being with the patient. 'Attitude' refers to providing a positive environment. 'Acceptance' refers to providing the patient with dignity and respect. 'Variability' refers to the aspect of caring with growth and change as the nurse acquires experience and knowledge. Together all five of these elements are important to the nurse's understanding of the concept of caring. See Figure 2.2 for a summary of Briloski and Wendler's (2005) five attributes of caring.

Figure 2.2

Five Attributes of Caring (Briloski & Wendler, 2005)

1. Relationship: providing a trusting atmosphere

2. Action: assisting the patient

3. Attitude: providing a positive setting

4. Acceptance: respecting the patient's opinion

5. Variability: allowing the concept of caring to change with experience

The concept of caring remains multifaceted and complex, and validates the human aspect of both the patient and the nurse. However, caring within the context of the ICU has another layer of complexity in comparison to other units within a hospital. Caring in the ICU means "being uncompromisingly on call in order to assess the critical illnesses and to strive continually to preserve patients' lives and eliminate threats" (Olausson, Ekebergh, & Osterberg, 2014).

Caring and Empowerment Research

Four case studies completed by Teasdale (1989) were reviewed by Malin and Teasdale (1990) to compare the concepts of caring and empowerment to understand which concept is more beneficial within the health system. The first case study identified as 'only a little scratch' explained how a nurse embraced her need to provide a caring environment by distracting and reassuring a nervous patient about to undergo surgery. The second case study identified as 'I didn't want to frighten you' discussed how providing empowerment through explaining pre-operatively what type of pain to expect prior to the patients surgery avoided the patient's frustration with the pain actually experienced post-operatively. The third case study 'you can't soften the blow' explained the benefits of empowering the patient by explaining the possible repercussions of the surgery pre-operatively allowing the patient to choose whether to go through with the surgery. The fourth case study 'a devious package' discussed how withholding news about the patient moving until the patient felt he was ready to move was a caring intention because it was protecting him from the stress of feeling forced into moving. These case studies found caring and empowerment are two separate approaches to providing a patient with information. A caring approach provides information a patient is able to predict, whereas an empowering approach provides information that allows the patient the ability to control the event. This research reported there is no right approach when communicating information to a patient, but did report the benefits of incorporating both caring and empowerment.

Caring Research within the ICU

In 2004, Wilkin and Slevin utilized a semi structured interview guide with 46 ICU nurses to understand the meaning of caring in ICU nursing and found one central theme: 'concept of

care' and three related themes 'nursing feelings', 'nursing knowledge', and 'nursing skills'.

'Nursing feelings' refers to the motivator of nursing action. The patient's vulnerability needed to

be identified and comforted in order to provide holistic nursing care. 'Nursing knowledge' refers

to the technical competence, knowledge and professional experience which helped the nurse in

becoming confident to care, and evolved from the data. 'Nursing skills' refers to the therapeutic

nurse-patient interaction, basic nursing care, providing emotional support, appropriate staffing

and time management. The research suggests that caring in the ICU is more than understanding

the technology; it is also about understanding what the patient wants, and establishing the

trusting relationship to act as an advocate for that individual. An ICU nurse demonstrates caring

through appreciating the patient's vulnerability, takes the time to notice the subtle cues through

the patient's change of breathing, heart rate, restlessness, and works together with the team to

enhance the patient's quality of life while they are in such a delicate state of life.

Price (2013) used an ethnographic approach to understand how technology affected

caring practice in an ICU setting and identified four themes: 'vigilance', 'focus of attention',

'being present', and 'expectations'. 'Vigilance' refers to maintaining safety, responding to

warnings, and relaying abnormalities to other members of the health care team which is similar

to Wilkin and Slevin's (2004) theme 'nursing knowledge'. 'Focus of attention' refers to

balancing the physical stability of the patient and providing the psychological support. 'Being

present' refers to building a relationship with the critically ill patient and their family and is

similar to Wilkin and Slevin's (2004) theme 'nursing skills'. 'Expectations' refers to the need to

stay busy, whether it was providing patient care or documenting progress. Both Price (2013) and

Wilkin and Slevin (2004) reported that the concepts of 'caring' and 'technology' could not be

separated, rather the focus was to prioritize based on the best interest of the patient. An ICU

nurse needs to balance their ability to understand and appreciate the patient's quality of life, while advocating on behalf of the patient to provide the best medical and technological support.

Mattson, Forsner, Castren, and Arman (2013) conducted an interpretive phenomenology approach to understand the meaning of nursing care in PICU nurses in Sweden and found three themes: 'medically oriented nursing', 'parent oriented nursing care', and 'smooth operating nursing care orientation'. 'Medically oriented nursing' referred to care provided at a minimum and only on an 'as needed basis'. 'Parent oriented nursing care' refers to nursing that informs the parents about what will happen and why nursing was being carried out in a certain way, in adult language, directed toward the parent, not the child. 'Smooth operating nursing care orientation' refers to nursing care in a more relaxed environment where medical interventions are provided based on the child and family's needs. The research reported when the situation changed to critical; nursing staff had a 'medically oriented' approach; which at times compromises the child's well-being by objectifying them. While 'smooth operating nursing care orientation' is ideal especially when crises occur; in order to process how to troubleshoot in a time sensitive environment, a certain amount of detachment occurs. It would be interesting to note for future research if this change in orientation was due to self-preservation of the nurse to ensure personal attachment did not cause moral distress when the patient's condition deteriorated; or if other factors may be the cause.

Olaussonet al. (2014) conducted a phenomenological survey in three Swedish ICU's and found an incongruence between the architectural design of the bed spaces and aspects that provide strength, hope, and well-being for the critically ill patients and their families. Five themes were identified within the study: 'observing and being observed', 'a broken promise',

'cherishing life', 'ethical predicament', and 'creating a caring atmosphere'. 'Observing and being observed' refers to simply seeing the patient in their critically ill state and the technology currently providing the support similar to Mattson et al.'s (2013) theme of 'medically oriented nursing'. 'A broken promise' refers to the inability to promote well-being because of the physical atmosphere within the ICU. 'Cherishing life' refers to providing comfort and recognizing the concerns of both patient and family; and is similar to Price's (2013) theme of 'focus of attention'. 'Ethical predicament' refers to the open physical layout of the ICU knowing that privacy may not always be provided. 'Creating a caring atmosphere' refers to establishing trust which is similar to Price's (2013) theme of 'being present' and Wilkin and Slevin's (2004) theme 'nursing skills'. This study emphasized the need to include the frontline ICU staff in future construction of ICU's to ensure patients are provided the best atmosphere for their critical care needs. The frontline staff are aware of what patients may need in order optimize their current health status, and by incorporating frontline staff's perspective in construction remodeling costs may be reduced.

Siffleet, Williams, Rapley, and Slatyer (2015) used a qualitative methodology grounded theory in a Western Australian ICU to understand ICU nurses' perceived emotional wellbeing within the ICU. Emotional wellbeing occurred when ICU nurses felt they had provided their best care to critically ill patients and families. Siffleet et al. (2015) reported that all 15 ICU nurses intended to remain in the ICU and this was due to their ability to protect themselves from distress. 'Protecting self from distress' is a basic psychological process, that involves three independent phases: 'delivering best care', 'validating care episodes', and 'distancing self from distress'. 'Delivering best care' refers to the ICU nurses' ability to experience personal satisfaction and emotional wellbeing from providing care to the patient and their family.

'Validating care' refers to reflecting on ICU incidences to find meaning and perspective in the care provided. 'Distancing self from distress' refers to the ICU nurses ability to develop a psychological barrier between the nurse and the distressing experience. This study emphasized the importance of how ICU nurses maintain emotional wellbeing through providing their best care to patients and families and seeking support and understanding when distressing events occur. The ICU nurses' ability to continue to provide best possible care in the midst of such a stressful environment impacts their desire to stay in the ICU.

Enns and Sawatzky (2016) used a qualitative descriptive design amongst 17 emergency room nurses in central Canada and reported six factors that affect caring: 'workload', 'lack of time', 'staffing issues', 'lack of management support', 'shift work', and 'lack of self care'. 'Workload' refers to nurses feeling "pulled" in several directions. 'Lack of time' refers to nurses not being able to provide care they feel the patient requires. 'Staffing issues' refers to shortage of nurse's impacts the quality of care they are able to provide. 'Lack of management support' refers to the nurse's desire to have a manager they can talk to and who would listen to their concerns. 'Shift work' refers to not the type of shifts worked, rather the expectation of nurses to work overtime. 'Lack of self care' refers to the nurses' inability to stop for a meal due to the pressure of meeting patient needs. This research is different from other research on caring because it focuses on the elements that impact caring rather than how the nurse perceives care.

Summary

As Enns and Sawatzky (2016) described, several variables impact nurses' ability to provide care. Nurses identify caring as an essential element of their job. The caring atmosphere within the ICU balances the need between the technology providing the necessities of life for the

patient; the open atmosphere that does not allow for private moments of reflection; the goal of

maintaining the patient's physical and emotional well-being; and the importance of relationships

between the nurse, the patient, and the patient's family (Wilkin & Slevin, 2004; Price, 2013;

Mattson et al., 2013; Olausson et al., 2014; Siffleet et al, 2015). One may infer that a fostering,

caring environment may have a direct association with job satisfaction and intent to stay, and an

inverse relationship with intent to leave.

Overall Summary

Each of the four concepts: empowerment, caring, job satisfaction, intent to leave, and

intent to stay are based on nurses' subjective perceptions. Throughout the literature,

empowerment was reported amongst ICU nurses who had support and experience. Caring was

identified within the research as essential to establish relationships with patients. Job satisfaction

was reported amongst ICU nurses who perceived experience, support, autonomy, access to

resources, and opportunity for teamwork. Intent to leave reported a direct association between

limited managerial support, fewer years of experience, and poor work environment. Intent to stay

research reported a direct association between dependent variables such as work hours and

overtime.

