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Impact of home hospital program on empowerment and professional practice behaviors

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IMPACT OF HOME HOSPITAL PROGRAM ON EMPOWERMENT AND

PROFESSIONAL PRACTICE BEHAVIORS

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ABSTRACT

Impact of Home Hospital Program on Empowerment and Professional Practice Behaviors

by

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The purpose of this study was to evaluate the impact of a Home Hospital Clinical Placement program on professional behaviors of nursing staff within the Home Hospital and professional behaviors of baccalaureate nursing students enrolled in the Home Hospital Clinical Placement program. The study used a conceptual model developed and tested by Manojlovich (2003).

The study was a non-experimental, cross-sectional design to compare selected attributes between students enrolled in a Home Hospital Clinical Placement and students enrolled in a traditional clinical placement and between registered nurses with high levels of teaching interaction with home hospital students and registered nurses with low levels of teaching interaction with home hospital students. The specific attributes were those included in the Manojlovich model (2003) depicting the relationships among structural empowerment, self-efficacy, and professional behaviors.

There were no significant differences noted in overall structural empowerment ratings between home hospital and non-home hospital students. However, there was a significant difference in one structural empowerment subscale. Home hospital students reported higher ratings of formal and informal power. There were no significant differences between home hospital and non-home hospital students in ratings of self-

efficacy, professional autonomy, and observed leadership behaviors of clinical faculty. Additionally, no significant differences were noted between home hospital students and non-home hospital students when controlling for clinical level.

In the registered nurse (RN) sample, there was no significant difference noted in overall structural empowerment between nurses with high levels of teaching interaction and nurses with low levels of teaching interaction. However, there was a significant difference on one structural empowerment subscale of opportunity. Registered nurses with a high level of teaching interaction reported higher ratings of access to opportunity. There were no significant differences noted within the registered nurse sample in ratings of self-efficacy and professional autonomy based on level of teaching interaction. There was a significant difference in one subscale of observed leadership behaviors, Challenge the Process. Registered nurses with a high level of teaching interaction reported higher ratings of observed clinical faculty leadership behaviors on the subscale.

In both samples, nursing student and registered nurse, a significant positive relationship was noted between structural empowerment and professional practice behaviors and structural empowerment and observed clinical faculty leadership behaviors. In the nursing student sample, a significant positive relationship was also noted between structural empowerment and ratings of self-efficacy. In both samples there was a significant positive relationship between professional practice behaviors and self-efficacy. In the RN sample, there was a significant positive relationship between professional practice behaviors and observed clinical faculty leadership. In the nursing student sample there was a significant positive relationship noted between observed faculty leadership and self-efficacy.

The relationship among the study attributes of structural empowerment, self-efficacy, and professional behaviors confirmed previous findings (Manojlovich, 2003). In this study, a significant positive relationship was noted in the nursing student sample between observed faculty leadership and self-efficacy. This finding has not been previously reported. Additionally, in the registered nurse sample, the significant positive relationship between clinical faculty leadership behaviors and professional practice behaviors has not been previously reported.

In conclusion, this study revealed that the home hospital model can be an effective intervention to provide clinical instruction for nursing students. These findings demonstrated that a non-traditional approach to employing clinical faculty can be effective. Additionally, the findings of this study expand knowledge on unique characteristics of the work environment that impact the quality of a registered nurse's professional life. High levels of teaching interaction were significantly related to increased ratings of structural empowerment as it related to access to opportunity. Ratings of faculty leadership were noted to have a positive relationship to professional practice behaviors of registered nurses. This supports the premise that clinical placement models should not only be evaluated for their impact on students but also the impact on the practice environment.

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I greatly appreciate the support and guidance given to me by many individuals during my doctoral studies. I am extremely thankful and fortunate for the advice and counsel given to me by my committee chair, Dr. Carolyn Yucha. I am also very grateful for the support of Dr. Susan Kowalski. I have come to know both as ardent supporters of scholarship and their insights and creativity not only influenced my thinking but their vision had significant impact on the practice environment of the home hospital program.

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CHAPTER 1

INTRODUCTION

Health care reform promises to radically change the current health care system.

In 2010, landmark legislation was passed signaling future changes in the way patient care

is delivered in the United States. The largest providers of health care are nurses. The

transformation of health care will present challenges to meet the demand for nursing care

as well as to achieve the professional skills required of nurses in a transformed health

system. In 2008 the Robert Wood Johnson Foundation and the Institute of Medicine

joined together to assess the future challenges facing the nursing profession and to offer

potential strategies in response to those challenges. The committee's charge included: (a)

reconceptualizing the role of nurses, (b) expanding nursing faculty, (c) examining

innovations in care delivery and professional education, and (d) attracting and retaining

nurses in the workforce (IOM, 2011). Key recommendations include ensuring nurses

practice to the full extent of their education and training and improving the nursing

education system to respond to faculty shortages and insufficient numbers of clinical

placements (IOM). This study examines an innovative model of clinical instruction that

provides one potential path to achieve the IOM recommendations.

Problem Statement

While the majority of clinical experiences for baccalaureate nursing students take

place in hospitals, there is little research that examines the impact of clinical education

models on both students and staff within the clinical learning environment. While there is

a growing body of literature examining the impact of the practice environment on a

nurse's ability to practice effectively (Drenkard & Swartwout, 2011), there is minimal literature that examines how nursing student education and placement impacts the practice environment. Also, while we know the practice environment impacts registered nurses, there is little research on whether a similar impact occurs with nursing students. Therefore, the purpose of this study is to examine the effect of a model wherein generic nursing students spend the majority of their clinical time on a limited number of units within one hospital.

Background and Significance to Nursing

Nevada ranks 49th among states in Registered Nurses (RNs) per capita (U.S. Department of Health and Human Services, 2010). While nationally in 2008 there was an estimated 854 RNs employed per 100,000 population, in Nevada the number was only 618 RNs per 100,000. Analysis of nursing workforce demands indicates that while intermittent workforce shortages vary by region and are normal, long-term structural issues exist that will negatively impact workforce supply (Bovbjerg, Ormond, & Pindus, 2009). While forecasted demand can be met by increasing the number of graduates, significant attention must also be given to creating and sustaining positive practice environments that contribute to maintaining and growing nursing workforce capacity.

Poor job satisfaction is a significant contributor to turnover among nurses (Bowles & Candela, 2005; Harriet, Folcarelli, Duprat, & Clifford, 1997; Spratley, Johnson, Sochlaski, Fritz, & Spencer, 2001). Overall, nurses report lower work satisfaction than reported by workers in the general population or other professionals (Spratley et al.). Approximately 70% of nurses report being satisfied in their current job compared to 85%

of general workers and 90% of professionals reporting satisfaction with their job (Spratley et al.). Staff nurses, regardless of educational preparation, reported lower levels of job satisfaction compared to peers that were not staff nurses. The position the nurse holds seems to have greater impact on job satisfaction than core job functions with the composition of the work being a key determinant (Spratley et al., p. 31).

Kovner, Brewer, Wu, Cheng, and Suzuki (2006) conducted a random sample survey of 4,000 nurses to examine factors associated with work satisfaction. The researchers tested a model examining the impact of four major groups of factors on job satisfaction: work setting, RN characteristics, metropolitan statistical area (MSA) characteristics, and movement constraints. Their results revealed that work-setting factors explained 54% of the variance in job satisfaction. The researchers also noted that high autonomy, high variety of work, and low organizational constraint contributed significantly to the nurse's job satisfaction. Researchers concluded that interventions targeted to improving key organizational characteristics including autonomy should lead to increased RN work satisfaction (Kovner et al.).

While there is strong evidence of the need to expand the nursing workforce, in 2010 U.S. nursing schools turned away 67,563 qualified applicants (American Association of Colleges of Nursing [AACN], 2011). The restrictions were based on lack of faculty, insufficient clinical and classroom resources, lack of clinical preceptors, and budget constraints. The ability of academic programs to respond to constraints is often hampered by fiscal structures within academia. Bovjerg et al. (2009) aptly note, "Given such institutional barriers, now is the time to further explore and promote new and

creative ways to expand capacities and share burdens – between hospital and universities, within universities, and through public-private partnerships" (p. 18).

Over the past 5 years, clinical placements for nursing students in Southern Nevada have become increasingly difficult to find. In this area, 700-800 nursing students per year from seven schools of nursing are in need of clinical placements at approximately 14 different hospitals and various outpatient settings. The number of students poses significant scheduling challenges that can lead to fragmented use of multiple clinical agencies, delayed clinical rotations, and in some cases, use of clinical sites that provide limited educational experiences. Together, these challenges can easily compromise the quality of education. For example, multiple clinical agencies can lead to a loss of 10 patient-care days per program of study because of orientation time. Multiple clinical agencies within a semester or across semesters can contribute to: (a) student anxiety, (b) increased faculty and student preparation time, and (c) fragmented hospital staff experience in providing clinical supervision of students.

Important factors impacting RN workforce supply include teaching capacity and attributes of the practice environment (Bovbjerg et al., 2009). As noted previously, while we know the practice environment impacts registered nurses, there is little research on whether a similar impact occurs with nursing students. Also, there is a need to examine new models of clinical instruction that can improve educational capacities and to evaluate the impact of such models on student outcomes and the practicing nurses. Little research has been conducted on the impact of interactions between students and nurses involved in their clinical education.

Purpose of Study

The purpose of this study was to evaluate the impact of a Home Hospital Clinical Placement program on professional behaviors of nursing staff within the Home Hospital and professional behaviors of baccalaureate nursing students enrolled in the Home Hospital Clinical Placement program. The study was based on a conceptual model developed and tested by Manojlovich (2003).

Assumptions

There were several assumptions underlying this study. The Home Hospital Clinical Placement Program had been in place since 2006. It was assumed that the home hospital and the registered nurses practicing at the hospital would benefit from the ongoing teaching interactions between registered nurse staff and baccalaureate students. Sponsoring students entering the profession of nursing would positively influence the professional characteristics of the work setting. Further, it was posited that providing registered nurses with an opportunity to witness students' clinical knowledge progression, rather than experiencing clinical education only through short-lived episodic interactions, would enhance a commitment to not only nursing students but the profession.

The Home Hospital clinical faculty are master's prepared nurses employed by the home hospital. In most cases, the Home Hospital clinical faculty hold positions as advanced practice nurses. It was assumed that the pre-existing relationship that existed between home hospital clinical faculty and home hospital registered nurses would strengthen student's access to clinical experiences and improve student's acceptance and

"sponsorship" by clinical unit staff. Since trust was already established with the faculty member this trust could be extended to the students under the home hospital faculty member's influence. This would serve to improve the student experience and also the experience of registered nurses working with baccalaureate students. In essence, students would not be perceived as an "added burden" in an already busy work day.

Clinical faculty are required to assign specific patients to nursing students based on student learning needs. This can be a complex process that requires the faculty member to be aware of the specific needs of a patient and also know the skills and experiential needs of the student. The match between student and patient is also complicated by the match among patient, student, and the registered nurse assigned to the patient. While a good match may be made between student and patient the clinical learning experience can be altered by a staff nurse mentor who is unwelcoming or is not sufficiently skilled in providing mentorship and constructive feedback.It was assumed that Home Hospital faculty would possess greater knowledge of patient needs as well as knowing the mentorship skills of individual staff nurses when making patient care assignments.It was assumed that Home Hospital faculty would have greater control and influence with unit-based leadership and staff when making patient care assignments versus the influence and control of clinical faculty assigned to the unit episodically for the clinical placement. Home Hospital faculty would be better able to manage the patient assignment process by first prioritizing patient care assignments to students based on their learning needs and then matching a staff nurse mentor with student and patient to achieve learning outcomes.

The Home Hospital program entails successive clinical rotations within the home hospital. It was assumed that having a "home" would provide students with an opportunity to develop stronger and more meaningful relationships with practicing nurses. These relationships would lead to greater access to patient care experiences. Additionally, it was assumed that a greater commitment to students would exist in the home hospital program since they would be seen less as an "outsider" and more as a "student-member" of the care-giving team.

Conceptual Definitions

Home hospital student group: baccalaureate nursing students assigned to the same hospital for successive clinical rotations throughout their program of study.

Traditional clinical placement group: baccalaureate nursing students assigned to multiple agencies for successive clinical rotations throughout their program of study.

Nursing staff group: registered nurses employed at the acute care hospital hosting the home hospital program.

Structural empowerment: access to Kanter's work empowerment structures: opportunity to learn, information, resources, and support.

Professional practice behaviors: attributes of professional autonomy including the ability to establish a therapeutic relationship, autonomy over practice, control over the clinical practice environment, and collaborative relationships.

Self-efficacy: one's confidence in his/her ability to establish a caring relationship.

Leadership practices: five key leadership behaviors: (a) challenging the process or the leader's action in taking risks or challenging common assumptions, (b) inspiring a shared

vision or the leader's ability to engage others in a view of the future, (c) enabling others

to act or the leader's ability to engage others in cooperative or participatory manner, (d)

modeling the way or the leader's ability to engage in practices that match his/her values,

and (e) encouraging the heart or the leader's ability to give positive feedback and public

acknowledgement.

CHAPTER 2

REVIEW OF LITERATURE

This review of literature will focus on attributes of the practice environment and registered nurse job satisfaction, structural empowerment and job satisfaction, structural empowerment and professional practice behaviors, and practice environment and student learning.

Attributes of the Practice Environment and Registered Nurse Job Satisfaction

Satisfaction with one's job or work can be considered multi-dimensional involving the interplay between person variables and organizational variables (Greguras & Ford, 2006). One measure of the interaction between person variables and organizational variables is the impact of the supervisor/employee relationship on job satisfaction and organizational commitment. Greguras and Ford examined this relationship through research based on leader-member exchange (LMX) theory. Four separate dimensions of the LMX relationship were examined: affect, loyalty, contribution, and professional respect (Greguras & Ford).

LMX theory posits that relationships develop between a supervisor and employee through social exchanges. Role theory serves as one of the foundations for the development of the LMX (Greguras & Ford, 2006). The supervisor and employee develop a relationship through a series of exchanges. In these exchanges the supervisor communicates work or role expectations and to the extent the employee fulfills these

expectations the supervisor provides further assignments, work opportunities and autonomy to the employee.

LMX is also grounded in social exchange theory. These exchanges, as opposed to monetary exchanges, are social in nature and result in feelings of "increased obligation, gratitude, and trust" (Greguras & Ford, 2006, p. 435). It is posited that as the number of social exchanges between the supervisor and employee increase the strength of the relationship is increased.

Greguras and Ford (2006) conducted a correlational study involving 422 matched employer/employee pairs to assess the validity of a multidimensional scale of leader-member exchange (LMX). Study participants were employed in a variety of settings including service (27.7%), human (14.7%), and governmental (11.4%) services. The researchers hypothesized that the LMX theory could be examined in a multi-dimensional manner, measuring job attitudes for both the supervisor and employee. The study participants completed a questionnaire that included the LMX scale measuring the leader-member exchange relationship using both the multi-dimensional and uni-dimensional scales and scales measuring satisfaction with one's supervisor (employee only), job involvement, and organizational commitment. The LMX scale measured the following dimensions of the leader-member relationship: affect, loyalty, contribution, and professional respect. The findings of the study revealed that multi-dimensional assessment, both supervisor and employee, yielded different predictors than one-dimensional assessment, employee only. The researchers concluded that affective dimensions are better predictors of the supervisor-employee relationship. However transactional dimensions (e.g. resource contributions) are more predictive of the

employee's job involvement and organizational commitment. Affective dimensions were more instrumental in predicting organizational commitment than job involvement. In other words, one is more likely to remain committed to his/her job than to the organization when he/she is less satisfied with the supervisor.