The CFPNR is a good framework to use to identify the interrelationships amongst job

satisfaction, caring, empowerment, intent to leave and intent to stay. Research suggests intent to

leave has an inverse relationship with job satisfaction, caring, empowerment, and intent to stay.

However, Canadian research exploring these interrelationships is limited.

A knowledge gap exists and more information is needed to understand why ICU nurses are intending to leave or stay. Such knowledge would assist in understanding why there is a current ICU nursing shortage and promote retention. The plan for Chapter Three will focus on describing the survey population, the plan for data collection, setting and sample size, and the measurement tools.

Chapter Three: Design and Measurement

This study explores the association between empowerment, caring; socio-demographic factors (age, years of experience in the ICU, and education), and job satisfaction as independent variables. Intent to leave or intent to stay are the dependent variables. In this chapter, study design, sample are described and measured. The plan for data analysis is presented.

Study Design and Sample

This study used a cross sectional design. A cross sectional design is a type of observational study that involves the analysis of data collected from a population at one specific point in time. The benefits of utilizing cross sectional designs include the ability to collect existing data in a short period of time at little or no expense and the ability to obtain information on large populations (Meyer, Wheeler, Weinberger, Chen, & Carpenter, 2014). The major limitation associated with cross sectional design is the inability to establish causality (Meyer et al., 2014). This study explored relationships at one point in time and a limitation is the inability to establish causation.

Questionnaires were submitted to practicing ICU nurses registered through the internet using the online survey tool Survey Monkey. The College of Registered Nurses of Manitoba provides this service for a nominal charge for researchers who wish to access a sample of RNs to answer research questions. With guidance from the Conceptual Framework for Predicting Nurse Retention (CFPNR), the questionnaire items intended to meet the following four research objectives:

1. To compare the reasons why ICU nurses intend to leave or intend to stay (outcome).

2. To explore the relationships among empowerment, caring, socio demographic factors (influencing factors), and job satisfaction (intermediary factor).

3. To examine the relationship between job satisfaction (intermediary factor) and intent to leave or intent to stay (outcome).

4. To examine the overall relationships among empowerment, caring, socio-demographic factors (influencing factors), job satisfaction (intermediary factor), and intent to leave or intent to stay.

The advantages of using online surveys are: low to no cost, convenience, accessibility, quick response time, anonymity, and precise results (Gingery, 2011). There are some disadvantages to online surveys and they include: limited response rate due to lack of internet accessibility, inflexible design, and possible inappropriateness of questions (Gingery, 2011). Questionnaires were disbursed to 630 Registered nurses employed within coronary, neonatal, pediatric, medical, surgical, and / or intermediate intensive care units electronically by the College of Registered Nurses of Manitoba (CRNM). The CRNM is a regulatory body for registered nurses since 1913 that sets standards for education, registration, practice, and order appropriate remedial or disciplinary actions when standards are not met (CRNM, 2014). The questionnaires were data collected and converted to SPSS data files and saved on two flash drives, one for the researcher and the other for her advisor. The contents of these two flash drives will be erased two years after approval of the study. Several factors influence the response rate from online surveys including target population, relationship with the participants, personalization of the email

invitation, survey length, complexity of questions, survey topic, incentives for participation, and

reminder emails (Porter, 2012). The average response rate for external audiences, or audiences

not known to the individual conducting the survey, is between 10-15% (Fryrear, 2015). For this

study, although survey questionnaire was only 59 items, the lack of personalization to the

audience and an incentive likely contributed to the response rate of 12%.

Measurements

Empowerment Questionnaire (Influencing Factor)

Empowerment was measured using the CWEQ II (Laschinger et al., 2001; Laschinger,

2008; Laschinger, Finegan, and Wilk, 2009). Research on hospital based nurses in Ontario

reported empowerment had a direct and indirect effect on trust in management and a significant

direct effect on respect, trust, job satisfaction, and organizational commitment (Laschinger &

Finegan, 2005). Laschinger (2008) reported organizational empowerment (using the CWEQ II)

had a positive effect on nurse leadership quality, nurses decisional involvement, nurse physician

collaboration, perceived staffing adequacy and influenced levels of job satisfaction. This study

was sited in Ontario.

In another study, Laschinger et al. (2009) used the CWEQ II (Laschinger et al., 2001), to

conduct research on hospital based Ontario nurses, reported unit-level organizational

empowerment positively influenced staff nurse's feelings of psychological empowerment and

organizational commitment at the individual level (Laschinger et al., 2009). Dr. Laschinger's

research reported that empowerment was directly associated to nurse perceived job satisfaction,

organizational commitment, and intent to leave. The research reported the CWEQ II (Laschinger

et al., 2001) has been positively associated with respect, trust, job satisfaction, organizational

commitment, nurse leadership quality, nurse decisional involvement, nurse physician

collaboration, and perceived staffing adequacy. In summary, the CWEQ II (Laschinger et al.,

2001) has demonstrated validity in Ontario samples of nurses in three separate studies.

The CWEQ II is composed of 19 items that measure the six components of empowerment

described by Kanter (1993) (opportunity, information, support, resources, formal power and

informal power), and a two item global empowerment scale used for construct validity. The

items are averaged on each of the six components to provide a score ranging on each subscale

from 1-5, and a total empowerment score from 6-30. Higher scores mean higher perceptions of

empowerment. The two global empowerment items are summed and averaged to provide a score

ranging from 1–5, rather is used to measure construct validity. This score is not included in the

structural empowerment score.

The CWEQ II has a good Cronbach's alpha reliability range of 0.79 to 0.82, and 0.71 to

0.90 for the six subscales (U.S. Department of Health and Human Services & U.S. Department

of Labor, 2005). Construct validity of the CWEQ II has been supported by a confirmatory factor

analysis through the two global empowerment questions, and has been correlated highly with a

global empowerment measure (U.S. Department of Health and Human Services & U.S.

Department of Labor, 2005). See Figure 3.

Figure 3

Conditions of Work Effectiveness Questionnaire II (Laschinger et al., 2001)

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

	None		Some		A lot
1. Challenging work	1	2	3	4	5
2. The chance to gain new skills and knowledge on the job.	1	2	3	4	5
3. Tasks that use all of your own skills and knowledge	1	2	3	4	5

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

	No Knowledge		Some Knowledge		Know A lot
1. The current state of the hospital.	1	2	3	4	5
2. The values of top management.	1	2	3	4	5
3. The goals of top management.	1	2	3	4	5

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

	None		Some		A lot
1. Specific information about things you do well.	1	2	3	4	5
2. Specific comments about things you could improve.	1	2	3	4	5
3. Helpful hints or problem solving advice.	1	2	3	4	5

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

	None		Some		A lot
1. Time available to do necessary paperwork.	1	2	3	4	5
2. Time available to accomplish job requirements.	1	2	3	4	5
3. Acquiring temporary help when needed.	1	2	3	4	5

IN MY WORK SETTING / JOB:

		None				A lot
1.	The rewards for innovation on the job are	1	2	3	4	5
2.	The amount of flexibility in my job is	1	2	3	4	5
3.	The amount of visibility of my work-related activities within the institution is	1	2	3	4	5

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

		None				A lot
1.	Collaborating on patient care with physicians.	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

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

Caring Efficacy Scale

Caring was measured using Coates (1997) Caring Efficacy Scale (CES). The CES was developed and based upon Watson's Transpersonal Theory of Caring and Bandura's Self-Efficacy Theory (Coates, 1997). The CES is composed of 30 items administered on a six point Likert Scale (-3 = strongly disagree, +3 = strongly agree) that measures an individual's ability to establish a caring relationship with patients. The 30 items are added up and averaged to provide a score ranging from 1-6 for each individual who responds. The cumulative scale score is equal to

caring efficacy. The CES has consistent reliability and a Cronbach's alpha of 0.88 (Coates,

1997). See Figure 3.1. Caring was measured in the research by Sawatzky and Enns (2012) as an

intermediary factor. In that study, it was operationalized with the contrast of compassion fatigue

and compassion satisfaction from the Professional Quality of Life Scale (Stamm, 2005) and as a

qualitative component. For this study, Coates' (1997) Caring Efficacy Scale was selected

because it captures the essence of caring and perceived self efficacy in caring quantitatively for

use in an online questionnaire.

Figure 3.1

Caring Efficacy Scale (Coates, 1997)

Rating Scale:

-3 strongly disagree   +1slightly agree
-2 moderately disagree   +2 moderately agree
-1 slightly disagree   +3 strongly agree

	Strongly disagree					Strongly agree
1. I do not feel confident in my ability to express a sense of caring to my clients / patients.	-3	-2	-1	+1	+2	+3
2. If I am not relating well to a client / patient, I try to analyze what I can do to reach him / her.	-3	-2	-1	+1	+2	+3
3. I feel comfortable in touching my clients / patients in the course of caregiving.	-3	-2	-1	+1	+2	+3
4. I convey a sense of personal strength to my clients / patients.	-3	-2	-1	+1	+2	+3
5. Clients / patients can tell me most anything and I won't be shocked.	-3	-2	-1	+1	+2	+3
6. I have an ability to introduce a sense of normalcy in stressful conditions.	-3	-2	-1	+1	+2	+3
7. It is easy for me to consider the multifacets of a client's / patient's care, at the same time as I am listening to them.	-3	-2	-1	+1	+2	+3
8. I have difficulty in suspending my personal beliefs and biases in order to hear and accept a client / patient as a person.	-3	-2	-1	+1	+2	+3
9. I can walk into a room with a presence of serenity and energy that makes clients / patients feel better.	-3	-2	-1	+1	+2	+3
10. I am able to tune into a particular client / patient and forget my personal concerns.	-3	-2	-1	+1	+2	+3
11. I can usually create some way to relate to most any client / patient.	-3	-2	-1	+1	+2	+3
12. I lack confidence in my ability to talk to clients / patients from backgrounds different from my own.	-3	-2	-1	+1	+2	+3

		Strongly disagree					Strongly agree
14.	I use what I learn in conversations with clients / patients to provide more individualized care.	-3	-2	-1	+1	+2	+3
15.	I don't feel strong enough to listen to the fears and concerns of my clients / patients.	-3	-2	-1	+1	+2	+3
16.	Even when I'm feeling self-confident about most things, I still seem to be unable to relate to clients / patients.	-3 -3	-2 -2	-1 -1	+1 +1	+2 +2	+3 +3
17.	I seem to have trouble relating to clients / patients.	-3	-2	-1	+1	+2	+3
18.	I can usually establish a close relationship with my clients / patients.	-3	-2	-1	+1	+2	+3
19.	I can usually get patients / clients to like me.	-3	-2	-1	+1	+2	+3
20.	I often find it hard to get my point of view across to patients / clients when I need to.	-3	-2	-1	+1	+2	+3
21.	When trying to resolve a conflict with a client / patient, I usually make it worse.	-3	-2	-1	+1	+2	+3
22.	If I think a client / patient is uneasy or may need help, I approach that person.	-3	-2	-1	+1	+2	+3
23.	If I find it hard to relate to a client / patient, I'll stop trying to work with that person.	-3	-2	-1	+1	+2	+3
24.	I often find it hard to relate to clients / patients from a different culture than mine.	-3	-2	-1	+1	+2	+3
25.	I have helped many clients / patients through my ability to develop close, meaningful relationships.	-3	-2	-1	+1	+2	+3
26.	I often find it difficult to express empathy with clients / patients.	-3	-2	-1	+1	+2	+3
27.	I often become overwhelmed by the nature of the problems clients / patients are experiencing.	-3	-2	-1	+1	+2	+3
28.	When a client / patient is having difficulty com-municating with me, I am able to adjust to his / her level.	-3	-2	-1	+1	+2	+3
29.	Even when I really try, I can't get through to difficult clients / patients.	-3	-2	-1	+1	+2	+3
13.	I feel if I talk to clients / patients on an individual, personal basis, things might get out of control.	-3	-2	-1	+1	+2	+3
30.	I don't use creative or unusual ways to express caring to my clients / patients.	-3	-2	-1	+1	+2	+3

Socio-Demographic Characteristics (Influencing Factor)

Age, education, and years of experience as an ICU nurse constitute the socio-demographic data that was collected. Along with empowerment and caring, socio-demographic characteristics comprise the influencing factors that prior studies show relate directly or indirectly (through job satisfaction) to intent to leave or intent to stay. Age was measured as a continuous variable and nurses were asked to provide their years of age. Education was measured as RN diploma, BN degree, MN degree, PhD degree, or other. Finally, years of experience as an ICU nurse were measured as a continuous variable in terms of total years of ICU experience. Gender was not included as historically nursing has been a female dominated profession.

Job Satisfaction Question (Intermediary Factor)

Job Satisfaction was measured using a single item question on a five point visual analogue scale (1= not at all satisfied; 5 = very satisfied). The single item score ranges from 1-5, and the higher the score the more satisfied an individual is with their job. Previous research supports the use of a single item job satisfaction question (Sawatzky & Enns, 2012; Nagy, 2002). See Figure 3.2 for the single item job satisfaction question.

Figure 3.2

<u>Job Satisfaction Question</u>

	Not at all				**Very**
	<u>Satisfied</u>				**<u>Satisfied</u>**
How satisfied are you with your current position?	1	2	3	4	5

Intent to Leave and Intent to Stay Question (Outcome)

Intent to leave was measured using a single item intent to leave question scored on two points of "yes" or "no". Single item intent to leave questions have been widely used throughout nursing research exploring nurses' intent to leave (Blake et al., 2013; Lai et al., 2007; Stone et al., 2009). See Figure 3.3.

Figure 3.3

<u>Intent to Leave Question</u>

	<u>Yes</u>	<u>No</u>
Do you intend to leave your current position in the ICU in the next 6 months?		

In order to learn more about participants' subjective motivation to leave, an open-ended

question was provided: "If yes, why do you intend to leave your position? You can give more

than one answer". Intent to stay was measured using single item intent to stay question scored on

two points of "yes" and "no". See Figure 3.4.

Figure 3.4

<u>Intent to Stay Question</u>

                                                                        <u>Yes</u>   <u>No</u>

Do you intend to stay in your current position in the ICU?

Similarly, an open-ended question was provided: "If yes, why do you intend to stay in

your position? You can give more than one answer". These two open-ended items captured ICU

nurses' perceived reasons for intending to leave or intending to stay.

Data Analysis Plan

For qualitative analysis, two open-ended items asked about nurses' intent to leave and

intent to stay in their current position. The question asked, "If yes, why do you intend to

leave/stay in your position?" Data from these two open-ended items was coded into major

themes by the researcher and her advisor.

For quantitative data, analyses were univariate (frequencies), bivariate, and multivariate.

Univariate analysis was used to describe the means, standard deviation, range and when

appropriate, the means and median of variables. Because of non-normal distributions and small

sample size, non-parametric bivariate analysis was conducted to explore the relationship between two variables. Finally, multivariate analysis (ordinal logistic regression) was used to explore the interrelationships among all of the variables in the Conceptual Framework for Predicting Nurse Retention model. Consultation was provided by a faculty member with expertise in multivariate analysis, Dr. Rashid Ahmed.

Ethical Review

The study received ethical approval from the thesis committee and by the Education Nursing Research Ethics Board on September 30, 2015. The Approval Certificate is found in Appendix A.

Summary

The CFPNR provided the theoretical model to study the relationships among empowerment, caring, socio-demographic factors, job satisfaction and intent to leave or intent to stay. A cross sectional design meant a one time data collection occurred across a large population of ICU nurses working within the province of Manitoba. A link to Survey Monkey was submitted electronically by the CRNM containing: 1. the three demographic questions regarding nurses' age, years of experience in the ICU, and education; 2. the five measures: single item job satisfaction question, single intent to leave question, single item intent to stay question, CWEQII, and the CES experience; and 3. the two single open-ended items. Follow- up occurred once in two weeks after the initial request was submitted. Data analysis was conducted at univariate, bivariate, and multivariate analytical levels to explore the relationships between the independent variables (influencing factors and intermediary factors) and the dependent variable (outcome).

Chapter Four: Data Analysis and Results

A survey questionnaire was submitted electronically to ICU nurses currently registered as practicing in the province of Manitoba as defined by the regulatory body, the College of Registered Nurses of Manitoba (CRNM). The four objectives of the study were:

1. To compare the reasons why ICU nurses intend to leave or intend to stay,

2. To explore the relationships among empowerment, caring, socio demographic factors, (influencing factors) and job satisfaction (intermediary factor),

3. To examine the relationship between job satisfaction (intermediary factor) and intent to leave or intent to stay (outcome), and

4. To examine the overall relationships among empowerment, caring, socio-demographic factors, job satisfaction, and intent to leave or intent to stay (entire CFPNR model).

This chapter provides the data analysis procedures and the results of the study.

Data Analysis

Data was analyzed with the Statistical Package for the Social Sciences (SPSS), version 22. Cronbach's alpha was used for testing reliability of the CWEQ II (Laschinger et al., 2001) and the CES (Coates, 1997). Univariate analysis (frequencies and measures of central tendency) were used to describe the study's variable bivariate analysis (Spearman's r_s and the Mann-Whitney U) was used to explore relationships between two variables. Logistic regression was used to explore the relationships among empowerment, caring, socio-demographic factors, job satisfaction, and intent to leave or intent to stay. A total of 82 ICU nurses responded, however

due to two participants not completing a large portion of the survey and an additional seven

participants who did not answer the questions appropriately, only 73 participants could be

included yielding a 12% response rate.

Results

Socio Demographic Factors (Influencing Factors)

The age of participants ranged from 27 to 63 years, and the mean age was 43 years. 40

ICU nurses (54.8% of the participants) had a BN degree, 28 (38.4% of the participants) had a RN

diploma, three (4.1%) had other type of certification to practice in critical care; and one (1.4% of

the participants) had a MN degree. The mean years of experience working within the ICU were

11 years, and the range of experience was 1 to 34 years.

These findings are similar to previous research (Mahon, 2014; Li & Lambert, 2008a;

Fitzpatrick et al., 2010; Siffleet et al., 2015; Browning, 2013; Ganz et al., 2012; Hauck et al.,

2011; Suominen et al., 2001) where ICU nurses' years of experience ranged from 1 to 34 years

(mean of 8 years of experience). Educational preparation for this study is similar to previous

research (Ganz et al., 2012; Suominen et al., 2001; Mattsson et al., 2014; Olausson et al., 2014;

Siffleet et al., 2015; Fitzpatrick et al., 2010) where the majority of nurses had a BN degree (58%

of participants). However, Penz et al. (2008) reported the majority of their ICU nurses were

diploma prepared, and Li and Lambert (2008a) reported the majority of their ICU nurses had a

secondary degree (which is obtained through studying nursing in high school).

Empowerment (Influencing Factor)

For this study, the CWEQ II (Laschinger et al., 2001) contained 19 items amongst six

subscales, plus two additional items that measured global empowerment for the purpose of

construct validation. The CWEQ II measures six components of empowerment (opportunity,

information, support, resources, formal and informal power) (Laschinger et al., 2001). The

construct validity has been previously reported by a confirmatory factor analysis to be a good fit

(χ^2=279, df=129, CFI=.992, IFI=.992, RMSEA=0.54) (Laschinger et al., 2001). In this study, the

Cronbach's alpha for the combined six subscales of the CWEQ II was 0.90. Cronbach's alpha for

each of the six subscales and the total scale are given in Table 1. The GE consists of two global

empowerment items at the end of the questionnaire. The Cronbach's alpha's for all subscales, the

total scale and the GE are all above .70.