Finegan (2000) conducted a correlational study of 300 employees of a large petrochemical company to examine person and organizational variables by exploring the relationships among personal values, organizational values, and organizational commitment. Study participants completed the Meyer and Allen Commitment scale. Each participant was asked to rate each value on the scale twice, once in regard to the participant's individual values, and once with regard to the participant's perception of how the organization viewed the value. The values were grouped into four scales: humanity, adherence to convention, "bottom-line" issues, and vision. Commitment variables were measured as affective commitment or the emotional attachment for the organization, normative commitment or feelings of obligation to the organization, and continuance commitment or accumulated investments in the organization.

The results indicated that personal values or the match between personal values and the organization were less important than perception of the values of the organization in determining commitment (Finegan, 2000). The value profiles that influence affective and normative commitment differed from the values profile impacting continuance commitment. Affective commitment was most influenced by values in the humanity and vision profile. Continuance commitment was most affected by the values of adherence to convention and "bottom-line" factors. The study provides useful insight into variables that may affect organizational commitment and influence workforce participation. The

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study concludes that an employee who believes the organization is concerned with his/her well-being is more likely to be affectively committed to the organization, whereas the employee who perceives the organization as being more concerned with authority or bottom-line issues is more influenced by continuance commitment. Continuance commitment has been shown to be negatively correlated with job satisfaction (Finegan).

Decker (1997) examined occupational and non-occupational factors that impact nurses' job satisfaction. The purpose of the study was to examine the relative importance of different factors, both occupational and non-occupational, on predicting job satisfaction and psychological distress. The study was conducted with nurses working in an urban teaching hospital. Study participants completed a questionnaire measuring job satisfaction and psychological distress. The researcher utilized measurement questions from previously constructed scales to measure both of the dependent variables: job satisfaction and psychological distress. Results of the study showed six variables contributed significantly to the prediction of a nurse's job satisfaction (Decker). The variables, in order of magnitude, were: head nurse relationship, job/nonjob conflict, co-workers, unit tenure, physician relationships, and relationships with other units or departments (Decker). The researcher concluded, "Further, if an administrator wants to alter both job satisfaction and psychological distress with the same interventions, a focus on both the *head nurse relation* (italics added) and job/nonjob conflict is indicated by the results here" (Decker, p. 462).

Kovner et al. (2006) conducted a survey of a random sample of 4,000 nurses in U.S. metropolitan areas to examine factors that were associated with work satisfaction. The researchers tested a model examining the impact of four major groups of factors on

job satisfaction: work setting, RN characteristics, metropolitan statistical areas (MSA) characteristics, and movement constraints.

Their study results revealed that work-setting factors explained 54% of the variance in job satisfaction. Again, supervisory support was found to be positively correlated with job satisfaction (Kovner et al., 2006). The researchers also noted that high autonomy, high variety of work, and low organizational constraint contributed significantly to the nurse's job satisfaction. Differences in work satisfaction were also found for ethnicity and RNs in poor or fair health. Researchers concluded that interventions targeted to key organizational characteristics including autonomy and supervisory support should lead to increased RN work satisfaction (Kovner et al.).

Davidson, Follcarelli, Crawford, and Clifford (1997) studied the effects of health care reform on nurses' job satisfaction and voluntary turnover among hospital-based nurses. The longitudinal study examined the impact of implementation of an integrated clinical practice model at a large tertiary care hospital in the Northeast. The integrated practice model had four major objectives: improving continuity of care across inpatient and outpatient services, strengthening the collaboration between physicians and nurses, implementation of programs for planned career development, and restructuring of roles for direct care givers. Study participants completed the survey instrument at two time intervals. Only nurses who were working at the hospital during the first survey administration were given the survey again. Work satisfaction and intent to leave were measured using two standardized nurse job satisfaction scales.

The researchers found, among other factors, that a negative perception of communication within the organization and the nurses' perception of their ability to make

their own decisions were predictors of the nurses' intent to leave the organization. Furthermore, nurses who expressed their intent to leave at the time of the first measurement were significantly more likely to leave, and intent to leave was related to dissatisfaction with instrumental communication, level of routinization in work, perceptions of job opportunity, and the ability to make decisions on the job (Davidson et al., 1997).

The 2004 and 2008 Survey of Registered Nurses reported on job satisfaction. The findings noted that staff nurses were less likely to report that they were moderately or extremely satisfied (U.S. Department of Health and Human Services, 2010). Registered nurses who were in senior or middle management and job categories such as advanced practice or education had higher reports of being extremely satisfied. Staff nurses and RNs in first-line management positions had the highest reports of moderate or extreme dissatisfaction. The data suggested that RNs in positions that experienced greater autonomy were more likely to be extremely satisfied.

<center>Summary</center>

Satisfaction with one's work is multi-dimensional, impacted by organizational and personal variables (Davidson et al., 1997; Decker, 1997; Finegan, 2000; Greguras & Ford, 2006; Kovner et al., 2006). The supervisor/employee relationship is a key variable impacting employee satisfaction and this is similar in the nursing profession as well (Decker; Kovner et al.). Work setting factors, specifically the nurse's decisional involvement, are also positive correlates with work satisfaction (Davidson et al.; Kovner et al.).

Organizational variables and the composition of one's work can contribute positively to job satisfaction and ultimately retention. Strategies that positively influence perceptions of the practice environment are important to retain nurses and to improve overall work satisfaction.

Structural Empowerment and Job Satisfaction

Research has shown that autonomy and a positive perception of one's ability to influence the work environment are positively correlated with job satisfaction. Laschinger, Finegan, Shamian, and Wilk (2001) tested an expanded model of Kanter's concept of structural empowerment on nurses' job strain and job satisfaction. Kanter posits that organizations that create job structure that provides access to information, support to do one's job, and growth opportunities are empowering (Laschinger et al.). The researchers hypothesized that psychological empowerment was a natural outcome of structural empowerment. The study tested the relationships between structural empowerment, psychological empowerment, and job strain and work satisfaction.

The model was tested using a nonexperimental design. A random sample of 400 Canadian staff nurses participated in the study. Structural empowerment was measured using the Conditions of Work Effectiveness Questionnaire. Psychological empowerment was measured using Spreitzer's Psychological Empowerment scale. The Job Content Questionnaire and the Global Satisfaction Scale were used to measure job strain and job satisfaction respectively.

The findings of the study revealed a good fit of the model to the data. Structural empowerment in the work setting was associated with higher levels of psychological

empowerment among study participants (Laschinger et al., 2001). In turn, psychological empowerment influenced job strain. Job strain was noted to occur in situations with high psychological demands coupled with little control over one's work (Laschinger et al.). It was noted that previous studies had found individuals with high-strain jobs had significantly higher levels of job dissatisfaction. In contrast, the researchers found that job strain did not independently predict job satisfaction. Job satisfaction was predicted directly by psychological empowerment. Creating work environments that provide structural elements for empowerment increases feelings of personal empowerment and, in turn, has a positive effect on both job strain and job satisfaction. Implementing workplace strategies that impact structural and psychological empowerment is important in addressing the needs of the existing and future nursing workforce.

Leiter and Laschinger (2006) tested the structural relationships in the Nursing WorkLife Model. Figure 1 depicts the Nursing WorkLife Model (Leiter & Laschinger, p. 139).
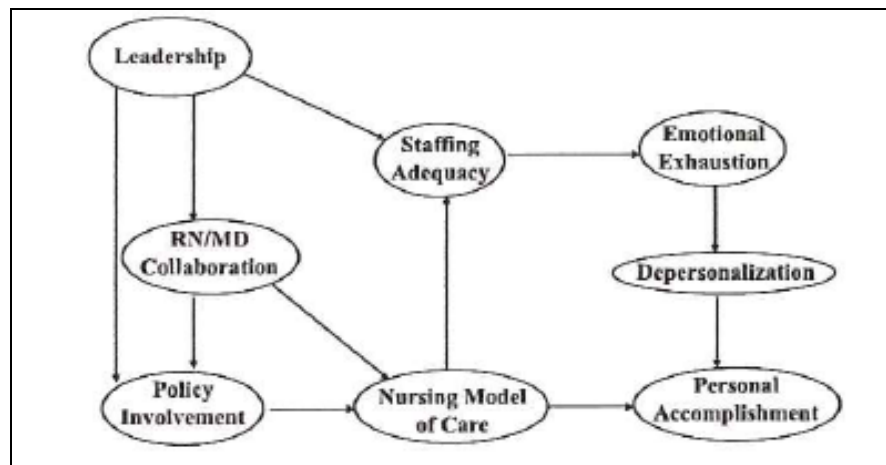
Figure 1. Leiter & Laschinger: Nursing Worklife Model.

The Nursing Worklife Model depicts the relationships between the five professional practice domains identified through research on Magnet Hospitals and burnout. The five domains are: (a) policy involvement – the extent to which nurses are involved in hospital decision-making and have perceived influence with hospital administration, (b) nursing model – nurses' perception that the hospital supported a nursing model of care delivery, (c) leadership – nurse manager leadership and support, (d) staffing – nurses' perception of the adequacy of resources, and (e) nurse-physician relationships – the quality of the working relationships between nurses and physicians (Leiter & Laschinger, 2006). Burnout was defined as "an occupationally based syndrome of emotional exhaustion, depersonalization, and personal accomplishment" (p. 138).

The hypothesized model has a beginning path starting with leadership with a direct influence on policy, staffing, and MD/Nurse relationships. The nursing model component has direct paths to staffing and personal accomplishment. The direct path from the nursing model to personal accomplishment predicts that a work environment with nursing model of care is associated with greater sense of personal accomplishment independent of issues associated with staffing (Leiter & Laschinger, 2006). Staffing adequacy has an independent path to personal accomplishment through the mediating factor of burnout or emotional exhaustion.

The structural model was tested using participants in a larger study conducted by Aiken in five countries, the *International Survey of Hospital Staff* (Aiken et al., 2001). Burnout was measured using the Maslach Burnout Inventory-Human Service Scale. The scale consists of 22 items measuring three subscales-emotional exhaustion, depersonalization, and personal accomplishment. The five professional worklife domains

were measured using Lake's Practice Environment Scale of Nursing Work Index (NWI-PES). The index consists of five subscales measuring the five dimensions of professional worklife environments.

The findings supported a structural model (nurse work-life model) that linked five worklife factors: leadership, decision-making, staffing adequacy, MD/RN relationships, policy involvement, and support for a nursing model of care. Results demonstrated a direct path from staffing adequacy to emotional exhaustion (negatively weighted) and a direct path from nursing model of care to personal accomplishment (positively weighted). A strong cluster of correlations existed between leadership, nursing model, and policy involvement.

The model supported the hypothesis related to the association between domains of professional nursing practice and burnout. Relationships were channeled through the two paths noted above: staffing to emotional exhaustion and nurse model to personal accomplishment. The researchers noted:

> The path from nursing model to personal accomplishment underscores the importance of shared values in hospital work. Regardless of their level of exhaustion or depersonalization, nurses who recognized elements of a nursing model of care operating within their hospital were able to derive a deeper sense of accomplishment from their work. This sense of professional efficacy is an important buffer against experiencing the full burnout syndrome (Leiter & Laschinger, 2006, p. 144).

While the importance of staffing in influencing burnout and ultimately one's sense of personal accomplishment cannot be minimized, the results of the study show the

equally important and independent impact of a highly visible nursing care model. Workplace strategies that improve and support a strong nursing model can be instrumental to effectively resolving issues facing the nursing workforce.

Laschinger and Leiter (2006) further tested the Nursing Worklife model to examine the impact of burnout on worklife factor and patient safety events. The researchers theorized that the work environment would have a direct impact on adverse events to the extent that the three qualities of burnout were influenced: emotional exhaustion, depersonalization, and personal accomplishment.

The data for the study was a subset of a larger study, the *International Survey of Hospital Staffing and Organization of Patient Outcomes* led by Aiken et al. (2001). Burnout was measured using the Maslach Burnout Inventory as previously described. Lake's modified Practice Environment Scale of Nursing Work Index (NWI-PES) was used to measure the five dimensions of professional worklife environments, also previously described. Adverse events were measured by nurse reports of frequency of four types of occurrences: falls, nosocomial infections, medications errors, and patient complaints.

The results of the study (Laschinger & Leiter, 2006) showed that workplace qualities affected adverse events to the extent they impacted the three elements of burnout/engagement. The two workplace qualities with direct paths to burnout, staffing adequacy and nursing model of care, influenced the prediction of adverse events. Both resource issues as identified by staffing adequacy and values issues as identified by personal accomplishment had a direct influence on reported incidence of adverse events.

Strategies that strengthen the nursing model of care positively influence the nurse's perception of personal accomplishment. In turn, this sense of personal accomplishment has a positive influence on patient outcomes.

Manojlovich and Laschinger (2007) tested an extended Nursing Worklife model by examining the influence of structural empowerment on the model's professional work environment factors that impact job satisfaction. The extended model is based on Kanter's theory of empowerment. The researchers posit that Kanter's elements of structural empowerment, opportunity and power through access to information, resources and support, will positively influence the workplace factors within the model and the Nursing Worklife model will explain variation in nursing job satisfaction.

The model was tested using data collected from 500 nurses practicing in Michigan. Perceptions of the practice environment were measured using the Conditions of Work Effectiveness Questionnaire II (CWEQ-II) and Lake's modified Practice Environment Scale of Nursing Work Index (PES -NWI). The CWEQ-II consists of 19 items with six subscales based on Kanter's theory of structural empowerment. The PES-NWI has been previously described. Nursing job satisfaction was measured using the Index of Work Satisfaction, Part B. The scale consists of 41 items measuring satisfaction with autonomy, pay, professional status, interaction with nurses and physicians, task requirements, and organizational policies (Manojlovich & Laschinger, 2007).

The findings of the study showed that structural empowerment could be added to the model. In addition, structural empowerment was shown to explain variance in nurse's job satisfaction (Manojlovich & Laschinger, 2007). Moreover, the researchers noted that implementing strategies in the workplace targeted at structural empowerment (i.e.

providing opportunities for staff to effect nursing practice) have an opportunity to positively impact the practice environment.

Laschinger (2008) tested an integrated model of nursing worklife, workplace empowerment, and nurse job satisfaction and perception of patient care quality. The elements of the model have been previously discussed.

Data were collected from 234 nurses employed in an urban tertiary care hospital in Ontario. Structural empowerment was measured using the CWEQ-II and Lake's professional environment scale as previously described. Work satisfaction was measured using a tool adapted from Hackman and Oldham's Job Diagnostic Survey. The nurse's perception of care quality was measured using a 1-item scale developed by Aiken and Patrician (Laschinger, 2008).

Findings of the study supported the previous research on structural empowerment, the nursing worklife model and work satisfaction. Structural empowerment yielded a positive effect on nursing leadership quality which was positively related to decisional involvement, nurse/physician collaboration, and perceived staffing adequacy. Staffing adequacy and structural empowerment impacted job satisfaction.

Empowering work conditions are foundational to creating positive professional work environments and positively influenced nurses' perceptions of improved quality of care.

Summary

Structural empowerment has been shown to have a positive impact on job strain and job satisfaction. Likewise, structural empowerment was noted to positively influence

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perceptions of a positive practice environment. Practice environments where nurses perceived a strong nursing care model were also positively related to nurse's perception of personal accomplishment and, in turn, have a positive influence on patient outcomes. Strategies that effectively influence structural empowerment are important to creating positive practice environments for current and future nurses.