Table 1

<div align="center">Comparison of Cronbach's alpha reliability coefficients</div>

	Opportunity	Information	Support	Resources	JAS	ORS	Total	GE
Laschinger et al., 2001	.81	.80	.89	.84	.69	.89	.93	.88
This study	.90	.88	.86	.83	.83	.78	.90	.91

For this study, ICU nurses reported an average structural empowerment score. Structural

empowerment scores are determined within the CWEQ II by averaging the combined score of

the six subscales. The total empowerment score was 3.34 out of 5.00 (means of all subscales) or

20.09 out 30.00 (cumulative score of all subscales) suggesting that participants felt moderately

empowered (Laschinger et al., 2001). Higher scores are equivalent to higher perceived structural

empowerment. These findings are similar in comparison to other studies that reported moderate

empowerment through structural empowerment scores (Armellino et al., 2010; Ganz et al.,

2012). The following tables describe the frequencies of each subscale.

Table 2

<u>CWEQ II: Subscale 1</u>

How much of each kind of opportunity do you have in your present job?

		None		Some		A lot
1.	Challenging work	0 (0%)	3 (4.1%)	10 (13.7%)	28 (38.4%)	32 (43.8%)

N=73

2.	The chance to gain new skills and knowledge on the job	1 (1.4%)	3 (4.1%)	15 (20.5%)	21 (28.8%)	33 (45.2%)

N=73

3.	Tasks that use all of your own skills and knowledge	0 (0%)	5 (6.8%)	8 (11%)	26 (35.6%)	33 (45.2%)

N=72

The first subscale (Table 2) asked 'how much of each kind of opportunity do you have in

your present job?' The majority of the participants reported their work was challenging within

the ICU; they had the chance to gain new skills and knowledge on the job; and they were

performing   tasks within their job that used all of their own skills and knowledge. It is

interesting to note that only one participant indicated 'none' for the 'chance to gain new skills

and knowledge on the job'. Overall the mean score for this subscale is 4.18 out of 5.00

suggesting that participants felt they had opportunities in their present job.

Table 3

CWEQ II: Subscale 2

How much access to information do you have in your present job?

		No Knowledge		Some Knowledge		Know a lot
1.	The current state of the hospital	2(2.7%)	12(16.4%)	37(50.7%)	19(26.0%)	2(2.7%)
N=72						
2.	The values of top management.	7 (9.6%)	16(21.9%)	30(41.1%)	16(21.9%)	2(2.7%)
N=71						
3.	The goals of top management.	11 (15.1%)	20 (27.4%)	23(31.5%)	16 (21.9%)	2 (2.7%)
N=72						

The second subscale (Table 3) asked 'how much access to information do you have in your present job?' Most of the participants felt that had some knowledge of the current state of the hospital; they knew some of the values of top management; and they knew some to no knowledge of the goals of top management. Overall the mean score for this subscale is 2.88 out of 5.00 suggesting participants reported they had some access to information in their present job. These findings are interesting as typically ICU nurses are physically isolated from the rest of the hospital. That is to say, most ICU departments are physically located away from the other departments, on a floor by themselves. One might speculate that the ICU nurses who are heavily involved with the stressors of attempting to stabilize their critically ill patients do not necessarily

have the time or feel it is relevant to meet and discuss the current state or strategic plans of the

facility.

Table 4

CWEQ II: Subscale 3

How much access to support do you have in your present job?

		None		Some		A lot
1.	Specific information about things you do well.	9(12.3%)	14(19.2%)	25(34.2%)	20(27.4%)	4(5.5%)
N=72						
2.	Specific comments about things you could improve	9 (12.3%)	14(19.2%)	27(37.0%)	15(20.5%)	8(11.0%)
N=73						
3.	Helpful hints or problem solving advice	5(6.8%)	16(21.9%)	27(37.0%)	17(23.3%)	8 (11.0%)
N=73						

The third subscale (Table 4) asked 'how much access to support do you have in your

present job?' Most felt they received some information about things they do well; they received

some specific about things they could improve; and they received some helpful hints or problem

solving advice. Overall the mean score for this subscale is 3.01 out of 5.00 suggesting

participants felt they received some access to support in their present job. These findings are

interesting as previous research on Magnet Status hospitals has identified that having a

'supportive nurse manager and supervisor' is one of the eight Essentials of Magnetism within a

Healthy Workplace Environment (Kramer & Schmalenberg, 2008).

Table 5

<u>CWEQ II: Subscale 4</u>

How much access to resources do you have in your present job?

		<u>None</u>		<u>Some</u>		<u>A lot</u>
1.	Time available to do necessary paperwork	3(4.1%)	8(11.0%)	24(32.9%)	29(39.7%)	9(12.3%)

N=73

2.	Time available to accomplish job requirements	1(1.4%)	4(5.5%)	22(30.1%)	37(50.7%)	9(12.3%)

N=73

3.	Acquiring temporary help when needed	7(9.6%)	13(17.8%)	23(31.5%)	22(30.1%)	8(11.0%)

N=73

The fourth subscale (Table 5) asked 'how much access to resources do you have in your

present job?' Most felt they had some to a lot of time to do their necessary paperwork. This

finding is interesting as ICU nurses' roles are heavily dependent on detailed documentation

above and beyond what is expected for a nurse working on a medical or surgical ward. ICU

nurses are expected to document such things as vital signs and urine output hourly, therefore it is

not surprising that the majority of ICU nurses felt they had the time allotted to complete the

necessary paperwork. The majority of participants also indicated they had some to a lot of time

to accomplish job requirements, and they had some to a lot of time to acquire temporary help

when needed. However, it is interesting to note, almost 10% of participants indicated 'none' for

'acquiring temporary help when needed'. This may be due to a lack of or limited access to

critical care float pools to assist when ICU nurse shortages arise. Overall the mean score for this

subscale is 3.42 out of 5.00 suggesting participants felt that they received some access to

resources in their present job.

Table 6

CWEQ II: Subscale 5

In my work setting / job:

		None				A lot
1.	The rewards for innovation on the job are	17(23.3%)	20(27.4%)	21(28.8%)	11(15.1%)	4(5.5%)

N=73

2.	The amount of flexibility in my job is	3 (4.1%)	20(27.4%)	30(41.1%)	9(12.3%)	11(15.1%)

N=73

3.	The amount of visibility of my work related activities within the institution is	11(15.1%)	20(27.4%)	25(34.2%)	11(15.1%)	6 (8.2%)

N=73

The fifth subscale (Table 6) asked participants to describe how much formal power they

receive in their job. Here, less optimism is noted. Overall, the mean score for this subscale is

2.78 out of 5.00 suggesting participants had little to some access to formal power. About ¼ of

participants (23.3%) indicated they received none to some reward for innovation on the job; they

receive some flexibility in their job (41.1%); and they received some visibility of their work

related activities within their job (34.2%). For "visibility", one might speculate this is due to the

physical location of the ICU which is typically away from other areas of the hospital. Feelings of

limited reward for innovations may be related to data from the third subscale (support) where

participants indicated moderate access to support involving receiving feedback and guidance

from others.

Table 7
CWEQ II: Subscale 6

How much opportunity do you have for these activities in your present job?

		None				A lot
1.	Collaborating on patient care with physicians	1(1.4%)	1(1.4%)	13(17.8%)	18(24.7%)	40(54.8%)

N=73

2.	Being sought out by peers for help with problems	2 (2.7%)	2(2.7%)	6(8.2%)	30(41.1%)	32(43.8%)

N=72

3.	Being sought out by managers for help with problems	15(20.5%)	15(20.5%)	22(30.1%)	14 (19.2%)	7(9.6%)

N=73

4.	Seeking out ideas from professionals other than physicians, e.g., physiotherapists, occupational therapists, dieticians	0 (0%)	6(8.2%)	18(24.7%)	19(26.0%)	30(41.1%)

N=73

The sixth subscale (Table 7) asked participants how much informal power participants

received in their job. Overall the mean score for this subscale is 3.82 out of 5.00 suggesting

participants have some to a lot of access to informal power. The majority indicated that they

collaborate a lot on patient care with physicians, and were sought out a lot by peers for help with

problems. These results are not surprising as within the ICU a large amount of staff and

physicians are readily accessible for each patient due to the complexity of their health needs. It is

interesting to note however that participants were neutral when responding to how often they

were sought out by managers for help with problems. One may infer this is either due to lack of

management or lack of management interaction with nurses. This may be a pattern as it links

with the findings from the support subscale and the item on "rewards for innovation" in the

formal power subscale. For the most part, participants sought out ideas from professionals other

than physicians. These findings are not surprising due to the collaborative team approach

available within the ICU.

Table 8

<u>CWEQ II: Global Empowerment Scale</u>

		<u>Strongly Disagree</u>				<u>Strongly Agree</u>
1.	Overall, my current work environment empowers me to accomplish my work in an effective manner.	2(2.7%)	6(8.2%)	18(24.7%)	35(47.9%)	12(16.4%)

N=73

2.	Overall, I consider my workplace to be an empowering environment.	7(9.6%)	9(12.3%)	20(27.4%)	26(35.6%)	11(15.1%)

N=73

The two item global empowerment scale (Table 8) asked participants to assess their global empowerment. It is interesting to note that only 16.4% (item 1) and 15.1% (item 2) of participants strongly agree they are empowered to do their work and the workplace is an empowering environment respectively. Combining the adjacent column to "strongly agree" column indicated that 64% (item 1) and 50.7% (item 2) indicated the 2/3 and ½ of participants agreed that they were empowered to do their work and that the workplace was an empowering environment. It is difficult to interpret this Global Empowerment Scale because there are only two anchors: strongly disagree and strongly agree.

However, it is noted from the frequencies of six subscales that the mean scores for the formal power subscale (mean of 2.78, Table 12), the access to support subscale (mean of 3.01,

Table 10) and the access to information subscale (mean of 2.88, Table 9) indicate moderate

empowerment. One might speculate the connections between having some access to information

and support, and feeling a lack of formal power in their job provides more detail on

empowerment compared with the Global Empowerment Scale.

Caring (Influencing Factor)

The 30 item Caring Efficacy Scale (CES) based on Watson's Transpersonal Theory of

Caring and Bandura's Self-efficacy Theory measures how nurses perceive their ability to express

caring behaviours with patients (Coates, 1997). In the ICU, patients are typically unable to recall

the events during their stay, therefore a scale measuring patient's perspective of caring would not

have been useful for this study. The CES was included in this study because it examines nurses'

perceived ability to establish a caring relationship with a patient. Participants were asked to rate

how they felt about each statement on a six point Likert scale**.** The content validity was

previously established by Watson's "carative" factor (Coates, 1997) Cronbach's alpha was

previously reported as 0.88 (Coates, 1997). This study reported a Cronbach's alpha of 0.91. For

this study, the majority of participants indicated a high perception of their ability to express

caring behaviours (mean score of 4.97 out of 6). The CES has been used in nursing research,

predominately within unpublished master's thesis or doctoral dissertations. Amendolair (2012) is

the only published study that used the CES along with the Index of Work Satisfaction (IWS)

amongst nurses working in medical-surgical units in North and South Carolina and reported a

direct association between caring and job satisfaction. The CES has a 6 point Likert scale from

strongly disagree to strongly agree. A collapsed version is reported here where strongly disagree

and moderately disagree were combined as "disagree". Slightly disagree and slightly agree are

combined as "neutral" and moderately agree and strongly agree were combined into "agree'. See

Appendix B for the complete univariate results from the CES without collapsed categories.

Bivariate and multivariate analyses were done with the complete (not collapsed version). See

Table 9 for the frequencies using the collapsed categories.

Table 9

Caring Efficacy Scale

		Disagree	**Neutral**	**Agree**
1.	I do not feel confident in my ability to express a sense of caring to my clients/ patients.	61(83.6 %)	5(6.8%)	6(8.2%)
N=72				
2.	If I am not relating well to a client / patient, I try to analyze what I can do to reach him/ her.	10(13.6%)	19(26.0%)	43(58.9%)
N=72				
3.	I feel comfortable in touching my clients / patients in the course of care giving.	**5(6.8%)**	8(11.0%)	60(82.2%)
N=73				
4.	I convey a sense of personal strength to my clients / patients.	3(4.1%)	17(23.2%)	53(72.6%)
N=73				
5.	Clients / patients can tell me most anything and I won't be shocked.	2(2.8%)	13(17.8%)	58(79.4%)
N=73				
6.	I have an ability to introduce a sense of normalcy in stressful conditions.	**5(6.9%)**	15(20.5%)	53(72.6%)
N=73				
7.	It is easy for me to consider the multifacets of a clients' patient's care, at the same time as I am listening to them	3(4.1%)	20(27.3%)	50(68.5%)
N=73				
8.	I have difficulty in suspending my personal beliefs and biases in order to hear and accept a client / patients as a person.	52(71.2%)	15(20.5%)	6(8.2%)
N=73				
9.	I can walk into a room with a presence of serenity and energy that makes clients / patients feel better.	5(6.9%)	19(26%)	49(67.1%)
N=73				

	Disagree	Neutral	Agree
10. I am able to tune into a particular client / patient and forget my personal concerns.	3(4.1%)	17(23.3%)	53(72.6%)

N=73

	Disagree	Neutral	Agree
11. I can usually create some way to relate to most any client / patient.	3(4.1%)	17(23.3%)	53(72.6%)

N=73

	Disagree	Neutral	Agree
12. I lack confidence in my ability to talk to clients / patients from backgrounds different from my own.	62(85.0%)	6(8.2%)	5(6.8%)

N=73

	Disagree	Neutral	Agree
13. I feel if I talk to clients / patients on an individual, personal bias, things might get out of control.	57(78.1%)	12(16.4%)	3(4.1%)

N=72

	Disagree	Neutral	Agree
14. I use what I learn in conversations with clients / patients to provide more individualized care.	6(8.2%)	10(13.7%)	57(78.1%)

N=73

	Disagree	Neutral	Agree
15. I don't feel strong enough to listen to the fears and concerns of my clients / patients.	66(90.4%)	4(5.5%)	3(4.1%)

N=73

	Disagree	Neutral	Agree
16. Even when I'm feeling self-confident about most things, I still seem to be unable to relate to clients / patients.	60(82.2%)	8(10.9%)	4(6.8%)

N=73

	Disagree	Neutral	Agree
17. I seem to have trouble relating to clients / patients.	67(91.8%)	5(6.9%)	0(0%)

N=72

	Disagree	Neutral	Agree
18. I can usually establish a close relationship with my clients / patients.	9(12.4%)	20(27.4%)	44(60.3%)

N=73

	Disagree	Neutral	Agree
19. I can usually get patients / clients to like me.	7(9.6%)	14(19.1%)	52(71.2%)

N=73

	Disagree	Neutral	Agree
20. I often find it hard to get my point of view across to patients / clients when I need to.	59(80.8%)	10(13.7%)	4(5.5%)
N=73			
21. When trying to resolve a conflict with a client / patients, I usually make it worse.	65(89.0%)	7(9.6%)	1(1.4%)
N=73			
22. If I think a client / patient is uneasy or may need help, I approach that person.	4(5.5%)	17(23.3%)	48(65.7%)
N=69			
23. If I find it hard to relate to a client / patient, I'll stop trying to work with that person.	58(79.5%)	14(19.2%)	1(1.4%)
N=73			
24. I often find it hard to relate to clients / patients from a different culture than mine.	63(86.3%)	7(9.5%)	3(4.1%)
N=73			
25. I have helped many clients / patients through my ability to develop close, meaningful relationships.	10(13.7%)	28(38.4%)	35(48%)
N=73			
26. I often find it difficult to express empathy with clients / patients.	58(79.4%)	11(15.1%)	4(5.5%)
N=73			
27. I often become overwhelmed by the nature of the problems clients / patients are experiencing.	59(80.8%)	13(17.8%)	1(1.4%)
N=73			
28. When a client / patient is having difficulty communicating with me, I am able to adjust to his / her level.	3(4.1%)	18(24.7%)	51(69.9%)
N=72			
29. Even when I really try, I can't get through to difficult clients / patients.	54(74%)	16(21.9%)	3(4.1%)
N=73			

	Disagree	Neutral	Agree
30. I don't use creative or unusual ways to express caring to my clients / patients.	45(61.6%)	18(24.6%)	**9(12.3%)**

N=72

Half of the participants reported confidence in their ability to express a sense of caring to their patients across scale items. Generally speaking, the participants disagreed with negative statements about caring ability and agreed with positive statements about caring ability.   One item seems to stand out, that is, the third item, "I feel comfortable touching my clients/patients in the course of caregiving". Combining the "disagree" and "neutral" categories means that 17.8% were not comfortable touching their patients. Touch is an essential element of nursing, especially within the ICU where most of the patients are bedbound and may be deconditioned requiring physical support to perform basic activities of daily living such as washing their hair, and repositioning them in bed. One might make a few speculations about discomfort with touching. It may be that patients in ICU have serious or even life-threatening infections and even with standardized techniques, nurses may be uncomfortable with touch. Patients in ICU may be disadvantaged people in society, homeless, unkempt, lacking medical contact and care, and nurses may be uncomfortable touching these patients. Another speculation is that ICU nurses may self-select into ICU because they are task-orientated or technology keen and their desire to touch patients is perhaps less so. It is uncertain why about 18% of participants would be uncomfortable touching their patients.

The majority of participants reported that they convey a sense of strength to their patients. They also stated that patients could likely tell them anything without causing surprise.

The majority of participants also reported that they are able to react calmly in a stressful environment. However 6.9% of participants are unable to remain calm in a stressful environment. This is interesting because ICU's are known to consistently be a stressful environment.

The majority of participants reported they are able to assess a patients care needs while listening to them. For the most part, participants reported they did not have difficulty separating their personal biases when providing care to a patient. They stated they could calm a client just by their presence in the room, and they could focus on their patients without personal distractions interfering. The majority of participants also stated confidence to talk to patients from different backgrounds.

The majority of participants did not report that talking to patients about personal issues would cause a problem. They also stated they could learn how to care for their patients by talking to them. For the most part, participants felt they were strong enough to listen to the fears of their patients. This is also another component quite pertinent in the ICU. Patients are critically ill and their fears are affected by their possibility of dying. An ICU nurse needs to incorporate this element of caring within their practice.

Half of the participants reported also felt they are able to establish a close relationship with their patient. The majority of participants stated they can get their clients to like them, and they were able to get their point across when needed to a patient. The majority of participants reported they were able to resolve conflict with a patient, and could also approach a patient if they needed help. The majority of participants stated they will continue to work with a patient despite having difficulty relating to them.

The majority of participants reported they helped their patients by the close relationship they were able to develop with them, and they did not find it difficult to express empathy with their patients. The majority of participants stated they did not feel overwhelmed by problems experienced by patients. The majority of participants reported they could adjust to the patient's level if issues arose with communication. The majority of participants reported that they could get through to a difficult patient, and could use creative ways to express caring to their patients. However 12.3% agreed with the statement, "I don't use creative or unusual ways to express caring to my clients/patients." This was an interesting finding as within the ICU, patients are quite often connected to various machines and monitors. In order to communicate with patients who are intubated and chemically sedated, ICU nurses need to be creative when providing care to ensure patients are comfortable. ICU nurses rely on what they may perceive as appropriate to determine the patients comfort; and to use cues such as respiration rate, heart rate and / or blood pressure as indicators of the patients comfort. Also, when patients are intubated and their speech is affected, ICU nurses may use picture boards or white boards in a creative way to communicate with their patients. It is significant to note that the word 'relate' came up in six separate questions within the CES. One may conclude that how well a nurse perceives they relate to their patient is directly associated to their perceived ability to care.