Structural Empowerment and Professional Practice Behaviors

Manojlovich (2003) examined the effects of structural empowerment, self-efficacy, and nursing leadership on professional nursing practice behaviors. The final model is depicted in Figure 2 (Manojlovich, p. 104).
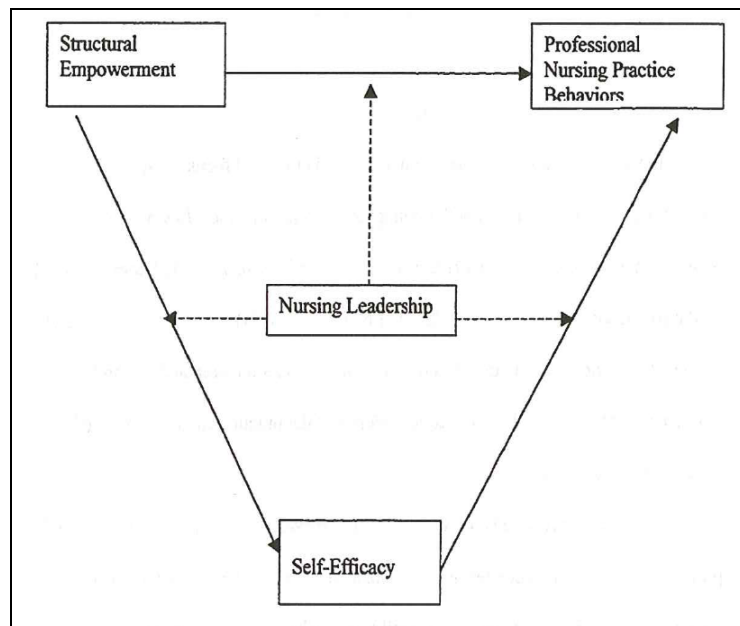
Figure 2. Manojlovich Model. Stuctural empowerment, self-efficacy, and professional nursing practice behaviors.

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The model was developed to better explain variation in professional nursing practice behaviors in hospital settings. Three hundred sixty-five nurses practicing in Michigan participated in the study. Structural empowerment was measured using the CWEQ-II as previously described. Self-efficacy was measured using the Caring Efficacy Scale (CES). The CES is a 30-item self-report tool that measures nurses' beliefs in their abilities to express caring orientations, attitudes and behaviors. Nursing leadership was measured using the Manager's Activities Scale (MAS), an 11-item tool that measures the manager's ability to mobilize resources from staff's perspective. Professional practice behaviors were measured using the Nursing Activity Scale (NAS). The NAS is a 30-item self-report with 4-point Likert scale to indicate likelihood of carrying out actions.

The study results showed that structural empowerment directly impacted professional practice behaviors. Indirectly, structural empowerment contributed to professional practice behaviors through self-efficacy. Self-efficacy was also noted to directly contribute to the presence of professional practice behaviors. While nursing leadership was found to have an overall moderating effect on the model, no direct relationship between nursing leadership behaviors and professional practice behaviors was found.

Livsey (2009) examined the associations between professional behaviors of baccalaureate nursing students and student perceptions of identified factors in the clinical learning environment including the role of clinical faculty leadership. The study utilized Manojlovich's conceptual model (2003). See Figure 4. The author examined nursing students' perceptions of structural empowerment, self-efficacy, professional practice

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behaviors, and perception of clinical faculty leadership in the clinical learning environment.

Participants in the study were recruited from the National Nursing Students' Associations enrolled in baccalaureate programs. There were 272 respondents. Structural empowerment was measured using the Conditions for Learning Effectiveness Questionnaire (CWEQ), self-efficacy was measured using the CES, Nursing Leadership was measured using the Leadership Practices Inventory-Observer (LPI-O) scale, and professional nursing behaviors were measured using the NAS.

The study findings revealed, in the full sample model, the direct path between structural empowerment and professional nursing practice behaviors was not significant. Differences were noted between low and high leadership groups. In the high leadership group, a significant positive relationship was found between structural empowerment and professional nursing practice behaviors. In the full sample, there was not a direct path between structural empowerment and student self-efficacy. However, when the groups were split the high leadership group showed a significant positive relationship with self-efficacy. Significant paths between self-efficacy and professional nursing practice behaviors were found in the full sample model. Students' self-efficacy had a significant impact on their professional nursing practice behaviors.

When influenced by strong leadership, students' reports of professional behaviors were positively influenced by perceptions of empowerment (Livsey, 2009). Structural empowerment is an important factor in contributing to the presence of professional practice not only in practicing nurses but in those learning the profession. The study underscores the importance of structural empowerment to both the current and future

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nursing workforce. More research is required to explore factors within the clinical learning environment that contribute to professional practice behaviors among students and practicing nurses.

Siu, Laschinger, & Vingilis (2005) tested Kanter's model of structural empowerment in nursing education. The researchers examined the differences in student's perceptions of structural and psychological empowerment in a problem-based learning program (PBL) versus a conventional learning program (CLL) and the association between structural empowerment and student's perception of psychological empowerment.

Participants were drawn from nursing students enrolled in a problem-based learning curriculum and nursing students enrolled in a conventional lecture learning program. Structural empowerment was measured using the Conditions for Learning Effectiveness Questionnaire (CLEQ). The tool is a modification of the Conditions of Work Effectiveness Questionnaire and was developed to assess students' perceptions of structural empowerment. Six subscales are rated on 5-point Likert scale: access to support, opportunity to learn and develop, access to information, access to resources, informal power, and formal power. Students' perceptions of psychological empowerment were measured using the Psychological Empowerment Scale (PES). The PES is a 12-item questionnaire with four subscales – meaning, competence, self-determination, and impact. Characteristics of the learning environment were measured using the Teaching-Learning Strategies Questionnaire (TLSQ). The TLSQ measures the student's exposure to problem-based and conventional learning approaches. The Clinical Problem-Solving

Scale (CPSS) was used to measure the students' perceptions of their ability to solve problems.

The study results supported Kanter's theory within nursing education environments. Students in the PBL program had significantly higher perceptions of structural empowerment than students in CLL program. Significant differences between groups were also noted for psychological empowerment when controlling for students' perceived degree of the teacher as a facilitator rather than information provider. Students with high levels of structural empowerment reported high levels of psychological empowerment.

The researchers noted that based on Kanter's theory, higher levels of empowerment among students in the PBL program may be attributed to greater involvement with their own and their peers' learning. "Their opportunity to develop stronger interpersonal networks (informal power) with faculty and peers with the PBL environment may also contribute to their empowerment." (Siu et al., 2005, p. 465). The study findings also noted that students' structural empowerment positively influenced psychological empowerment regardless of the type of learning program. It is significant to note the influence of the structure of the environment.

Summary

Structural empowerment has been shown positively influence the practice environment. Work and learning environments that are empowering can be linked empirically not only to practicing nurses' perceptions of job satisfaction and positive work outcomes but also to the clinical learning of students. Previous research has

demonstrated the important links between structural empowerment and the professional

practice environment and important work force issues such as job satisfaction and quality

of nursing care. As noted in the Manojlovich (2003) study, structural empowerment

contributes directly and positively to the presence of professional practice behaviors.

Strategies that contribute to empowerment in the clinical environment provide an

opportunity to address the current and future needs of the nursing workforce.

Practice Environment and Student Learning

Nursing students must engage in clinical practice as an important and integral part

of the nursing curriculum. Just as attributes of the practice environment are instrumental

to nurses' perceptions of satisfaction with their work experience, attributes of the practice

environment impact students' perceptions of their learning experience.

Chan (2001) developed the Clinical Learning Environment Inventory (CLEI) as a

means for assessing students' perception of the clinical learning environment. Six scales

were identified: individualization, innovation, satisfaction, involvement, personalization,

and task orientation. The CLEI was used by Chan (2001, 2004) to examine the

association between learning outcomes during clinical placement and students'

perception of the learning environment. Students' satisfaction with the clinical placement

served as the outcome measure. Students perceived personalization or the emphasis on

opportunities for individualized interaction with the instructor and/or nursing staff and

personal concern for the student's welfare as most instrumental to their learning

outcomes. Insufficient time to learn the routines of the unit and/or to develop

relationships in the clinical environment was seen by students as being detrimental to

their learning. In addition, task orientation was reported by students as being significant to their learning experience. Chan (2001) noted that students are often paired with different nurses with each nurse performing a nursing procedure in a preferred way. Students preferred learning environments are those where consistent direction and experiences can be attained. Students also noted that the interpersonal skills and approachability of nurses was critical to their learning experience (Chan, 2004).

In an Australian study of 229 undergraduate nursing students Dunn and Hansford (1997) identified factors important to students' perceptions of the clinical learning environment. The study used the Clinical Learning Environment Scale (CLES) as well as participant interviews. Nursing staff in the practice environment had the most influence on student perceptions. Registered nurse engagement in student learning and actions to make the student a part of the team was seen as most important by students. Students also perceived leadership support as instrumental to their learning. Leaders that provided visible support for student learning or that role-modeled positive behaviors or attitude on the unit were seen as contributing positively to the student's ability to learn and to benefit from teaching opportunities.

The impact of interactions with registered nurse staff during student's clinical placement was also noted by Papp, Markkanen, and von Bonsdorff (2003). The researchers used a phenomenological approach to assess student perceptions of their clinical learning experiences. Clinical staff had a significant influence on students' perception of their success. Students considered learning difficult when the registered nurse did not provide adequate communication or support. Severinsson and Sand (2010) found students viewed a supportive yet challenging relationship with a staff nurse mentor

as the most important factor in their professional development. Such a relationship was predicated on time spent together and the development of trust where the student felt open to discuss his/her learning.

The importance of the clinical instructor to a student's learning was examined by Campbell, et al. (1994). Students in the study identified the clinical instructor as most instrumental to their learning outcomes. Acting as a role model was instrumental to their learning. Clinical expertise by the faculty member helped to shape student learning. Feedback and encouragement by the clinical instructor was also viewed as being instrumental to clinical learning. Students noted that negative feedback from staff practicing on the unit could easily erode their self-confidence. However, on units where the clinical instructor was well-regarded and could effect decisions that impacted their learning, students believed their learning and experience was enhanced. "The students were of the opinion that effective instructors could 'fashion' the environment to ensure that the situation was conducive to their learning". (p. 1128)

Within the practice environment, despite the important influence of student and registered nurse interactions, staff nurses themselves are often ambivalent about working with nursing students (Matsumura, Callister, Palmer, Cox, & Larsen, 2004). Matsumura, et al. examined staff nurse perceptions of the contributions made by students during their clinical placements. Staff nurses were asked to rate 54 items on a scale ranging from -5 (extremely negative) to +5 (extremely positive). Of the top 10 ranked items, five items noted positive contributions and five were negative effects. The top ranked item was allowing opportunity for mentoring. The other positive contributions included assisting with the patient care responsibilities on the unit, individualizing interactions with patients

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and family members, stimulating staff intellectually, exposing staff to new perspectives, and enhancing the clinical setting as a learning environment. On the negative side, students were seen as threatening to professional role development, making staff feel insecure about their own practice, a source of frustration when he/she was a 'problem student', and not appreciative of the support provided by staff nurses. The positive and negative outcomes noted by registered nurses when their practice setting is used for clinical instruction underscores the challenge of creating capacity for clinical education.

Leners, Stizman, and Hessler (2006) conducted a qualitative study examining the impact of clinical placement on 15 agencies in the Midwest. Several themes emerged about the impact of acting as a sponsor for clinical learning. Very often agencies were concerned about the burden placed on registered nurses. To avoid assigning more than one student to an individual nurse, some agencies required instructors to assign students to nurses and whatever patients were assigned to the specified nurse became the student's assignment. Differing expectations across agencies that placed students at the same site was also seen as burdensome. Additionally, variations in student and faculty preparation were noted as dissatisfiers when acting as a clinical site. Supervision of students was noted to be most effective when supervision was provided by agency employees. The most effective learning experiences were predicated on close communication and active collaboration between the clinical site and the school sponsoring student placement.

Summary

Successful entry into practice requires students to have the required theoretical knowledge coupled with skills to practice within a chosen clinical setting. Practice

settings that are conducive to learning ensure an active engagement between registered

nurses and students (Dunn & Hansford, 1977; Papp, Markkanen, & von Bonsdorff, 2003;

Severinsson & Sand, 2010). Both registered nurses (Chan, 2001; 2004) and the clinical

instructor (Campbell, et al., 1994) significantly influence students' perceptions of the

clinical learning environment. In turn, student presence shapes staff nurses' perceptions

of the impact of clinical learning on the practice environment (Matsumura, et al., 2004).

While clinical placements provide practicing nurses with an opportunity to provide

mentorship to students and to grow personally, students can also be a source of added

burden. In order to identify strategies that will effectively expand educational capacity, it

is important to assess effectiveness not only in terms of the number and quality of

students "produced" but also the impact on the practice environment.

Conclusion

The literature concludes that job satisfaction is positively influenced by the

composition of nurses' work as well as characteristics of the work environment. Job

satisfaction is important for retention and workforce participation. Positive practice

environments are related to higher ratings of structural empowerment and job

satisfaction. Structural empowerment has been shown to positively influence professional

practice behaviors and self-efficacy in both students and registered nurses. There is

evidence that high levels of leadership positively impact professional practice behaviors

in both students and registered nurses. Therefore, structural empowerment, self-efficacy,

professional practice behaviors and observed leadership are appropriate measures to

examine the impact of a model of clinical placement on both students and nurses at the participating agency.

The interaction between students and practicing nurses can have significant impact. Student's learning can be enhanced or hindered by the relationship and mentorship of students can be viewed as an opportunity or a burden by registered nurses. In the Nursing Worklife Model the attributes of positive practice environments were identified. Environments that promote decisional involvement, collaboration, and have visible models of nursing care contribute to attracting and retaining nurses. While clinical placements can place a strain on the work environment, a greater potential exists for improvement by creating educational models aimed at leveraging the attributes known to increase registered nurse job satisfaction. This holds the potential to build workforce capacity while simultaneously building educational capacity.

CHAPTER 3

CONCEPTUAL FRAMEWORK

In this chapter, the conceptual framework for this study is presented. Research

questions and hypotheses are presented. The conceptual model is based on research

examining the impact of structural empowerment and self-efficacy in nursing. Structural

empowerment and self-efficacy will be presented first followed by operational definitions

for the study and the conceptual model to be examined.

Structural Empowerment

Structural empowerment is based on Kanter's work on organizational structures

(1993) that impact empowerment. The conceptualization of structural empowerment

within nursing has been the subject of previous studies (Laschinger & Finegan, 2005;

Manojlovich & Laschinger, 2007).

Kanter (1993) posits that behavior within organizations is determined by access to

opportunity, power, and the social composition of people in various parts of the

organization. Opportunity refers to future prospects and expectations. It is characterized

by access to challenging work or access to increase in one's skills and concomitant

rewards. Individuals low in opportunity tend to have lower self-esteem and perceptions of

competence, are less likely to seek change through direct action, are less likely to

promote self-efficacy through task accomplishment, form greater attachment to the "local

unit" rather than the larger organization, and are most concerned with basic survival and

extrinsic rewards (Kanter). In contrast, individuals high in opportunity have high self-

esteem and sense of value or their competence, see work as a central life interest, take action to create change, see themselves as part of a larger whole, and are concerned about the intrinsic rewards of work such as opportunities for learning (Kanter).

Power in organizations refers to the capacity to mobilize resources (Kanter, 1993). It is marked by a capacity to take actions that lead to positive outcomes both for the individual as well as the organization. Individuals low in power foster lower morale amongst the group, act in more controlling ways and in a manner that lessens autonomy, and discourage growth of others. In contrast, individuals high in organizational power promote higher morale, act in ways that promote cooperation and behave in ways that promote the development of others.

Social composition in any organization refers to the relative number of people in the same situation (Kanter,1993). Being under-represented can lead an employee to feel vulnerable. Being underrepresented provides greater challenge in finding sponsorship for greater opportunity or reward. On the other hand, people whose "type" is highly represented in the work group find it easier to fit in, are more likely to be sponsored by others of higher status, and are more likely to feel they are accurately judged by others.

A major assumption underlying Kanter's organizational theory is that work is not simply the relationship between the person and his/her job. In large measure, people's work experiences are determined by the larger setting in which the work takes place. (Kanter, 1993). Kanter further notes that the quality of work life is as important as a metric of organizational success as are economic metrics. Effective behavior at work is predicated on environments where access to opportunity and power are not constrained.