Job Satisfaction (Intermediary Factor)

A total of 72 of the 73 participants responded to the job satisfaction single item question. Four participants (5.5%) stated they were 'not at all satisfied' with their job, and five participants (6.8%) were slightly dissatisfied with their job. Fifteen participants (20.5%) were 'neutral', 28 participants (38.4%) were slightly satisfied with their job, and 20 participants (27.4%) were very

satisfied with their job. Overall, if the frequencies for dissatisfied and those for satisfied are combined, it appears that 12.3% were dissatisfied, 20.5% were neutral, and 65.8% were satisfied. Thus, about 2/3rds of nurses indicated that they were satisfied with their jobs.

Previous research suggests that most ICU nurses are satisfied with their jobs (Galletta et al., 2014; Myrhen et al., 2013). Studies on job satisfaction within the ICU have reported a direct association to: recognition of job performance, increased communication, increased experience, increased supervision, easier workload, and humor (Wu et al., 2014; Mahon et al., 2014; Li & Lambert, 2008; Myhren et al., 2013). However unlike the studies by Wu et al. (2014), Li & Lambert (2008), Li & Lambert (2008), and Myhren et al. (2013), this study did not collect data on why the ICU nurses had a particular perceived level of job satisfaction. This is a limitation to the study that may be beneficial to incorporate into future research.

Thesis Research Objectives

Objective #1 (Outcome)

The first objective was to compare the reasons why ICU nurses' intend to leave or intend to stay within the ICU. A qualitative analysis was used to interpret the results of nurses' intent to leave and intent to stay. A total of 73 participants answered the intent to leave and intent to stay question. This study identified that 12 nurses (16.4% of the participants) currently working in the ICU intended to leave. These findings are similar to other research which indicated 15%-50% of ICU nurses report their intention to leave (Stone et al., 2006; Stone et al., 2009; Lai et al., 2007; VanDam et al., 2012; Liu et al., 2013).

Participants provided 10 comments identifying reasons why they intended to leave. Five

themes were identified from the responses provided: 'shift work', 'not enough staffing',

'inappropriate clients and lack of autonomy', 'completing graduate studies', and 'compassion

burnout'. Participants were free to provide as little or as much information as they chose so it is

not completely clear what the some of these reasons meant. Some speculation was required.

'Shift work' likely referred to the hours required to work in the ICU not accommodating

to their lifestyle or family life. Shift work may negatively affect personal and family

relationships. This may lead to ICU nurses' intent to leave especially if their family life is not

able to accommodate the shift work hours. Three participants cited 'shift work' as their reason

to leave. Previous research indicated that work, personal or family reasons, retirement, and poor

working conditions were reasons nurses intended to leave the ICU (Stone et al., 2006; Stone et

al., 2009; Blake et al., 2013).

Two participants indicated that 'not enough staffing' as their reason for intending to

leave. 'Not enough staffing' likely referred to the staff to patient ratio which might not allow

staff to provide the care they felt patients required in order to improve. Two participants

indicated 'inappropriate clients and lack of autonomy'. 'Inappropriate clients' likely referred

either to patients who did not want to be placed in the ICU when they became ill, or to patients

who were not sick enough to require an ICU admission. 'Lack of autonomy' might refer to

nurses' or patients' lack of independence to make decisions. A sense of autonomy was

mentioned within previous research as having an inverse relationship with intent to leave

(Sawatzky et al., 2015; Hauck et al., 2011). Two participants indicated 'completing graduate

studies' was the reason they intended to leave. 'Completing graduate studies' likely referred to

staff who intended to leave to complete a graduate study program or were currently in a graduate

program. Leaving work to pursue higher education does not necessarily reflect negatively on the

workplace environment. 'Compassion burnout' likely referred to this staff member recognizing a

change in the desire to help those who are critically ill. The stress in the ICU is high due to the

acuity of the patients. One may infer that if ICU nurses do not feel they have the ability to de-

stress, they may become burnt out. While compassion burnout is not a surprising find, it is

perhaps more surprising that only one participant identified this as the reason they intended to

leave. Please see Table 10 for the reasons participants stated they intended to leave.

Table 10

<div align="center">Intent to Leave Reasons</div>

Themes	n=
Shift work	3
Not enough staffing	2
Inappropriate clients, and lack of autonomy	2
Completing graduate studies	2
Compassion burnout	1

This study also reported 61 (83.6% of the participants) intended to stay in the ICU. This

contrasts with previous research which reported only 28% of ICU nurses intended to stay (Liu et

al., 2013). It is important to note within Liu et al.'s (2013) study that over 60% did not indicate

their intent to leave or stay leaving one to ponder what the results might have been if the 40%

who did indicate a preference had formed the base for analysis.

Within this study, an additional 44 comments were provided by participants identifying

reasons participants intended to stay. Six themes were identified from the responses provided:

'love what I do', 'close to retirement or retired', 'enjoy co-workers', 'lifestyle', 'experience', and 'requirement to work in Emergency Room (ER)'. Of interest, the themes derived for reasons for stay are different from those given as reasons to leave. 'Love what I do' likely refers to the staff enjoying their work environment and the care they provide to patients. Seven of the 18 participants who referred to 'loving what they did' specifically said the word 'love' in reference to their job and was why they intended to stay. This study also found 'close to retirement or retired' as a reason ICU nurses intended to stay. This finding is rather ironic, as it was also identified in this study as also a reason ICU nurses intended to leave. One might imagine that a nurse with a short period of time before retirement would state this as a reason to leave, and those with perhaps a longer period of time before retirement would say that is a reason to stay. 'Close to retirement or retired' likely refers to nurses who remain in their current position because they do not feel the desire to transition to new position before they retire from nursing. Seven participants felt 'close to retirement or retired' was the reason they intended to stay. It is also interesting to note that two participants were retired but remained as casual employees within the ICU. We might infer that they loved what they did and were not ready to leave, or it may have been an economic necessity.

Seven participants identified 'enjoy co-workers' as the reason they intended to stay. 'Enjoy co-workers' likely refers to the positive staff relationships with their colleagues that reinforced their intention to stay in their current position. A positive relationship with staff was identified as a reason to stay in the ICU in the study by Van Dam et al. (2012). In that study, ICU nurses indicated that the social supports derived from colleagues, educators and supervisors enhanced the desire to stay in the current position (Van Dam et al., 2012). Certainly for the informal power subscale of the CWEQ II, participants indicated having some to a lot of informal

power (mean of 3.82 out of 5.) and the items in this subscale included ones that emphasized connections, communication and using information channels with physicians, peers, managers and members of the health care team.

'Lifestyle' likely refers to flexibility in their current work hours that allowed them balance their work and personal life or family life. Similar research identified socio demographic factors such as the hours and overtime worked affected intent to stay (Nowrouzi et al., 2016). Seven participants stated 'lifestyle' was the reason they intended to stay in the ICU.

'Experience' likely refers to the staff's enjoyment of continually learning within the ICU. One may infer that if educational opportunities are not provided and utilized by ICU nurses, then the ICU nurses may seek alternative education, similar to the two participants who were pursuing their graduate studies and intended to leave. Four participants stated within the 'experience theme' they were 'still challenged / growing', needing to 'gain more experience', able to provide 'holistic care', and continue to 'learn daily' and the reason they intended to stay in the ICU. 'Requirement to work in ER' likely refers to the expectation that staff need to work in the ICU before they are allowed to work in the emergency. One participant stated this was the reason they intended to stay in the ICU. This is interesting to note as only one person indicated this, and it is not common knowledge for that ICU experience is preferred for hiring in the emergency room. See Table 11 for the reasons participants stated they intended to stay.

Table 11:

<div align="center">Intent to Stay Reasons:</div>

Themes	n=
Love what I do	18
Close to retirement or retired	7
Enjoy co-workers	7
Lifestyle	7
Experience	4
Requirement to work in the ER	1

Objective #2

The second objective was to explore the relationships between empowerment, caring, socio demographic factors, and job satisfaction. These are the influencing factors in the CFPNR model. As indicated in chapter 4, the distribution of variables in this study failed to follow the normality assumption so non-parametric tests were used to address the research objectives and p-values are reported to show the strength and significance of correlation between the two variables. If p-values are less than 0.05, it means that the correlation between the two variables is significant compared with no correlation.

The findings on Table 18 indicate a high correlation between empowerment (CWEQII) and job satisfaction (Spearman's r_s= 0.568, n=72, p<.0001). Laschinger et al. (2014) also reported a direct association between empowerment and job satisfaction among medical/surgical and critical care nurses in Ontario. Their study examined the relationships among empowerment, job satisfaction, self-esteem, self-efficacy, emotional stability and locus of control but intent to leave or stay was not measured.

There was a moderate correlation between caring and job satisfaction (Spearman's r_s=0.263, n=73, p<.05). Amendolair (2012) using the CES, reported similar findings in her study of medical/ surgical nurses in North and South Carolina. This was the only study using the CES that could be found in the published literature; use of the CES currently is found primarily in unpublished Master's and Doctoral thesis. Sawatzky and Enns (2012) included caring in their CFPNR model-based research on emergency room nurses but the concept of caring was measured indirectly through compassion fatigue and compassion satisfaction. While the concept of caring has been a focus of research, more often the studies take a phenomenological approach, seeking to learn the meaning of caring.

The findings on Table 12 also indicate a high correlation between age of participants and number of years of experience as an ICU nurse (Spearman's r_s=0.775, n=73, p<.000). Previous studies of nurses' intent to leave or empowerment have also reported a direct association between nurses' age and years of experience (Ganz & Toren, 2014; Armellino et al., 2010). Intuitively, this finding is not surprising. The range of years of experience for this sample of ICU nurses was 1 to 43 years with a mean of 11 (median =8). Although turnover in Canadian ICU nurse has been reported as 26.% (O'Brien-Pallas et al., 2010), in this study's sample of ICU nurses, 16% indicated that they intended to leave. Please see Table 18 for the correlations and significant findings.