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Self-Efficacy

Townsend and Scanlan (2011) utilized concept analysis to understand the application of self-efficacy to the clinical learning of nursing students. Self-efficacy has its roots in social cognitive theory developed by Bandura (1986). Bandura defines self-efficacy as one's belief in him or herself to accomplish tasks or goals. High levels of belief lead to approach behaviors while low levels of belief lead to avoidance behaviors. Townsend and Scanlan note the importance of self-efficacy to nursing students' ability to learn and master complex tasks in the clinical setting. Students with high levels of self-efficacy will seek out opportunities to learn and achieve mastery while students with low self-efficacy will avoid situations where they fear failure.

Similar concepts have been applied to registered nurses (Manojlovich, 2005). In the practice setting, self-efficacy can be an important antecedent to nurses' self-confidence to act autonomously as a decision-maker, to establish collaborative relationships with other disciplines, and in creating and sustaining therapeutic relationships with patients (Manojlovich).

Conceptual Model
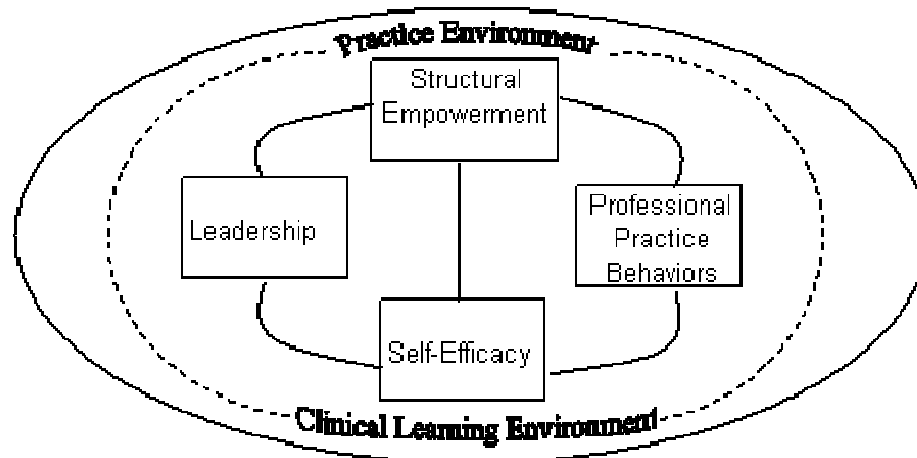
Figure 3. Conceptual model to be tested

The conceptual model is based on research conducted by Manojlovich (2003). The study showed that structural empowerment and self-efficacy directly impacted professional practice behaviors. In the model, leadership was found to have an overall moderating effect on the relationships between structural empowerment, self-efficacy and professional practice behaviors. Livsey (2009) utilized Manojlovich's model to examine the same relationships and impact on nursing students. Her results showed a positive relationship between structural empowerment and professional practice behaviors in students perceiving a high level of clinical faculty leadership. Additionally, the high leadership group also showed a significant relationship between students' self-efficacy and professional practice behaviors.

The environment in which nurses practice also serves as a clinical learning environment for students. Student learning is impacted by the practice environment and in turn the presence of students influences nurses' perceptions of their work. The Home Hospital program links the practice environment and clinical learning environment together. The hypothesized model predicts that the Home Hospital program influences nurses' perceptions of empowerment by providing opportunities for growth and professional development by acting as mentors in the clinical education of individuals entering the nursing profession. Registered nurse empowerment will influence the presence of professional practice behaviors via greater opportunity for decisional-involvement through their active teaching and interaction with the home hospital faculty and opportunities for collaboration through sponsorship of students. Additionally, the hypothesized model predicts perceptions of leadership are enhanced when clinical faculty are clinical leaders employed at the home hospital. For students, the home hospital program enhances their opportunities for learning and growth by strengthening relationships with practicing nurses. The Home Hospital program strengthens the sponsorship of students in the practice setting by connecting students with an influential member of the home hospital's nursing team – the home hospital clinical faculty member.

This study will examine the influence of a non-traditional clinical placement program, the Home Hospital program, on the nursing students and registered nurse ratings of structural empowerment, self-efficacy, and professional practice behaviors. The study will also examine if differences exist in ratings of clinical faculty leadership between home hospital and non-home hospital students and between registered nurses with high versus low teaching interactions with baccalaureate students.

Operational Definitions

Structural empowerment: refers to four empowerment dimensions of perceived access to opportunity, support, information and resources in an individual's work setting. It is measured using the Conditions of Work Effectiveness II Questionnaire (CWEQII) in registered nurses and the Conditions of Leaning Effectiveness Questionnaire (CLEQ) in nursing students.

Self-efficacy: refers to registered nurses' and nursing students' ratings of their confidence and ability to establish a caring relationship with patients. Self-efficacy is measured using the Caring Efficacy Scale (CES).

Professional practice behaviors: refers to registered nurses' and nursing students' reports of professional autonomy that is defined by ability to establish a therapeutic relationship, autonomy over practice, control over the clinical practice environment, and establishment of collaborative relationships. Professional practice behaviors are measured using the Nursing Activity Scale (NAS) professional autonomy scale.

Leadership practices: refers to behaviors displayed that are characteristics of exemplary leaders. Leadership practices is measured using the Leadership Practices Inventory-Observer instrument.

Home hospital students: nursing students who are assigned to one home hospital for successive clinical rotations throughout their program of study.

Non-home hospital students: nursing students assigned to multiple agencies for successive clinical rotations throughout their program of study.

Home hospital clinical faculty: master's prepared nurses employed by the home hospital that are responsible for an assigned clinical group's rotation at the home hospital.

Responsibilities include planning, ensuring learning outcomes, and grading of students in assigned group.

Registered nurses with high teaching interaction: this is defined as registered nurses who reported that during a semester they typically worked with a nursing student always, almost always, or often.

Registered nurses with low teaching interaction: this is defined as registered nurse who reported that during a semester they typically worked with a nursing student sometimes or seldom.

Research Questions

Students

1. Do structural empowerment ratings differ between Home Hospital students and non-Home Hospital students?

2. Do self-efficacy ratings differ between Home Hospital students and non-Home Hospital students?

3. Do professional practice behavior ratings differ between Home Hospital students and non-Home Hospital students?

4. Do ratings of clinical faculty leadership differ between Home Hospital students and non-home Hospital students?

5. What is the relationship between elements of the model (structural empowerment, self-efficacy, professional practice behaviors and observed faculty leadership behaviors)?

Registered Nurses employed in Home Hospital

6. Do structural empowerment ratings differ between nurses with high teaching interactions with Home Hospital students and nurses with low teaching interactions with Home Hospital students?

7. Do self-efficacy ratings differ between nurses with high teaching interactions with Home Hospital students and nurses with low teaching interactions with Home Hospital students?

8. Do professional practice behavior ratings differ between nurses with high teaching interactions with Home Hospital students and nurses with low teaching interactions with Home Hospital students?

9. Do ratings of clinical faculty leadership differ between nurses with high teaching interactions with Home Hospital students and nurses with low teaching interactions with Home Hospital students?

10. What is the relationship between elements of the model (structural empowerment, self-efficacy, professional practice behaviors and observed faculty leadership behaviors)?

<div align="center">Hypotheses</div>

Students

1. Nursing students enrolled in the Home Hospital program have higher perceptions of structural empowerment and self-efficacy.

2. Nursing students with high levels of structural empowerment and self-efficacy will have higher reports of professional practice behaviors/autonomy.

3. Nursing students enrolled in the Home Hospital program perceive stronger clinical faculty leadership behaviors.

4. Nursing students with high levels of clinical faculty leadership behaviors have higher perceptions of structural empowerment, self-efficacy and reported professional practice behaviors.

Registered Nurses employed in Home Hospital

5. Registered nurses with high teaching interactions with Home Hospital students have higher perceptions of structural empowerment and self-efficacy.

6. Registered nurses with high levels of structural empowerment and self-efficacy will have higher reports of professional practice behaviors/autonomy.

7. Registered nurses with high teaching interactions with Home Hospital students perceive stronger clinical faculty leadership behaviors.

8. Registered nurses with high levels of clinical faculty leadership behaviors have higher perceptions of structural empowerment, self-efficacy and reported professional practice behaviors.

CHAPTER 4

METHODOLOGY

Research Design

The study was a non-experimental, cross-sectional design to compare selected attributes between students enrolled in a Home Hospital Clinical Placement and students enrolled in a traditional clinical placement and between nurses with high levels of teaching interaction with home hospital students and nurses with low levels of teaching interaction with home hospital students. The specific attributes are those included in the Manojlovich model (2003) and are depicted in the conceptual model outlined in Chapter Three.

Ethical considerations for the study included informed consent as well as confidentiality for study participants. No information was collected that would allow for individual identification of study participants. All participants were informed they could refuse to participate as well as withdraw from participation at any time. The researcher had no responsibility for hiring and/or evaluation of registered nurse staff at the home hospital. The researcher had no responsibility for student evaluation and/or teaching for student subjects that participated in the study. The participants were informed of the risks and benefits of the study. Completion of the study instruments was taken as consent to participate. The study had minimal risk. Following endorsement by Dissertation Committee members, approval for this study was obtained through the University of Nevada, Las Vegas Institutional Review Board (IRB). The study qualified for an exempt research project and was reviewed and approved per IRB requirements.

Sample

Subjects for the study included two groups: nursing students and registered nurses. The samples and instruments used for each group are outlined below. A power analysis was conducted to determine sufficient sample size for both groups.

Using previously reported data on structural and psychological empowerment (Siu, et al., 2005) scores for nursing students, it was determined the nursing student sample size required to study structural empowerment was 10 experimental subjects and 10 control subjects to be able to reject the null hypothesis that the population means of the experimental and control groups are equal with probability (power) 0.8 (Dupont & Plummer, 2009). The Type I error probability associated with this test of this null hypothesis is 0.05 (Dupont & Plummer). The reported findings for psychological empowerment were also used to estimate sample size. Using reported values for psychological empowerment the sample size required was 23 experimental subjects and 23 control subjects to be able to reject the null hypothesis that the population means of the experimental and control groups are equal with probability (power) 0.8 (Dupont & Plummer). The Type I error probability associated with this test of this null hypothesis is 0.05 (Dupont & Plummer). The effect size for both sample estimates was moderate. Given there were 164 students enrolled in the baccalaureate program and to ensure effect size, it was determined an attempt would be made to recruit all students to participate.

Using previously reported data on structural empowerment scores for registered nurses (Manjlovich, 2003), it was determined that 15 experimental subjects and 15 control subjects would be required to be able to reject the null hypothesis that the population means of the experimental and control groups are equal with probability

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(power) 0.8 (Dupont & Plummer, 2009). The Type I error probability associated with this test of this null hypothesis is 0.05 (Dupont & Plummer). This would achieve moderate to strong effect size. Since home hospital students were assigned to all units within the home hospital, it was decided to recruit as many registered nurse subjects as possible.

Nursing Students

The sample was recruited from students enrolled in a baccalaureate degree program at a large metropolitan University in the Southwestern United States. The program was selected based on a non-traditional program for student clinical placement called the "Home Hospital Program." Students were recruited from all clinical levels including those enrolled and those not enrolled in the Home Hospital program.

The Home Hospital program was designed to keep students within the same hospital for all of their four medical-surgical nursing rotations: Fundamentals of Nursing, Nursing Care of the Older Population, Nursing Care of Acutely Ill, and Complex Nursing Care (a total of 12 clinical credits).

To recruit students, the PI contacted the lead faculty for each clinical level. A data collection session was scheduled at the conclusion of class. The PI provided students with an explanation of the study at the start of class and students wishing to participate remained for the data collection session at the end of the class. Completion of the instruments was taken as an agreement to participate in the study. The PI had no responsibility for student evaluation and/or teaching. To promote participation those agreeing to complete the survey instruments were provided pizza. Following completion of the survey instruments participants were entered into a drawing for a $100 gift card

that was awarded at the end of the data collection session. The individual instruments are described below. A total of four instruments, requiring approximately 30 minutes, were completed.

Instruments

Conditions of Learning Effectiveness Questionnaire (CLEQ)

Siu et al. (2005) developed the CLEQ as a means to assess student's perception of structural empowerment. The CLEQ is a modification of the Conditions of Work Effectiveness Questionnaire (Laschinger et al., 2001). The instrument is based on Kanter's (1993) theory of structural empowerment. The instrument has six subscales that measure empowerment. The six subscales are: access to support (seven items), opportunity to learn and develop (six items), access to information (six items), access to resources (five items), informal power (four items) and formal power (two items). All items are rated using a 5-point Likert scale. The subscale scores were summed to achieve an overall structural empowerment score. Reliability and validity for the CLEQ are shown in Table 1. The instrument is paper and pencil and takes approximately 10 minutes to complete.

Caring Efficacy Scale (CES)

The CES was developed by Coates (1997) as a means to assess an individual's belief or confidence in their ability to express caring and to establish a caring relationship with patients. The original CES was adapted and can be used with nursing students (Watson, 2009). The instrument is based on the theory of self-efficacy. The instrument consists of 30 self-report items. Items are rated on a 6-point Likert scale. The CES scale is balanced for positive and negative items. The CES scores were summed and averaged

to obtain an overall rating with higher scores associated with higher beliefs of caring self-efficacy. Reliability and validity for the CES are shown in Table 1. The instrument is paper and pencil and takes approximately 10 minutes to complete.

Nursing Activity Scale (NAS)

The NAS is a revision of the Schutzenhofer Professional Autonomy Scale (SPNAS) that was developed to measure professional autonomy in nurses (Schutzenhofer, 1987; Schutzenhofer & Musser, 1994). The instrument is based on feminist theory with the core tenet that professional autonomy is grounded in an occupation's ability to have control over one's activities. The items on the instrument relate to situations where a nurse must exercise professional judgment. The instrument consists of 35 items of which 30 are scored. The five non-scored items are used for measurement of internal consistency. An overall score was obtained by multiplying the respondents score by the weight of the item. NAS scores range from 60 to 240. The reported breakdown of scores is as follows:

- 60 to 120 = lower level of professional autonomy

- 121 to 180 = mid level of professional autonomy

- 181 to 240 = higher level of professional autonomy

Reliability and validity for the NAS are reported in Table 1. The instrument is paper and pencil and takes approximately 10 minutes to complete.

Leadership Practice Inventory – Observer (LPI-O)

The Leadership Practice Inventory (LPI) was developed by Kouzes and Posner (2003) to measure leadership practices. The instrument is based on five key leadership behaviors: (a) challenging the process or the leader's action in taking risks or challenging

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common assumptions, (b) inspiring a shared vision or the leader's ability to engage others in a view of the future, (c) enabling others to act or the leader's ability to engage others in cooperative or participatory manner, (d) modeling the way or the leader's ability to engage in practices that match his/her values, and (e) encouraging the heart or the leader's ability to give positive feedback and public acknowledgement. The instrument has two versions, a self instrument and an observer instrument. The observer instrument was used in this study. The LPI-O contains 30 items to rate the frequency of leadership actions. Each item is rated using a 10-point Likert scale with 1 = almost never and 10 = almost always. Reliability and validity for LPI-O are shown in Table 1. The instrument is paper and pencil and takes approximately 10 minutes to complete.

Registered Nurses employed in Home Hospital

The sample was recruited from nurses employed at a for-profit hospital in the Southwestern United States. The hospital was selected based on its participation in a non-traditional program for student clinical placement called the "Home Hospital Program." Nurses recruited for the study were employed on various clinical units that participate in the clinical rotations for these students.

To recruit registered nurses the PI contacted the system and hospital leadership to obtain approval for subject recruitment. Participation was voluntary and occurred during non-work hours. A brief written notice was provided to registered nurse staff with an explanation of the study. Completion of the instruments was taken as an agreement to participate in the study. The PI had no affiliation with the participating hospital at the time of data collection. To promote participation those agreeing to complete the survey instruments were provided pizza or bagels. Following completion of the survey

instruments, participants were entered into a drawing for a $100 gift card that was awarded at the end of the data collection session. The individual instruments are described below. A total of four instruments were completed. Completion of all instruments took approximately 30 minutes.

Instruments

Conditions of Work Effectiveness Questionnaire II (CWEQ)

The CWEQ-II is a modification of the original Conditions of Work Effectiveness Questionnaire developed by Laschinger, Finegan, Shamian, and Wilk (2001). The CWEQ was developed to assess an individual's perception of structural empowerment. The Conditions for Work Effectiveness Questionnaire is designed to measure dimensions of empowerment based on Kanter's theory of structural empowerment. The instrument has six components: opportunity, information, support, resources, formal power and informal power. Opportunity refers to one's opportunity to gain new knowledge or skill or to grow within the organization. Support refers to support for risk taking and ability to autonomously make decisions. Information refers to having information on the organization's goals. Resources refer to one's ability to have the required resources to get work done. Empowerment is facilitated by both formal and informal power characteristics in the organization.

The CWEQ-II has 19 items. All items are rated using a 5-point Likert scale. The subscale scores were summed to achieve an overall structural empowerment score ranging from 6 to 30. Higher scores are associated with higher perceptions of structural

empowerment. Reliability and validity for the CWEQ-II are shown in Table 1. The instrument is paper and pencil and takes approximately 10 to 15 minutes to complete.

Caring Efficacy Scale (CES)

See previous description.

Nursing Activity Scale (NAS)

See previous description.

Leadership Practice Inventory – Observer (LPI-O)

See previous description.

A summary of all study variables and instruments used in both groups is provided in Table 1.

Data Analysis

Students

An unpaired t-test was used to analyze the following research questions. A significance level of $p < .05$ was used.

1. Do structural empowerment ratings differ between Home Hospital students and non-Home Hospital students?

2. Do self-efficacy ratings differ between Home Hospital students and non-Home Hospital students?

3. Do professional autonomy ratings differ between Home Hospital students and non-Home Hospital students?

4. Do ratings of clinical faculty leadership differ between Home Hospital students and non-home Hospital students?

A correlation matrix was generated to describe the relationships between study variables and to analyze the following research questions. A significance level of $p < .05$ was used.

5. What is the relationship between elements of the model (structural empowerment, self-efficacy, professional autonomy and observed faculty leadership behaviors)? Each hypothesis and analysis conducted is detailed in Table 2.

Data Analysis

Registered Nurses employed in Home Hospital

An unpaired t-test was used to analyze the following research questions. A significance level of $p < .05$ was used.

Registered Nurses employed in Home Hospital

6. Do structural empowerment ratings differ between nurses with high teaching interactions with Home Hospital students and nurses with low teaching interactions with Home Hospital students?

7. Do self-efficacy ratings differ between nurses with high teaching interactions with Home Hospital students and nurses with low teaching interactions with Home Hospital students?

8. Do professional autonomy ratings differ between nurses with high teaching interactions with Home Hospital students and nurses with low teaching interactions with Home Hospital students?

9. Do ratings of clinical faculty leadership differ between nurses with high teaching interactions with Home Hospital students and nurses with low teaching interactions with Home Hospital students?

A correlation matrix was generated to describe the relationships between study variables and to analyze the following research questions. A significance level of $p < .05$ was used.

10. What is the relationship between elements of the model (structural empowerment, self-efficacy, professional autonomy and observed faculty leadership behaviors)?

The correlation matrix included all 4 instruments with the subscales for the CWEQ-II and LPI-O. Table 3 outlines the measurement and analysis for each hypothesis.

CHAPTER 5

FINDINGS

The results of data analyses are presented in this chapter. The results for both samples, nursing student and registered nurse, are reviewed.

Nursing Student Sample

Descriptive statistics, reliability assessment

All nursing students enrolled in a baccalaureate program hosting the Home Hospital program were invited to participate in the study. The program consisted of four clinical levels. Table 4 provides the response rate by clinical level.

A total of 97 students enrolled in the study representing a 59% participation rate. Of the 97 students, 62 (64%) were non-Home Hospital students and 35 (36%) were Home Hospital participants. The Home Hospital program has two participating clinical sites, each sponsoring a clinical rotation of eight students per level. During the data collection sessions, there were relatively equal participation rates across clinical levels except for Level III students. While a majority of students had expressed interest in participating in the study at the start of the class session, the class ended early and many students subsequently elected not to remain for the data collection session.

Table 5 provides an overview of the demographic variables across the participating students. Of the 97 students participating, 95 provided usable surveys for all data collection instruments. Two of the subjects did not complete the LPI-O tool and were subsequently removed from the data analysis involving observed leadership practices. Four subjects had one missing score on the NAS and three subjects had one

missing score on the CES. The mean score for the question was entered for the missing

data. Table 6 provides the mean and standard deviation scores for each variable by

clinical level.

A one-way ANOVA was conducted to determine if any significant differences

existed between clinical levels on the study variables. The two subjects not completing

the LPI-O were excluded from the analysis of observed leadership behaviors. There were

no significant differences by clinical level in age, NAS, or LPI-O scales. Significant

findings are presented in Table 7. There was a significant finding between clinical levels

for structural empowerment as measured by the total CLEQ score. Nursing students in

level IV scored higher on the CLEQ than did nursing students in level III and level II.

Significant differences in mean scores for three of the five subscales of the CLEQ,

opportunity, information and resources, were also noted across clinical levels. Nursing

students in level IV scored higher than levels II and III. A significant difference was also

noted between level I students and those in levels II and III. Level I students had higher

mean scores on the CLEQ subscale of opportunity than did level II and III students and

higher scores than level III students on the CLEQ subscale of resources. Students in level

IV also scored higher on self-efficacy than did students in level I and level II.

These findings suggest that ratings of structural empowerment (CLEQ) increase

as the student progresses through his/her education program. This was also noted in

higher ratings of self-efficacy. Since the dependent variable in this study was

participation in the home hospital program it was appropriate to proceed with further

analysis.

Prior to proceeding with data analysis, the data collected from the study instruments were examined to determine if normality assumptions were met. Table 8 provides the mean, standard deviation, skewness and kurtosis for each instrument including subscales. Skewness values ranges from -1.13 to .28 and kurtosis values ranged from -.62 to 1.22. Skewness and kurtosis values between -3.0 to +3.0 are considered acceptable (Tabachnick & Fidell, 2007).

Reliability of the instruments and subscales was evaluated using Cronbach's alpha coefficients. The Cronbach alpha measures the internal consistency of the scales. Alpha values greater than .7 are considered acceptable (George & Mallery, 2011). Table 9 provides the reliability results for the full sample (registered nurses and nursing students), student sample, and registered nurse sample. There were no findings below acceptable values.

Results

Research Questions 1 - 4

1. Do structural empowerment ratings differ between Home Hospital students and non-Home Hospital students?

Independent sample t-tests were performed to determine if any significant differences existed in the study variable based on participation in the Home Hospital program. No significant differences were noted in overall structural empowerment ratings as measured by the total CLEQ scores between non-home hospital and home hospital nursing students. However, there was a significant difference in the subscale of formal and informal power as measured by the CLEQ. The results are noted in Table 10. Home

hospital students reported higher levels of informal and formal power as measured on the CLEQ subscale ($t(95) = 2.05$, $p < .05$). Cohen's $d = 0.42$. The strength of association of the two groups on the dependent variable was moderate (Cohen, 1988).

2. Do self-efficacy ratings differ between Home Hospital students and non-Home Hospital students?

Independent sample t-tests were performed to determine if any significant difference existed in the study variable based on participation in the Home Hospital program. There was no significant difference between non-home hospital and home hospital students in self-efficacy as measured by the CES.

3. Do professional autonomy ratings differ between Home Hospital students and non-Home Hospital students?

Independent sample t-tests were performed to determine if any significant differences existed in the study variable based on participation in the Home Hospital program. There was no significant difference between non-home hospital and home hospital students in professional practice behaviors as measures by the NAS.

4. Do ratings of clinical faculty leadership differ between Home Hospital students and non-home Hospital students?

Independent sample t-tests were performed to determine if any significant differences existed in the study variables based on participation in the Home Hospital program. Two subjects who did not complete the LPI-O correctly were excluded from the analysis of the leadership variables. There were no significant differences between non-home hospital and home hospital students in ratings of leadership behaviors of clinical instructors as measures by the LPI-O.

Additional analyses were performed to determine if any significant differences existed between non-home hospital and home hospital students based on clinical level. This was completed to determine if length of time in the home hospital program had any significant impact on differences between groups. The analyses were performed by first excluding level I, then excluding levels I and II, and finally examining only differences in the level IV students. No significant differences were noted between home hospital students and non-home hospital students when controlling for clinical level.

Research Question 5

5. What is the relationship between elements of the model (structural empowerment, self-efficacy, professional autonomy and observed faculty leadership behaviors)?

A correlation matrix was generated in order to examine the relationship among the study variables. See Table 11. The sample for the correlation matrix excluded the two subjects not completing the LPI-O. All of the bivariate correlation coefficients were < .9 thus demonstrating adequate divergent validity among the constructs.

The CLEQ had a weak positive relationship to both the NAS ($r(93)$=.31, $p < .01$) and CES ($r(93)$=.33, $p < .01$). This suggests that structural empowerment in the clinical learning environment is positively related to professional practice behaviors and self-efficacy. Stronger relationships were noted between the CLEQ and observed leadership behaviors of clinical instructors as measured by the LPI-O. Scale correlations ranged from $r(93)$=.58, $p < .01$ for Model the Way subscale to $r(93)$=.48, $p < .01$ for Encourage the Heart subscale. This suggests that there is a moderate positive relationship between

student's perceptions of structural empowerment and observed faculty leadership behaviors.

The NAS had a moderate positive relationship with the CES ($r(93)=.52, p < .01$). This suggests that self-efficacy is related to professional practice behaviors. There was no significant relationship between NAS or professional practice behaviors and observed leadership behaviors as noted on the LPI-O.

Self-efficacy, as measured by the CES, had a weak positive relationship with observed faculty leadership behaviors. One subscale of the LPI-O, Model the Way ($r(93)=.22, p < .05$) showed a weak positive relationship with self-efficacy.

Table 12 provides a summary of the variable relationships for nursing students.

Registered Nurse Sample

Descriptive statistics, reliability assessment

All registered nurses working at one hospital participating as a clinical site in the Home Hospital program were invited to participate in the study. Seventy-four registered nurses participated in the study. This represented approximately a 20% response rate of employed registered nurses at the hospital. Table 13 summarizes the demographics of the registered nurse sample. The registered nurses ranged in age from 23 to 65 years of age. This compares to a national average age of 45.5 years based on findings from the 2008 National Survey of Nurses (2010). The mean years of experience were almost 21 years with the average years of experience at the hospital close to 9 years. Eighty percent of the sample was female compared to a national average of 93% as reported in the 2008 RN Survey. Of the registered nurses participating, 50% were white and slightly over 34% of

the participants were Asian. Nationally, 5.8% of the registered nurse workforce is reported as Asian. Sixty-one percent of the nurses participating in the study held a bachelor's degree which is higher than the national average of 36.8%. Ninety-six percent of the registered nurses were employed full-time which is higher than the reported national average of 63.2%.

Of the 74 registered nurses participating in the study, 10 subjects did not complete the LPI-Observer instrument. Those subjects were removed from the analyses involving observed leadership practices. Five subjects missed one question on the NAS and three subjects missed one question on the CES. The mean score for the question was entered for the missing data.

Prior to proceeding with data analysis, the data collected from the study instruments were examined to determine if normality assumptions were met. Table 14 provides the mean, standard deviation, skewness and kurtosis for each instrument including subscales. Skewness values ranges from -.80 to .26 and kurtosis values ranged from -.56 to .77. All values were within an acceptable range of -3 to +3.

Reliability of instruments and subscales was evaluated using Cronbach's alpha coefficients (see previous results reported in Table 9). All coefficients were above the recommendation of .7 except for the CWEQII subscale of opportunity. Since the subscale consisted of only three items, the coefficient was considered acceptable to proceed.

The mean and standard deviation of study variables by type of position held are presented in Tables 15 and 16. Position was identified as possibly influencing registered nurse scores. Findings from the 2008 National Survey of Nurses (2010) reported lower levels of job satisfaction among staff nurses than nurses in positions such as

administration or advanced practice. Laschinger (2008) noted the relationship between structural empowerment and job satisfaction.

A one-way ANOVA was conducted to examine any differences within the registered nurse sample based on position. No significant differences were found in registered nurse scores on the NAS, CES, CWEQII, or LPI-O based on position.

Research Questions 6 – 10

To examine the impact of the home hospital program on the study variables, the registered nurse sample was divided into two groups: high levels of teaching interaction and low levels of teaching interaction. Results are shown in Table 17. Approximately 58% of the sample had interaction with a baccalaureate student. Of those indicating teaching interaction with nursing students, all except one of the participants indicated he/she had contact with students in the home hospital program. Those subjects who indicated that during the semester they worked often, or always, or almost always, with a student were placed in the high teaching interaction group. Those subjects who indicated that during the semester they worked sometimes, seldom, and never or almost never, were placed in the low teaching interaction group.

6. Do structural empowerment ratings differ between nurses with high teaching interactions with Home Hospital students and nurses with low teaching interactions with Home Hospital students?

Independent sample t-tests were conducted to examine differences between the two groups: registered nurses with high levels of teaching interaction and registered with low levels of teaching interaction. No significant differences between groups were noted

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for total CWEQII score and CWEQII subscales except opportunity. A significant difference was noted with registered nurses with high levels of teaching interaction ($t(42)= 2.28, p < .05$) scoring higher than registered nurses with low levels of teaching interaction for opportunity. Cohen's $d = 0.70$. The strength of association of the two groups on the dependent variable was moderate (Cohen, 1988). The results are shown in Table 18.

7. Do self-efficacy ratings differ between nurses with high teaching interactions with Home Hospital students and nurses with low teaching interactions with Home Hospital students?

Independent sample t-tests were conducted to examine differences between the two groups: registered nurses with high levels of teaching interaction and registered with low levels of teaching interaction. No significant differences between groups was noted for self-efficacy as measured by the CES.

8. Do professional autonomy ratings differ between nurses with high teaching interactions with Home Hospital students and nurses with low teaching interactions with Home Hospital students?

Independent sample t-tests were conducted to examine differences between the two groups: registered nurses with high levels of teaching interaction and registered with low levels of teaching interaction. No significant differences between groups was noted for professional practice behaviors as measured by the NAS.

9. Do ratings of clinical faculty leadership differ between nurses with high teaching interactions with Home Hospital students and nurses with low teaching interactions with Home Hospital students?

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Independent sample t-tests were conducted to examine differences between the two groups: registered nurses with high levels of teaching interaction and registered with low levels of teaching interaction. Before examining the differences between groups in observed leadership behaviors, those subjects that had not completed the LPI-O were removed from the sample. The remaining sample consisted of 64 subjects. Table 19 summarizes the results. A significant difference was noted with registered nurses with high levels of teaching interaction ($t(42) = 2.153$, $p < .05$) scoring higher on the LPI-O subscale of Challenge the Process than registered nurses with low levels of teaching interaction. Cohen's $d = 0.72$. The strength of association of the two groups on the dependent variable was moderate (Cohen, 1988).

Research Question 10

10. What is the relationship between elements of the model (structural empowerment, self-efficacy, professional autonomy and observed faculty leadership behaviors)?

A correlation matrix was generated in order to examine the relationship among the study variables. See Table 20. All of the bivariate correlation coefficients were $< .9$ thus demonstrating adequate divergent validity among the constructs.