Table 12

Spearman Correlation Coefficients
Prob > |r| under H0: Rho=0
Number of Observations

	Caring	CWEQII	Age	ICU Exp	Job Satisfaction
Caring	1.00	0.20	0.15	0.26	0.31
		(0.09)	(0.21)	(0.02)	(0.00)
Empowerment	0.20	1.00	0.09	0.20	0.55
	(0.09)		(0.44)	(0.09)	(0.00)
Age	0.15	0.09	1.00	0.81	0.01
	(0.21)	0.44		(0.00)	(0.92)
Years of Experience	0.26	0.20	0.81	1.00	0.05
	(0.02)	(0.09)	(0.00)		(0.69)
Job Satisfaction	0.31	0.55	0.01	0.05	1.00
	(0.00)	(0.00)	(0.92)	(0.69)	

Objective #3 and Objective #4

Objectives #3 and #4 are discussed together. The third objective was to examine the relationship between job satisfaction and intent to leave or intent to stay. To examine the bivariate relationship between job satisfaction and intent to leave or intent to stay, the "intent to leave" group and the "intent to stay" group were treated as independent samples. The Mann-Whitney U, a non-parametric test was used to obtain the probability that two independent

samples were from the same population (McKillup, 2012). Job satisfaction had been measured as a single Likert item with values of 1 to 5. Results indicated that the 'intent to leave group' scored lower on job satisfaction (mean of 2.64) compared with the 'intent to stay" group (mean of 3.94) and these differences were statistically significant (p<0.001).

The fourth objective was to examine the overall relationships among empowerment, caring, socio-demographic factors, job satisfaction and intent to leave or intent to stay. This objective encompassed the entire CFPNR model which suggested the intermediary factors (for this study, job satisfaction) may intercede with influencing factors (for this study, age, years of experience in ICU) with the intent to leave/ intent to stay, the outcome variable for this study. (Education, a categorical variable was not included in the model.) Bivariate analyses (using Spearman's r_s) had indicated that: age and years of experiences were directly correlated; caring and job satisfaction were directly correlated; and empowerment and job satisfaction were directly correlated. Bivariate analyses (using Mann-Whitney U) had indicated a direct relationship between job satisfaction and intent to stay.

"Logistic regression is used to determine which variables affect the probability of a particular outcome" (Munro, 2001, p.268). For this study, multivariate analysis (an ordinal logistic regression model) initially examined the influencing factors (age, years of experience, empowerment and caring) in relation to the outcome variable, intent to leave/intent to stay, and only empowerment was significantly related to intent to stay (p<0.00). Please see Table 13 (Model 1).

Table 13

Model 1 and 2: Probability of intent to leave / intent to stay

	Model 1		Model 2	
	Odds Ratio	p-values	Odds Ratio	p-values
	[95% Confidence Interval]		[95% Confidence Interval]	
Age	0.928	0.21	0.875	0.12
	[0824, 1.045]		[0.740, 1.035]	
Years of Experience	1.044	0.51	1.044	0.62
	[0.917, 1.189]		[0.880, 1.238]	
Caring	0.737	0.58	1.340	0.63
	[0.244, 2.229]		[0.400, 4.485]	
Empowerment	0.131	0.00	0.448	0.34
	[0.033, 0.524]		[0.083, 2.405]	
Job Satisfaction			0.235	0.00
			[0.083, 0.663]	

The final step of the logistic regression analysis was to place the intermediary factor, job satisfaction into model along with influencing factors. When this was done, empowerment was no longer statistically significant. The only factor in the CFPNR model that remained statistically significant in relation to the outcome (intent to leave/intent to stay) was job satisfaction. Please see Table 13 (Model 2).

Although caring and empowerment were statistically significantly associated with job satisfaction when bivariate analyses were performed and empowerment was statistically significantly associated with intent to stay in the earlier steps of the regression model, once job satisfaction was entered into the model, empowerment became not significant. Job satisfaction remained as only statistically significant relationship with intent to stay.

Conclusion

The CFPNR model suggested a relationship among influencing and intermediary factors and outcome. This study attempted to explore and compare why ICU nurse intend to leave or intend to stay in their positions (research objective #1). Findings indicated that the reasons are different and five themes were identified to describe why ICU nurses intend to leave their current position, and six themes were identified to describe why ICU nurses intend to stay in their current position. This study introduced empowerment and caring as potential influencing factors in the CFPNR. Bivariate relationships between job satisfaction (intermediary factor) and caring and empowerment (influencing factors) were statistically significant (research objective#2). Job satisfaction and the outcome variable of intent to leave/intent to stay were statistically significant with a direct association between job satisfaction and intent to stay (research objective #3). The final ordinal logistic regression model indicated that job satisfaction was the only variable having a statistically significant relationship with the outcome variable; job satisfaction is directly associated with intent to stay (research objective #4). In this study, job satisfaction was measured with a five point Likert scale ranging from not at all satisfied to very satisfied. This single item measure of job satisfaction has been used by others (Sawatzky et al., 2012) but it is not helpful in

identifying what kinds of qualities of worklife contribute to job satisfaction. For this study, it is

suggestive that empowerment and to a lesser extent, caring might be related to job satisfaction.

Chapter Five: Discussion

The concepts of caring and empowerment related to job satisfaction, and intent to leave or intent to stay for ICU nurse have not been thoroughly researched. The focus of this study was to identify the relationships among these concepts. Specifically the research objectives were:

1. To compare the reasons why ICU nurses intend to leave or intend to stay.

2. To explore the relationships among empowerment, caring, socio demographic factors, and job satisfaction.

3. To examine the relationship between job satisfaction and intent to leave or intent to stay.

4. To examine the overall relationships among empowerment, caring, socio-demographic factors, job satisfaction, and intent to leave or intent to stay.

Discussion

As indicated earlier, although caring and empowerment were statistically significantly associated with job satisfaction when bivariate analyses were performed, and empowerment was statistically significantly associated with intent to stay in the earlier steps of the logistic regression model, once job satisfaction was entered, empowerment became not significant. Only job satisfaction was statistically significantly associated with intent to stay.

In this study, job satisfaction was measured with a five point Likert scale ranging from not at all satisfied to very satisfied. This single item Likert measure of job satisfaction has been used by others (Sawatzky et al., 2012) but a single item is not helpful in identifying what kinds

of qualities of work life contribute to job satisfaction. This could have been addressed by having

a follow-up open-ended item asking about what contributed most to having job satisfaction. For

the items on intent to leave and intent to stay, open-ended questions were posed; "If yes, why do

you intend to leave/stay in your position. You can give more than one answer." However, these

open-ended questions were fraught with their own problems. It was difficult to decipher what

was meant by "shift work" for example, and being an anonymous internet-based questionnaire,

there was no opportunity to seek clarification.

For this study, it is suggestive that empowerment and to a lesser extent, caring might be

related to job satisfaction. Certainly, the frequencies for the subscales of the CWEQ II

(empowerment) showed some areas where nurses indicated less power, including having access

to support and information, and formal power. In particular within the formal power, for the item

that asked, "The rewards for innovation on the job are ___", where almost ¼ of participants

indicated "none". The mean value of the formal power subscale was the lowest of all of the

subscales (mean value of 2.78 out of 5.00) meaning little to some access to formal power. The

use of the CWEQ II is not widespread and most studies have come from the work of Laschinger

and her colleagues whose work is focused on nurses in Ontario. That being said, the CWEQ II

seemed to perform well in this study with good reliability (Cronbach's alpha) and a statistically

significant bivariate relationship with job satisfaction.

The CES has not been widely used but for this study it performed well in terms of

reliability (Cronbach's alpha). One item drew attention and that was the item where 17.8% of

participants either disagreed or were neutral in response to the statement, "I feel comfortable in

touching my clients/patients in the course of caregiving". While several speculations have been

for this finding, the only way to delve into it would be through a qualitative approach.

Finally the question arises about the usefulness of the CFPNR model. For this study, the

CFPNR model was useful. The premise of the CFPNR is that "influencing factors" such as

organizational climate may be related to the "intermediary factors" such as job satisfaction, and

both the influencing factors and intermediary factors may influence the primary outcome, that is

intent to leave (Sawatzky & Enns, 2012; Sawatzky et al., 2015). For this study, the model

provided a framework for testing how empowerment and caring might theoretically fit into the

model and the multivariate findings indicated that job satisfaction had primacy in relation with

the intent to stay. The task remains to explore and discover what kinds of qualities of worklife

contribute to job satisfaction for nurses.

Limitations

Three limitations have been identified. First and foremost is the response rate. The

response rate, although considered average for an external audience, was only 12% of the total

population of registered ICU nurses in Manitoba. In retrospection, perhaps an enticing incentive

for participation, such as a draw for an iPad, would have increased the response rate. No

inducement for participation was provided in this study. Another incentive might have been to

link the reporting of findings directly to leadership in the Winnipeg Regional Health Authority,

that is, to ICU managers, and the regional director of ICU. The researcher contacted the regional

director who is interested in the findings but support among managers was not garnered by the

researcher so this assurance could not be provided. The fact remain that the vast majority of ICU

nurses chose not to participate which is their prerogative but it is unclear how results might have been different had the response rate been more representative.

A second limitation was the related to the measurement of a major variable, job satisfaction as a single item, five point Likert measure. As indicated earlier, this measure has been used in studies on nurses' intent to leave but a single item is not helpful in identifying what kinds of qualities of work life contribute to job satisfaction. This could have been addressed by having a follow-up open-ended item asking about what contributed most to having job satisfaction but an anonymous internet survey questionnaire may not be the best methodology to explore the qualities of work life that contribute to job satisfaction. This requires a methodology that includes qualitative approach and one that allows for clarification and dialogue between the researcher and participants.