The CWEQII had a positive weak relationship to the NAS ($r(62)=.33$, $p < .01$). This suggests that structural empowerment in the clinical environment is positively related to professional practice behaviors. There was no significant relationship between structural empowerment as measured by the CWEQII and self-efficacy as measured by the CES. Weak positive relationships were seen between the CWEQII and observed leadership behaviors of clinical instructors as measured by the LPI-O. Scale correlations ranged from $r(62)=.42$, $p < .01$ for Inspire a Shared Vision subscale to $r(62)=.28$, $p < .05$

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for Enable Others subscale. This suggests that structural empowerment among registered nurses is positively related to observed faculty leadership behaviors.

The NAS had a weak positive relationship to the CES ($r(62)=.44, p < .01$). This suggests that self-efficacy is related to professional practice behaviors. Professional practice behaviors as measured by the NAS had a weak positive relationship with observed leadership behaviors of clinical instructors as measured by the LPI-O. Scale correlations ranged from $r(62)=.43, p < .01$ for Inspire a Shared Vision subscale to $r(62)=.29, p < .05$ for Enable Others subscale. This suggests that professional practice behaviors are positively related to observed faculty leadership behaviors. No significant relationships were seen between self-efficacy as measured by CES and observed leadership practices as measured by the LPI-O. Table 21 provides a summary of the variable relationships.

CHAPTER 6

DISCUSSION, CONCLUSIONS, and RECOMMENDATIONS

This chapter provides a discussion and interpretation of the study findings and the study limitations. Recommendations for nursing educators are included.

Discussion and Interpretation

The purpose of this study was to evaluate the impact of a Home Hospital Clinical Placement program on structural empowerment and professional practice behaviors of nursing students enrolled in the program and to examine the impact of the program on nursing staff practicing at the home hospital. A conceptual model was developed to serve as a basis for the study and was grounded in previous research showing positive relationships between structural empowerment, self-efficacy, professional practice behaviors, and leadership (Manojlovich, 2003; Livsey, 2009). Figure 4 shows the relationships within the conceptual model based on study findings.
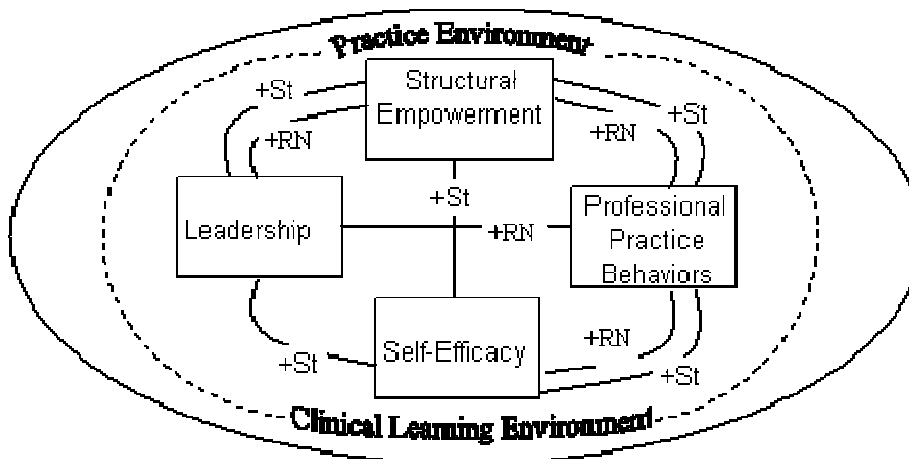
Figure 4. Revised Conceptual model. Double lines signify significant positive relationship between variables for both nursing students (St) and registered nurses (RN).

It was assumed that the Home Hospital program would influence both the practice environment and the clinical learning environment at the home hospital. Additionally, the home hospital program provided an opportunity to evaluate leadership from the perspective of clinical teaching.

Structural empowerment was based on Kanter's empowerment structure: opportunity to learn, information, resources and support. Previous research had demonstrated structural empowerment directly impacts professional practice behaviors (Manojlovich, 2003). The mean scores for structural empowerment were consistent with student empowerment scores as reported by Siu et al. (2005).

While there was no significant difference in the overall rating of structural empowerment between home hospital and non-hospital students a significant difference was noted between home hospital and non-home hospital students in access to empowerment structures as measured by formal and informal power. Home hospital nursing students had higher ratings than did non-home hospital students. Formal power is derived from characteristics of the work and connection with organizational purpose and goals. Informal power is derived from social connections or the development of communication and support from peers or sponsors.

The clinical faculty for the home hospital students are advanced practice nurses employed by the home hospital. They may be able to better connect students with other mentors and/or experiences within the organization to enhance student opportunities and clinical learning and thus impact overall ratings of formal and informal power. Campbell (1994) found that students perceived the clinical instructor as being most important for achieving their learning outcomes. She noted that students reported that clinical

instructors deemed to be the most influential were those that had 'control' over the learning environment and that control contributed most to the students access to learning opportunities.

For both home hospital and non-home hospital students, there was a positive relationship between observed faculty leadership and student ratings of self-efficacy. This correlation was not found in the registered nurse sample of this study. Previous research also did not find a direct correlation between leadership and self-efficacy (Manojlovich, 2003). This suggests that clinical faculty leadership may be more influential to student learning than previously identified. Townsend and Scanlan (2011) noted the importance of self-efficacy to nursing students' ability to seek out opportunities to achieve mastery within the clinical environment. Today's health care environment is marked by short length of stays and hospitalizations only for the most acute of conditions. Student learners are faced with learning in increasingly complex clinical situations. This finding suggests that clinical faculty leadership is important to supporting students' confidence and is critical to their learning experience.

A significant difference in rating of structural empowerment was noted for registered nurses within the study. Registered nurses with high levels of teaching interaction with students had higher ratings on the empowerment subscale: access to opportunity.

The home hospital program had a positive impact on the practice environment by providing opportunity through clinical instruction. hile the teaching of nursing students could be viewed as burdensome in the context of providing care to patients, this finding counters that argument. This finding also supports the mutually beneficial nature of

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partnerships between hospitals and universities in the education of nursing students. Kanter (1993) noted that individuals high in opportunity have high self-esteem and place a high value on their competence, take action to change, and see themselves as part of a larger whole. atsumura, et al. (2004) found registered nurses were ambivalent in their perceptions of the impact of students on the nursing unit. The findings from this study indicate that registered nurses value their interactions with students. While it could be that nurses with pre-existing high levels of empowerment sought out teaching experiences it seems likely that registered nurses perceive teaching not as an added duty but as a reflection of increased autonomy, added variety in work, and high organizational involvement.

Structural empowerment was found to have a positive relationship with professional practice behaviors for both registered nurses and nursing students in the study. A positive relationship was also found between structural empowerment and self-efficacy in nursing students. Dunn and Hansford (1997) found students' perceptions of the learning environment were influenced by registered nurse engagement in their learning. Registered nurses who promoted student involvement and were inclusive contributed most to student learning. This finding underscores the importance of self-efficacy to clinical learning of nursing students.

The home hospital program eliminates the rotation to multiple clinical agencies during the student's progression through the program and reduces the clinical hours that must be devoted to orientation with each new agency or clinical site. It also provides an opportunity for both students and staff to develop relationships over time. While the study did not show a difference between ratings of self-efficacy between home hospital

and non-home hospital students, self-efficacy increased with time in the program. Students in their senior level clinical placement (level IV) had higher self-efficacy ratings. The importance of ensuring adequate time within the academic program for clinical placement is supported by this finding. It would seem reasonable that creating a "home" for student clinical learning would support greater levels of self-efficacy and contribute positively to learning.

There was no significant difference in the perceptions of professional practice behaviors between home hospital and non-hospital students. The mean score for both groups was high for professional practice behaviors. Minimizing rotations to clinical agencies through participation in the Home Hospital program did not further enhance professional practice behaviors.

Likewise, there were no significant differences in the ratings of professional practice behaviors between nurses with high and low levels of teaching interaction. Of note, nurses in the home hospital setting had high mean rating of professional autonomy. Ratings of 181 to 240 are associated with higher levels of professional autonomy (Kelly, 2001). The mean rating was 200 in registered nurses within the home hospital. This high level may have obscured an ability to see an effect of the student interaction on autonomy.

Overall, there was no significant relationship between observed faculty leadership and professional practice behaviors in the student sample. A positive relationship was noted in the registered nurse sample between observed faculty leadership behaviors and professional practice behaviors. Previous research did not find that leadership was directly related to professional practice behaviors (Manojlovich, 2003).

For registered nurses, there was also a significant difference in ratings of observed faculty leadership between nurses with high levels of teaching interaction and nurses with low levels of teaching interaction in the home hospital program. This was noted on the subscale, Challenge the Process of the LPI-O. Kouzes and Posner (2003) characterize the leadership practice of Challenge the Process as a leader's influence and actions to create change. Nurses with higher levels of teaching interaction in the home hospital program rated clinical instructors higher in practices that demonstrate change, growth, and improvement. This finding suggests the home hospital model could enhance nurses' perception of the leadership role played by clinical faculty within the practice environment.

A great deal of emphasis has been placed on safety and evidence based practice within the practice setting. Laschinger and Leiter (2006) found leadership practices were related to patient safety outcomes. The IOM Report on the Future of Nursing (2010) details the important role nurses play in creating and sustaining safe patient care environments. Little to no research has examined leadership within the context of clinical teaching. The relationship between leadership and professional practice behaviors has largely focused on traditional leadership roles such as managers. The finding in this study that faculty leadership behaviors are positively related to professional practice behaviors suggests that there is a positive influence exerted by teachers as leaders within the practice environment. It could be that when there is active support for nursing student education within the practice environment, the nurses' own professional practice behaviors are enhanced.

While there were no significant differences in the ratings of perceived clinical instructor leadership behaviors between home hospital and non-hospital students this finding is noteworthy. One measure of the effectiveness of clinical instruction is student's perceptions of faculty leadership behaviors. Faculty leadership is important to student's perception of the effectiveness of the clinical learning environment (Campbell, 1994). This finding suggests that home hospital faculty could effectively balance the priorities related to their organizational role with the teaching priorities expected of "traditional" clinical faculty members without negatively impacting the student's clinical learning experience.

Posner (2008) reported correlations of LPI-O scores with the impact of leadership behaviors. A statistically significant difference was noted across three impact groups: weak, moderate, and strong impact leaders. Of note, both home hospital and non-home hospital clinical faculty leadership behaviors were rated consistent with the rating for leaders in the moderate or strong impact groups. This supports the important role clinical faculty play in the education of future nurses.

Study Limitations

Results of the study may be difficult to generalize as the data were collected using one hospital and one school of nursing. Also, the phenomena studied were measured at one point in time. The relationships between variables may change over time and thus influence study results. The data collected were based on self-report. Participant reports could be influenced by a desire to provide a desirable response when rating their own

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behaviors. Also, participants' ratings could be influenced by intrinsic factors that cannot be controlled. For example, a nurse respondent may have experienced a stressful work day that influenced his/her response at the time of the data collection.

An additional study limitation is the relatively small sample size for students and registered nurses. Overall the relative number of home hospital students was small and influenced the overall sample size. With a larger sample size, other relationships might have been significant.

Conclusions

In conclusion, this study revealed that the home hospital model can be an effective intervention to provide clinical instruction for nursing students. There was a positive difference noted between home hospital and non-hospital students in structural empowerment rating as evidenced by their rating of formal and informal power. The effectiveness of the program may also be evaluated by noting that no significant differences existed between the student groups in their ratings of self-efficacy and observed faculty leadership behaviors. In essence, these findings demonstrated that a non-traditional approach to employing clinical faculty can be effective. Yucha, Kowalski, and Cross (2009) found that students participating in a home hospital program had perceived a reduced academic load and lower perceptions of anxiety. The consistency provided by the home hospital program and the close ties between faculty and staff were noted to contribute to a reduction in student stress. The model provides an opportunity to sustain needed clinical instruction outcomes while expanding the numbers of clinical faculty through effective partnerships between the hospital and university.

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The impact of clinical faculty leadership within the practice setting warrants further study. While the impact of leadership has been examined in the past, research has almost exclusively been limited to traditional leadership roles. Nurses in teaching roles have an opportunity to make significant impact not only on the entry of students into the profession but also the quality and outcomes achieved by those already in practice. This study noted the faculty leadership had a positive relationship with professional practice behaviors of nursing staff. Clinical faculty outside of models such as the home hospital may view themselves as only "guests" within the practice setting. The results of this study indicate that a much stronger opportunity for influence may exist. The study also demonstrated that organizations could effectively support master's prepared nurses who functioned both as teachers as well as expert clinicians within the practice environment. Past restructuring in the hospital setting has often led to the elimination of key roles such as the Clinical Nurse Specialist. Clinical Nurse Specialists functioned both as an expert clinician but also as teacher. Further study could help to demonstrate the positive impact of such positions on nursing practice and student learning in the hospital setting.

The findings of this study expand knowledge on characteristics of the work environment that impact the quality of nurse's worklife. More specifically, this study examined the impact of a clinical placement model on variables within the Nursing Worklife Model. High levels of teaching interaction were significantly related to increased ratings of structural empowerment for access to opportunity and higher ratings of faculty leadership. This supports the premise that clinical placement models should not only be evaluated for their impact on students but also the impact on the practice environment.

While self-efficacy has been noted as important in the context of understanding learning, especially in clinical disciplines, little research actually exists concerning self-efficacy in nursing (Townsend & Scanlan, 2011). This study demonstrated that important relationships exist between self-efficacy, structural empowerment, and faculty leadership. Further study could help identify effective strategies to help students learn and achieve mastery within the complexities of the practice setting. Further study could also examine ways to strengthen self-efficacy, especially for students in their first or second clinical practicum.

Findings from this study supported previous research that found positive relationships between structural empowerment, professional practice behaviors and self-efficacy in registered nurse staff (Manojlovich, 2003; 2005). The positive relationship between observed leadership and structural empowerment was also noted as in previous studies. However, previous studies did not find significant relationships between professional practice behaviors and leadership (Manojlovich). In this study, a significant relationship was found between professional practice behaviors and clinical faculty leadership. Further study is required to examine if teachers as leaders have differing spheres of influence from traditional nurse leaders. It demonstrates the important impact that clinical instruction can have on registered nurses working in the settings where clinical instruction occurs. It also provides support that partnerships to provide clinical instruction not only benefit academia but hold promise for positively impacting the service setting.

For future studies, it is recommended that a larger sample size be used in order to better understand the relationships between clinical placement model and study variables.

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Further study could be undertaken to understand the relationship between clinical faculty leadership, structural empowerment and the impact of professional practice behaviors on registered nurses.

Table 1

Study Variables and Measurement Instruments

Variable	Measure	# of items	Reliability (alpha)	Validity	Source
Structural empowerment	Conditions of Work Effectiveness Questionnaire – II (CWEQ-II)	19	.78 - .94 (overall)	Construct and content validity	Laschinger (n.d., CWEQ)
Structural empowerment	Conditions of Learning Effectiveness Questionnaire (CLEQ)	30	.94	Construct and content validity	Laschinger (n.d., CWEQ)
Self-efficacy	Caring Efficacy Scale (CES)	30	.85 - .95	Content and concurrent validity	Watson (2009)
Professional Nursing Practice	Nursing Activity Scale (NAS)	35	.81 - .92	Content and concurrent validity	Schutzenhofer (1987)
Nursing Leadership	Leadership Practices Inventory – Observer	30	.88 - .92	Construct and content validity	Leadership Practices Inventory (2002)

Table 2

Nursing Student: Hypotheses, Measurement, and Analyses

Hypothesis – students	Measurement	Analysis
Nursing students enrolled in the Home Hospital program have higher perceptions of structural empowerment.	Condition of Learning Effectiveness Questionnaire (CLEQ)	t-test
Nursing students enrolled in the Home Hospital program have higher perceptions of self-efficacy.	Caring Efficacy Scale (CES)	t-test
Nursing students enrolled in the Home Hospital Program perceive stronger clinical faculty leadership behaviors.	Leadership Practices Inventory – Observed (LPI-O)	t-test
Nursing students enrolled in the Home Hospital Program will have higher reports of professional practice behaviors.	Nursing Activity Scale (NAS)	t-test
Nursing students with high levels of clinical faculty leadership behaviors have higher perceptions of structural empowerment, self-efficacy and reported professional practice behaviors.	CLEQ, NAS, CES, LPI-O	Correlation

Table 3

Registered Nurses: Hypotheses, Measurement, and Analyses

Hypothesis – registered nurses	Measurement	Analysis
Registered nurses with high teaching interactions with Home Hospital students have higher perceptions of structural empowerment.	Condition of Work Effectiveness Questionnaire II (CLEQ-II)	t-test
Registered nurses with high teaching interactions with Home Hospital students have higher perceptions of self-efficacy.	Caring Efficacy Scale (CES)	t-test
Registered nurses with high teaching interactions with Home Hospital students perceive stronger clinical faculty leadership behaviors.	Leadership Practices Inventory – Observed (LPI-O)	t-test
Registered nurses with high teaching interactions with Home Hospital students will have higher reports of professional practice behaviors.	Nursing Activity Scale (NAS)	t-test
Registered nurses with high levels of clinical faculty leadership behaviors have higher perceptions of structural empowerment, self-efficacy and reported professional practice behaviors.	CWEQ-II, NAS, CES, LPI-O	Correlation

Table 4

Number of Student Participants by Clinical Level and Home Hospital Program

| | No. eligible students: HH vs. Non-HH | | | | | No.eligible students participating: HH vs. Non-HH | | | | | |
| | Non-HH | | HH | | Total | Non-HH | | HH | | l | |
Clinical Level	n	%	n	%	n	n	%	n	%	n	%
Level I	32	67%	16	33%	48	21	66%	10	63%	31	65%
Level II	37	71%	15	29%	52	21	57%	10	67%	31	60%
Level III	15	50%	15	50%	30	2	13%	7	47%	9	30%
Level IV	20	59%	14	41%	34	18	90%	8	57%	26	76%
Total	104	63%	60	37%	164	62	60%	35	58%	97	59%

Table 5

Demographics of Nursing Students: Categorical Variables

		n	Percentage
Gender	Female	77	79.4%
	Male	20	20.6%
Ethnicity	Not Hispanic/Latino	89	91.8%
	Hispanic or Latino	8	8.2%
Race	American Indian or Alaska Native	2	2.1%
	Asian	30	31.6%
	Black/African American	4	4.2%
	Native Hawaiian or Pacific Islander	5	5.3%
	White	54	56.8%
Highest level of other education	Associate Degree	12	12.3%
	Bachelor's Degree	13	13.4%
	Master's Degree	1	1.0%
	Doctorate	0	0%
	Other	0	0%
Clinical level	Level I	31	32.0%
	Level II	31	32.0%
	Level III	9	9.3%
	Level IV	26	26.8%
Participation in Home Hospital program	No	62	63.9%
	Yes	35	36.1%
Home Hospital site	Site 1	21	60.0%
	Site 2	14	40.0%

Table 6

Study Variable Results by Clinical Level

Variable		n	Mean	Std. Deviation
Age	Level I	31	25.8	6.19
	Level II	31	23.1	4.21
	Level III	9	26.4	4.22
	Level IV	26	26.2	7.37
Total CLEQ Score	Level I	31	19.3	2.30
	Level II	31	17.9	2.27
	Level III	9	16.8	2.96
	Level IV	26	19.8	3.33
CLEQ subscale: Opportunity	Level I	31	3.9	0.58
	Level II	31	3.5	0.61
	Level III	9	3.1	0.69
	Level IV	26	4.1	0.73
CLEQ Subscale: Information	Level I	31	4.2	0.54
	Level II	31	3.9	0.50
	Level III	9	3.7	0.46
	Level IV	26	4.3	0.65
CLEQ Subscale: Support	Level I	31	4.1	0.74
	Level II	31	3.9	0.67
	Level III	9	3.5	0.98
	Level IV	26	4.0	0.74
CLEQ Subscale: Resources	Level I	31	3.8	0.47
	Level II	31	3.4	0.61
	Level III	9	3.4	0.53
	Level IV	26	4.1	0.76
CLEQ Subscale: Formal/Informal Power	Level I	31	3.3	0.74
	Level II	31	3.1	0.59
	Level III	9	3.1	0.85
	Level IV	26	3.3	0.91
LPI-O: Model the Way	Level I	31	50.4	8.50
	Level II	29	48.1	7.03
	Level III	9	44.9	8.94
	Level IV	26	50.0	8.94
LPI-O: Inspire a Shared Vision	Level I	31	48.3	10.37

Variable		n	Mean	Std. Deviation
	Level II	29	46.4	9.43
	Level III	9	41.2	13.04
	Level IV	26	48.1	9.37
LPI-O: Challenge the Process	Level I	31	47.4	10.34
	Level II	29	46.5	7.52
	Level III	9	41.1	11.92
	Level IV	26	46.7	10.92
LPI-O: Enable Others to Act	Level I	31	51.6	8.57
	Level II	29	49.2	7.17
	Level III	9	45.3	8.67
	Level IV	26	52.5	8.84
LPI-O: Encourage the Heart	Level I	31	47.9	11.09
	Level II	29	42.1	10.46
	Level III	9	41.8	12.91
	Level IV	26	46.2	14.77

Table 7

Differences in Study Variables by Clinical Level

			Mean Differences	Std. Error	Sig.
Total CLEQ	Level IV	Level I	0.42	0.71	0.93
		Level II	1.88*	0.71	0.05
		Level III	2.93*	1.03	0.03
CLEQ subscale: Opportunity	Level I	Level II	.471*	0.16	0.02
		Level III	.82*	0.24	0.01
		Level IV	-0.16	0.17	0.80
	Level IV	Level I	0.16	0.17	0.80
		Level II	.63*	0.17	0.00
		Level III	.99*	0.25	0.00
CLEQ subscale: Information	Level IV	Level I	0.11	0.15	0.89
		Level II	0.34	0.15	0.10
		Level III	.60*	0.21	0.03
CLEQ subscale: Resources	Level I	Level II	.46*	0.15	0.02
		Level III	0.37	0.23	0.37
		Level IV	-0.26	0.16	0.39
	Level IV	Level I	0.26	0.16	0.39
		Level II	.72*	0.16	0.00
		Level III	.63*	0.24	0.04
Mean CES Score	Level I	Level II	0.15	0.12	0.61
		Level III	-0.28	0.18	0.42
		Level IV	-0.44	0.13	0.01
	Level II	Level I	-0.15	0.12	0.61
		Level III	-0.44	0.18	0.09
		Level IV	-0.59*	0.13	0.00

Table 8

Nursing Student Sample: Skewness & Kurtosis for Study Instruments

	Total CLEQ Score	CLEQ subscale: Opportunity	CLEQ Subscale: Information	CLEQ Subscale: Support	CLEQ Subscale: Resource	CLEQ Subscale: Formal/ Informal Power	
Mean	18.78	3.77	4.09	3.99	3.72	3.21	
Std. Deviation	2.80	.71	.57	.75	.67	.75	
Skewness	-.12	-.28	-.27	-.68	-.19	.29	
Kurtosis	-.62	-.32	-.36	.26	-.54	-.52	
	LPI-O: Model the Way	LPI-O: Inspire a Shared Vision	LPI-O: Challenge the Process	LPI-O: Enable Others to Act	LPI-O: Encourage the Heart	NAS Score	CES Score
Mean	49.08	46.99	46.32	50.52	45.09	201.3	5.05
Std. Deviation	8.29	10.14	9.89	8.39	12.29	19.80	.53
Skewness	-.74	-1.13	-.81	-1.13	-.86	-.44	-.25
Kurtosis	-.13	1.22	.09	.70	.27	-.16	-.59

Table 9

Cronbach Alpha Coefficients for Study Instruments

Instrument	No. of items	Full sample	Student sample	RN sample
CES	30	0.91	0.85	0.82
NAS	30	0.83	0.92	0.90
CLEQ	30	na	0.94	na
Support	7	na	0.90	na
Opportunity	6	na	0.86	na
Information	6	na	0.78	na
Resources	5	na	0.75	na
JAS/ORS	6	na	0.83	na
CWEQII	19	na	na	0.91
Opportunity	3	na	na	0.68
Information	3	na	na	0.89
Support	3	na	na	0.93
Resources	3	na	na	0.83
JAS	3	na	na	0.82
ORS	4	na	na	0.78
LPI-Model	6	0.94	0.87	0.96
LPI-Inspire	6	0.95	0.91	0.96
LPI-Challenge	6	0.94	0.87	0.97
LPI-Enable	6	0.95	0.90	0.97
LPI-Encourage	6	0.95	0.92	0.97

Table 10

Study Variables by Home Hospital Participation: Structural Empowerment

	Participation in Home Hospital program	N	Mean	Std. Deviation	t*	df	Sig. (2-tailed)
CLEQ Subscale: Formal/Informal Power	Yes	35	3.4	.81	2.05	95	0.043**
	No	62	3.10	.69			

*t-test based on equal variances assumed
**$p < .05$

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Table 11

Nursing Student: Correlation Matrix of Study Variables

Variable	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
(1) Total CLEQ Score	--											
(2) Opportunity	.85**	--										
(3) Information	.82**	.67**	--									
(4) Support	.84**	.67**	.67**	--								
(5) Resources	.76**	.61**	.55**	.43**	--							
(6) Formal/ Informal Power	.79**	.50**	.49**	.62**	.51**	--						
(7) Total NAS Score	.31**	.19	.33**	.19	.30**	.24*	--					
(8) Mean CES Score	.33**	.33**	.32**	.21*	.28**	.19	.52**	--				
(9) LPI-O Model	.58**	.47**	.58**	.49**	.42**	.41**	.20	.22*	--			
(10) LPI-O Inspire	.58**	.45**	.53**	.47**	.41**	.48**	.13	.17	.83**	--		
(11) LPI-O Challenge	.51**	.39**	.49**	.44**	.26*	.48**	.12	.09	.75**	.75**	--	
(12) LPI-O Enable	.50**	.50**	.51**	.38**	.33**	.33**	.15	.18	.70**	.67**	.72**	--
(13) LPI-O Encourage	.48**	.38**	.39**	.38**	.38**	.43**	.07	.13	.72**	.64**	.73**	.83**

**Correlation is significant at the 0.01 level (2-tailed).

*Correlation is significant at the 0.05 level (2-tailed).

Table 12

Nursing Student: Summary of Variable Relationships

	Professional nursing behaviors (NAS)	Self-efficacy (CES)	Observed faculty leadership (LPI-O)
Structural empowerment (CLEQ)	+	+	++
Professional nursing behaviors (NAS)	--	++	No significant findings
Self-efficacy (CES)	++	--	+

 + = weak positive correlation ($r < .5$)

++ = moderate positive correlation ($r > .5$ to .7)

 +++ = strong positive correlation ($r > .7$)

Strength of association based on Cohen (1988).

Table 13

Demographics of Registered Nurses

		n	Percentage
Gender	Female	59	79.7%
	Male	15	20.3%
Ethnicity	Not Hispanic/Latino	66	90.4%
	Hispanic or Latino	7	9.6%
Race	American Indian or Alaska Native	2	2.9%
	Asian	24	34.3%
	Black/African American	4	5.7%
	Native Hawaiian or Pacific Islander	3	4.3%
	White	37	52.9%
Highest level of nursing education	Diploma	2	2.7%
	Associate Degree	21	28.4%
	Bachelor's Degree	45	60.8%
	Master's Degree	5	6.8%
	Doctorate	1	1.4%
Highest level of other education	Associate Degree	0	0%
	Bachelor's Degree	7	58.3%
	Master's Degree	3	25.0%
	Doctorate	1	8.3%
	Other	1	8.3%
Employment status	Part-time	3	4.1%
	Full-time	71	95.9%
Type of position	Staff nurse	47	63.5%
	Charge nurse	8	10.8%
	CNS or Educator	4	5.4%
	Admin/Management	8	10.8%
	Other	6	8.1%
Other title	Case manager	4	5.4%
	PI Specialist	1	1.4%
	Specialty RN	1	1.4%

Table 14

Registered Nurse Sample: Skewness and Kurtosis for Study Instruments

	Total CWEQII Score	CWEQII subscale: Opport.	CWEQII subscale: Infor.	CWEQII subscale: Support	CWEQII subscale: Resource	CWEQII: subscale: JAS	CWEQII subscale: ORS
Mean	21.55	4.34	3.44	3.50	3.06	3.46	3.74
Std. Deviation	3.61	0.62	0.88	0.95	0.87	0.86	0.77
Skewness	0.01	-0.61	0.01	-0.24	0.26	-0.39	-0.23
Kurtosis	-0.29	-0.37	0.12	-0.12	0.01	0.39	-0.56

	Total NAS Score	Mean CES Score	LPI-O: Model the Way	LPI-O: Inspire a Shared Vision	LPI-O: Chall. the Process	LPI-O: Enable Others to Act	LPI-O: Enc. the Heart
Mean	203.07	5.22	43.06	41.41	40.58	43.38	41.97
Std. Deviation	19.60	0.57	9.69	10.87	11.55	10.59	11.67
Skewness	-0.44	-0.72	-0.46	-0.40	-0.40	-0.80	-0.61
Kurtosis	0.67	0.20	0.14	0.00	-0.40	0.77	0.53

Table 15

Study Variable Results (excluding LPI-O) by Position Held by Registered Nurse

		N	Mean	Std. Deviation
Total CWEQII Score	Staff nurse	48	21.3	3.76
	Charge nurse	8	21.4	1.46
	CNS or Educator	4	21.0	3.61
	Admin/Management	8	23.2	4.50
	Other	6	22.0	3.56
CWEQII subscale: Opportunity	Staff nurse	48	4.4	.58
	Charge nurse	8	4.3	.64
	CNS or Educator	4	4.2	.64
	Admin/Management	8	4.3	.74
	Other	6	4.0	.76
CWEQII subscale: Information	Staff nurse	48	3.3	.91
	Charge nurse	8	3.4	.49
	CNS or Educator	4	3.7	.27
	Admin/Management	8	4.3	.97
	Other	6	3.1	.57
CWEQII subscale: Support	Staff nurse	48	3.4	1.00
	Charge nurse	8	3.5	.53
	CNS or Educator	4	3.5	1.11
	Admin/Management	8	3.7	1.01
	Other	6	3.7	1.08
CWEQII subscale: Resources	Staff nurse	48	3.2	.84
	Charge nurse	8	2.8	.66
	CNS or Educator	4	2.2	1.00
	Admin/Management	8	2.9	1.00
	Other	6	3.1	.96
CWEQII: subscale: JAS	Staff nurse	48	3.3	.90
	Charge nurse	8	3.5	.53
	CNS or Educator	4	3.9	.57
	Admin/Management	8	3.9	.79
	Other	6	3.9	.74
CWEQII subscale: ORS	Staff nurse	48	3.6	.76
	Charge nurse	8	3.9	.35
	CNS or Educator	4	3.6	.78

		N	Mean	Std. Deviation
	Admin/Management	8	4.2	1.03
	Other	6	4.2	.70
Total NAS Score	Staff nurse	48	201.3	19.86
	Charge nurse	8	194.1	9.79
	CNS or Educator	4	204.8	4.35
	Admin/Management	8	218.3	23.44
	Other	6	208.0	20.59
Mean CES Score	Staff nurse	48	5.2	.65
	Charge nurse	8	5.1	.43
	CNS or Educator	4	5.1	.17
	Admin/Management	8	5.6	.42
	Other	6	5.1	.25