A third limitation relates to the decision to follow-up the question on nurses' intent to leave and intent to stay in their position. The questions asked, "If yes, why do you intend to leave/stay in your position. You can give more than one answer." As indicated earlier, these open-ended were difficult to decipher and with an anonymous internet-based questionnaire, there was no opportunity to seek clarification. It may be that as with the measurement of job satisfaction, as discussed above, a different methodology is needed to elicit the reasons why ICU nurses' intend to leave or stay in their positions.

Practice Implications

The findings from this study are suggestive in relation to practice implications. Nursing shortages continue to be prevalent within the ICU setting and this research suggests some ways to proceed. Clearly, job satisfaction is critical in retaining ICU nurse but manager and regional directors must work to identity what contributes to job satisfaction. Bivariate analyses indicate that empowerment and caring were statistically associated with job satisfaction. These are two areas that might be further explored.

Analysis of CWEQ II suggested that ICU nurses' access to information, support and formal power could be improved. This is based on univariate analysis but there is some confirmation in that at one point in the regression process, empowerment was statistically significantly associated with intent to stay.

Exit interviews with nurses who leave their positions in ICUs might shed light on why nurses leave and lead to ways of managing or improving whatever areas are identified for improvement. This is what was attempted in this study with the open-ended items on reasons for nurses' selecting intent to leave or intent to stay in their positions.

Recommendations for Future Research

Future research is essential in developing a better understanding of ICU nurses' intent to leave and intent to stay in their positions. Longitudinal studies would be ideal. With longitudinal panel studies, a group of ICU nurses who intend to leave and a group of ICU nurses who intend to stay in their position could be followed to learn more about the factors of job satisfaction and what contributes to it. This would help immensely to see the link between intent to leave and

actually leaving and the link between intent to stay and actually staying in the position. A

qualitative and quantitative approach could be taken with qualitative work on the qualities of

work life that contribute to job satisfaction and the reasons for intent to leave and intent to stay.

Quantitative work could include empowerment, caring and other measures related to stress in the

workplace, social support and access to formal power.

The CWEQ II and CES are relatively new to nursing research but both of them demonstrate

good reliability (Cronbach's alpha) and some fit with job satisfaction and perhaps with intent to

leave and intent to stay. The CFPNR model is also relatively new but seems to offer a means to

include concepts that seem relevant to intent to leave/intent to stay outcomes as either

influencing or intermediary factors.

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Appendix A

UNIVERSITY
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APPROVAL CERTIFICATE

September 30, 2015

TO: Amanda Jacoby   (Advisor L. Guse)
           Principal Investigator

FROM: Thomas Falkenberg, Chair
           Education/Nursing Research Ethics Board (ENREB)

Re: Protocol #E2015:078
           "ICU Nurses' Perceived Empowerment, Caring, Job Satisfaction, and Intent
           to Leave within Central Canadian Hospitals"

Please be advised that your above-referenced protocol has received human ethics approval by
the Education/Nursing Research Ethics Board, which is organized and operates according to
the Tri-Council Policy Statement (2). **This approval is valid for one year only.**

Any significant changes of the protocol and/or informed consent form should be reported to the
Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- If you have funds pending human ethics approval, please mail/e-mail/fax
(261-0325) a copy of this Approval (identifying the related UM Project Number) to the
Research Grants Officer in ORS in order to initiate fund setup. (How to find your UM
Project Number: http://umanitoba.ca/research/ors/mrt-faq.html#pr0)

- If you have received multi-year funding for this research, responsibility lies with
you to apply for and obtain Renewal Approval at the expiry of the initial one-year
approval; otherwise the account will be locked.

The Research Quality Management Office may request to review research documentation from
this project to demonstrate compliance with this approved protocol and the University of
Manitoba *Ethics of Research Involving Humans.*

The Research Ethics Board requests a final report for your study (available at:
http://umanitoba.ca/research/orec/ethics/human_ethics_REB_forms_guidelines.html) in order
to be in compliance with Tri-Council Guidelines.

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Appendix B

<u>Caring Efficacy Scale</u>

	<u>Strongly Disagree</u>	<u>Moderately Disagree</u>	<u>Slightly Disagree</u>	<u>Slightly Agree</u>	<u>Moderately Agree</u>	<u>Strongly Agree</u>
I do not feel confident in my ability to express a sense of caring to my clients/ patients. N=72	41(56.2%)	20(27.4%)	5(6.8%)	0(0%)	2(2.7%)	4(5.5%)
If I am not relating well to a client / patient, I try to analyze what I can do to reach him/ her. N=72	5(6.8%)	5(6.8%)	6(8.2%)	13(17.8%)	22(30.1%)	21(28.8%)
I feel comfortable in touching my clients / patients in the course of care giving. N=73	2(2.7%)	3(4.1%)	4(5.5%)	4(5.5%)	24(32.9%)	36(49.3%)
I convey a sense of personal strength to my clients / patients. N=73	1(1.4%)	2(2.7%)	5(6.8%)	12(16.4%)	30(41.1%)	23(31.5%)
Clients / patients can tell me most anything and I won't be shocked. N=73	1(1.4%)	1(1.4%)	8(11.0%)	5(6.8%)	23(31.5%)	35(47.9%)
I have an ability to introduce a sense of normalcy in stressful conditions. N=73	1(1.4%)	4(5.5%)	3(4.1%)	12(16.4%)	25(34.2%)	28(38.4%)

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
It is easy for me to consider the multifacets of a clients' patient's care, at the same time as I am listening to them N=73	1(1.4%)	2(2.7%)	5(6.8%)	15(20.5%)	26(35.6%)	24(32.9%)
I have difficulty in suspending my personal beliefs and biases in order to hear and accept a client / patients as a person. N=73	32(43.8%)	20(27.4%)	9(12.3%)	6(8.2%)	3(4.1%)	3(4.1%)
I can walk into a room with a presence of serenity and energy that makes clients / patients feel better. N=73	1(1.4%)	4(5.5%)	6(8.2%)	13(17.8%)	27(37.0%)	22(30.1%)
I am able to tune into a particular client / patient and forget my personal concerns. N=73	1(1.4%)	2(2.7%)	8(11.0%)	9(12.3%)	31(42.5%)	22(30.1%)
I can usually create some way to relate to most any client / patient. N=73	1(1.4%)	2(2.7%)	4(5.5%)	13(17.8%)	28(38.4%)	25(34.2%)
I lack confidence in my ability to talk to clients / patients from backgrounds different from my own. N=73	44(60.3%)	18(24.7%)	4(5.5%)	2(2.7%)	2(2.7%)	3(4.1%)
I feel if I talk to clients / patients on an individual, personal bias, things might get out of control. N=72	37(50.7%)	20(27.4%)	6(8.2%)	6(8.2%)	2(2.7%)	1(1.4%)

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
I use what I learn in conversations with clients / patients to provide more individualized care. N=73	2(2.7%)	4(5.5%)	2(2.7%)	8(11.0%)	30(41.1%)	27(37.0%)
I don't feel strong enough to listen to the fears and concerns of my clients / patients. N=73	45(61.6%)	21(28.8%)	4(5.5%)	0(0%)	3(4.1%)	0(0%)
Even when I'm feeling self-confident about most things, I still seem to be unable to relate to clients / patients. N=73	40(54.8%)	20(27.4%)	6(8.2%)	2(2.7%)	3(4.1%)	1(2.7%)
I seem to have trouble relating to clients / patients. N=72	47(64.4%)	20(27.4%)	4(5.5%)	1(1.4%)	0(0%)	0(0%)
I can usually establish a close relationship with my clients / patients. N=73	1(1.4%)	8(11%)	4(5.5%)	16(21.9%)	30(41.1%)	14(19.2%)
I can usually get patients / clients to like me. N=73	0(0%)	7(9.6%)	5(6.8%)	9(12.3%)	35(47.9%)	17(23.3%)
I often find it hard to get my point of view across to patients / clients when I need to. N=73	26(35.6%)	33(45.2%)	9(12.3%)	1(1.4%)	3(4.1%)	1(1.4%)
When trying to resolve a conflict with a client / patients, I usually make it worse. N=73	39(53.4%)	26(35.6%)	7(9.6%)	0(0%)	1(1.4%)	0(0%)

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
If I think a client / patient is uneasy or may need help, I approach that person. N=69	1(1.4%)	3(4.1%)	7(9.6%)	10(13.7%)	26(35.6%)	22(30.1%)
If I find it hard to relate to a client / patient, I'll stop trying to work with that person. N=73	31(42.5%)	27(37.0%)	10(13.7%)	4(5.5%)	1(1.4%)	0(0%)
I often find it hard to relate to clients / patients from a different culture than mine. N=73	43(58.9%)	20(27.4%)	5(6.8%)	2(2.7%)	2(2.7%)	1(1.4%)
I have helped many clients / patients through my ability to develop close, meaningful relationships. N=73	4(5.5%)	6(8.2%)	7(9.6%)	21(28.8%)	21(28.8%)	14(19.2%)
I often find it difficult to express empathy with clients / patients. N=73	45(61.6%)	13(17.8%)	8(11.0%)	3(4.1%)	1(1.4%)	3(4.1%)
I often become overwhelmed by the nature of the problems clients / patients are experiencing. N=73	30(41.1%)	29(39.7%)	7(9.6%)	6(8.2%)	0(0.0%)	1(1.4%)
When a client / patient is having difficulty communicating with me, I am able to adjust to his / her level. N=72	0(0.0%)	3(4.1%)	4(5.5%)	14(19.2%)	33(45.2%)	18(24.7%)
	Strongly	Moderately	Slightly	Slightly	Moderately	Strongly

	Disagree	Disagree	Disagree	Agree	Agree	Agree
Even when I really try, I can't get through to difficult clients / patients.	20(27.4%)	34(46.6%)	12(16.4%)	4(5.5%)	1(1.4%)	2(2.7%)
N=73						
I don't use creative or unusual ways to express caring to my clients / patients.	22(30.1%)	23(31.5%)	16(21.9%)	2(2.7%)	6(8.2%)	3(4.1%)
N=72						