Table 16

Study Variables by Position Held by Registered Nurse: LPI-O

		N	Mean	Std. Deviation
LPI-O: Model the Way	Staff nurse	38	42.3	9.99
	Charge nurse	8	44.1	7.02
	CNS or Educator	4	43.5	13.10
	Admin/Management	8	45.1	11.68
	Other	6	43.7	8.21
LPI-O: Inspire a Shared Vision	Staff nurse	38	41.3	11.00
	Charge nurse	8	41.5	8.50
	CNS or Educator	4	39.3	17.80
	Admin/Management	8	45.6	10.24
	Other	6	38.0	10.37
LPI-O: Challenge the Process	Staff nurse	38	40.6	11.07
	Charge nurse	8	41.5	10.94
	CNS or Educator	4	39.5	16.38
	Admin/Management	8	40.4	14.20
	Other	6	40.5	12.63
LPI-O: Enable Others to Act	Staff nurse	38	43.8	9.70
	Charge nurse	8	44.8	9.97
	CNS or Educator	4	39.3	18.91
	Admin/Management	8	43.4	10.98
	Other	6	41.7	13.19
LPI-O: Encourage the Heart	Staff nurse			
	Charge nurse	8	44.8	10.58
	CNS or Educator	4	37.3	20.84
	Admin/Management	8	43.3	11.99
	Other	6	39.8	13.96

Table 17

Breakdown of Registered Nurse Sample by Teaching Interaction

		n	percentage
Interaction with student	UNLV nursing student	15	20.3%
	Other nursing student	1	1.4%
	Both	28	37.8%
	No student interaction	30	40.5%
Level of teaching interaction(1)	High	14	31.8%
	Low	30	68.2%

Table 18

Structural Empowerment and Level of Teaching Interaction

	Level of teaching interaction	N	Mean	Std. Deviation	Std. Error Mean	t	df	Sig. (2-tailed)
CWEQII subscale: Opportunity	High	14	4.5	.46	.12	2.28	42	0.027*
	Low	30	4.1	.70	.13			

*p < .05

Table 19

LPI-O: Differences in Study Variables based on Level of Teaching Interaction

	Level of teaching interaction	N	Mean	Std. Deviation	Std. Error Mean	t	df	Sig. (2-tailed)
LPI-O: Challenge the Process	High	14	41.57	14.95	4.00	2.153	42	0.037*
	Low	30	29.90	17.49	3.19			

*p < .05

Table 20

Registered Nurses: Correlation Matrix of Study Variables

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
(1) Total CWEQII	--													
(2) CWEQII : Opportunity	.57**	--												
(3) CWEQII: Information	.62**	0.23	--											
(4) CWEQII: Support	.86**	.42**	.44**	--										
(5) CWEQII subscale: Resources	.67**	.27*	.26*	.53**	--									
(6) CWEQII:JAS	.81**	.40**	.34**	.69**	.38**	--								
(7) CWEQII ORS	.70**	.30*	.32**	.51**	.28*	.62**	--							
(8) Total NAS Score	.33**	0.02	.39**	0.19	0.21	.28*	.27*	--						
(9) Mean CES Score	0.15	0.04	.29*	-0.03	.27*	-0.01	0.02	.44**	--					
(10) LPI-O: Model the Way	.36**	0.08	.40**	0.24	0.14	.40**	.25*	.36**	0.12	--				
(11) LPI-O: Inspire a Shared Vision	.42**	0.20	.50**	.25*	.25*	.33**	0.24	.43**	0.22	.85**	--			
(12) LPI-O: Challenge the Process	.31*	0.12	.31*	0.18	0.22	.30*	0.16	.40**	0.14	.857**	.87**	--		
(13) LPI-O: Enable Others to Act	.28*	0.05	.28*	0.19	0.19	.27*	0.16	.29*	0.11	.86**	.82**	.89**	--	
(14) LPI-O: Encourage the Heart	.34**	0.13	.34**	0.20	0.19	.37**	0.20	0.21	0.11	.80**	.79**	.75**	.86**	--

**. Correlation is significant at the 0.01 level (2-tailed).*. Correlation is significant at the 0.05 level (2-tailed).

Table 21

Registered Nurses: Summary of Variable Relationships

	Professional nursing behaviors (NAS)	Self-efficacy (CES)	Observed faculty leadership (LPI-O)
Structural empowerment (CWEQII)	+	No significant findings	+
Professional nursing behaviors (NAS)	--	+	+
Self-efficacy (CES)	+	--	No significant findings

+ = weak positive correlation ($r < .5$)

++ = moderate positive correlation ($r > .5$ to .7)

+++ = strong positive correlation ($r > .7$)

Strength of association based on Cohen (1988).

CONDITIONS OF LEARNING EFFECTIVENESS QUESTIONNAIRE (HSIU & LASCHINGER, 2006)

Please answer the following questions as they relate to your learning experiences in clinical setting.

Indicate your choice by circling the appropriate number on the scale beside each item.

How much support for the following is present?

		None		Some		A Lot
1.	Specific information about the 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
4.	Encouragement to pursue your own learning needs.	1	2	3	4	5
5.	Encouragement to challenge ideas.	1	2	3	4	5
6.	Active engagement in learning activities.	1	2	3	4	5
7.	Open discussion of learning concerns with your teacher.	1	2	3	4	5

How much opportunity for each of these activities is there?

		None		Some		A Lot
1.	Tasks that use all of your skills and knowledge.	1	2	3	4	5
2.	Challenging learning opportunities.	1	2	3	4	5
3.	Chance to learn new skills.	1	2	3	4	5
4.	Design learning experiences according to individual learning needs.	1	2	3	4	5
5.	Accomplish learning goals in your own way.	1	2	3	4	5
6.	Share with others what you have learned.	1	2	3	4	5

How much access to information about each of the following do you have?

	None		Some		A Lot
1. Teaching/learning values of faculty.	1	2	3	4	5
2. Goals of the nursing curriculum.	1	2	3	4	5
3. Teacher expectations of you.	1	2	3	4	5
4. Expertise of your peers gained from their learning experiences.	1	2	3	4	5
5. Teacher expertise relevant to your learning experiences.	1	2	3	4	5
6. Formal knowledge that helps you to solve patient care problems.	1	2	3	4	5

How much access to the following resources do you have?

	None		Some		A Lot
1. Time available to accomplish learning goals.	1	2	3	4	5
2. Teacher availability for help with your learning needs	1	2	3	4	5
3. Availability of peers for sharing information about their learning experiences with.	1	2	3	4	5
4. Availability of health care professionals (i.e., nurses, doctors, and other members of health care team) for consultation on learning needs.	1	2	3	4	5
5. Availability of other people to help with your learning goals (i.e., other professors, librarian, community service members).	1	2	3	4	5

To what extent is each of the following present?

	None		Some		A Lot
1. Rewards for innovative approaches to learning.	1	2	3	4	5
2. Flexibility allowed in the learning process.	1	2	3	4	5
3. Collaborating with teachers on learning activities.	1	2	3	4	5
4. Being sought out by peers for help with learning problems.	1	2	3	4	5
	1	2	3	4	5
5. Being sought out by teachers for help with learning activities.	1	2	3	4	5

6. Seeking out ideas from professionals other than nursing teachers (e.g., other teachers, nurses, doctors, physiotherapists, occupational therapists).

GLOBAL EMPOWERMENT SCALE

Please indicate the extent to which you agree or disagree with each statement.

	Strongly Disagree				Strongly Agree
1. Overall, my current learning environment empowers me to learn in an effective way.	1	2	3	4	5
2. Overall, I consider the learning environments in this program to be very empowering.	1	2	3	4	5

THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.

Appendix B

CARING EFFICACY SCALE
Coates (Copyright)
Version B
30 items

Instructions: When completing these items, think of your work in clinical settings and/or similar experiences. Complete the following scale based on your work with clients or patients. Please indicate your degree of agreement with each item. (Circle the number which best expresses your opinion.)

-3	strongly disagree	+1	slightly 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 care giving.	-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 multi-facets 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 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 form backgrounds different from my own.	-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
14. I use what I learn in conversation with clients/patients to provide more individuals care.	-3	-2	-1	+1	+2	+3
15. I don't feel strong enough to listen to the fears and	-3	-2	-1	+1	+2	+3

100

	strongly disagree					strongly agree

concerns of my clients/patients.

16. Even when I'm felling self-confident about most things, I still seem to be unable to relate to clients/patients.	-3	-2	-1	+1	+2	+3
17. I seem to be unable to relate 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 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 some 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 forma 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 communicating 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
30. I don't use creative or unusual way to express caring to my clients/patients.	-3	-2	-1	+1	+2	+3

Appendix C

Nursing Activity Scale

The following items describe situations in which a nurse must take some action that requires the exercise of some degree of professional nursing judgment. You are asked to respond to each item according to how likely you would be to carry out the action in each item. Please respond to each item even if you have not encountered such a situation before. Use the following scale in responding to the items.

     1 = Very unlikely of me to act in this manner
     2 = Unlikely of me to act in this manner
     3 = Likely of me to act in this manner
     4 = Very likely of me to act in this manner

Circle the number after each situation that most accurately describes how you would act as a nurse. There are no right or wrong answers, just different ways of responding to a situation. Please do not add qualifying statements to the items to justify your answer. Answer the items as stated.

1.	Develop a career plan for myself and regularly review it for achievement of steps in the plan.	1	2	3	4	
2.	Consider entry into independent nursing practice with the appropriate education and experience.	1	2	3	4	
3.	Voice opposition to any medical order to discharge a patient without an opportunity for nursing follow-up if the teaching plan for the patient is not completed.	1	2	3	4	
4.	Initiate nursing research to investigate a recurrent clinical nursing problem.	1	2	3	4	
5.	Refuse to administer a contraindicated drug despite the physician's insistence that the drug be given.	1	2	3	4	
6.	Consult with the patient's physician if the patient is not responding to the treatment plan.	1	2	3	4	
7.	Depend upon the profession of	1	2	3	4	

	nursing and not on physicians for the ultimate determination of what I do as a nurse.					
8.	Evaluate the hospitalized patient's need for home nursing care and determine the need for such a referral without waiting for a physician's order.	1	2	3	4	
9.	Propose changes in my job description to my supervisor in order to develop the position further.	1	2	3	4	
10.	Answer the patient's questions about a new medication or change in medication before administering drug, whether or not this has been done previously by the physician.	1	2	3	4	
11.	Institute nursing rounds on the patient unit.	1	2	3	4	
12.	Withhold a medicine that is contraindicated for a patient despite pressure from nursing peers to carry out the medical order.	1	2	3	4	
13.	Consult with other nurses when a patient is not responding to the plan of nursing care.	1	2	3	4	
14.	Routinely implement innovations in patient care identified in the current nursing literature.	1	2	3	4	
15.	Initiate a request for a psychiatric consult with the patient's physician if my assessment of the patient indicated such a need.	1	2	3	4	
16.	Promote innovative nursing activities, like follow-up phone calls to recently discharged patients, to evaluate the effectiveness of patient teaching.	1	2	3	4	
17.	Assess the patient's level of understanding concerning a diagnostic procedure and its risks before consulting with the patient's physician if a patient has questions	1	2	3	4	

	about the risks of the procedure.					
18.	Assume complete responsibility for my own professional actions without expecting to be protected by the physician or hospital in the case of a malpractice suit.	1	2	3	4	
19.	Develop effective communication channels in my employing institution for nurses' input regarding the policies that affect patient care.	1	2	3	4	
20.	Develop and refine assessment tools appropriate to my area of clinical practice.	1	2	3	4	
21.	Record in the chart the data from my physical assessment of the patient to use in planning and implementing nursing care.	1	2	3	4	
22.	Initiate discharge planning concerning the nursing care of the patient, even in the absence of discharge planning by the physician.	1	2	3	4	
23.	Report a physician who harasses me to the appropriate manager or administrator.	1	2	3	4	
24.	Offer input to administrators concerning the design of a new nursing unit or the purchase of new equipment to be used by nurses.	1	2	3	4	
25.	Complete a psychosocial assessment on each patient and use this data in formulating nursing care.	1	2	3	4	
26.	Adapt assessment tools from other disciplines to use in my clinical practice.	1	2	3	4	
27.						

	Carry out patient care procedures utilizing my professional judgment to meet the individual patient's needs even when this means deviating from the "cookbook" description in the hospital procedure manual.	1	2	3	4	
28.	Decline a temporary reassignment to a specialty unit when I lack the education and experience to carry out the demands of the assignment.	1	2	3	4	
29.	Initiate referrals to social service and dietary at the patient's request even in the absence of a physician's order.	1	2	3	4	
30.	Write nursing orders to increase the frequency of vital signs of a patient whose condition is deteriorating even in the absence of a medical order to increase the frequency of such monitoring.	1	2	3	4	
TOTAL SCORE						

Scores can range from 60 to 240 with the following breakdown for approximate levels of autonomy:

60 to 120 = lower level of professional autonomy
121 to 180 = mid level of professional autonomy
181 to 240 = higher level of professional autonomy

Questions regarding scoring should be sent to:
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CONDITIONS OF WORK EFFECTIVENESS QUESTIONNAIRE - II

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 1   2   3   4   5
    within the institution is

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

LPI OBSERVER
Leadership Practices Inventory

by JAMES M. KOUZES
& BARRY Z. POSNER

Instructions

You are being asked to assess the person described at the top of the next page. Below the person you will find thirty statements describing various leadership behaviors. Please read each statement carefully, and using the RATING SCALE on the right, ask yourself:

"How frequently does this person engage in the behavior described?"

When selecting your response to each statement:

- Be realistic about the extent to which this person *actually* engages in the behavior.

- Be as honest and accurate as you can be.

- Do NOT answer in terms of how you would like to see this person behave or in terms of how you think he or she should behave.

- DO answer in terms of how this person typically behaves on most days, on most projects, and with most people.

- Be thoughtful about your responses. For example, giving this person 10s on all items is most likely not an accurate description of his or her behavior. Similarly, giving someone all 1s or all 5s is most likely not an accurate description either. Most people will do some things more or less often than they do other things.

- If you feel that a statement does not apply, it's probably because you don't see or experience the behavior. That means this person does not frequently engage in the behavior, at least around you. In that case, assign a rating of 3 or lower.

For each statement, decide on a response and then record the corresponding number in the square to the right of the statement. After you have responded to all thirty statements, go back through the LPI one more time to make sure you have responded to each statement. *Every* statement *must* have a rating.

The RATING SCALE runs from 1 to 10. Choose the number that best applies to each statement.

1	=	Almost Never
2	=	Rarely
3	=	Seldom
4	=	Once in a While
5	=	Occasionally
6	=	Sometimes
7	=	Fairly Often
8	=	Usually
9	=	Very Frequently
10	=	Almost Always

When you have completed the LPI-Observer, please return it to:

_____

_____

_____

Thank you.

Leader you are evaluating: Clinical Instructor

Choose <u>one</u> person. The person I am rating is ☐ Home Hospital Instructor-DSH Clinical Nurse Specialist ☐ UNLV Instructor ☐ Non-UNLV Instructor

To what extent does this leader typically engage in the following behaviors? Choose the response number that best applies to each statement and record it in the box to the right of that statement.

He or She:

1.	Sets a personal example of what he/she expects of others.	☐
2.	Talks about future trends that will influence how our work gets done.	☐
3.	Seeks out challenging opportunities that test his/her own skills and abilities.	☐
4.	Develops cooperative relationships among the people he/she works with.	☐
5.	Praises people for a job well done.	☐
6.	Spends time and energy making certain that the people he/she works with adhere to the principles and standards that we have agreed on.	☐
7.	Describes a compelling image of what our future could be like.	☐
8.	Challenges people to try out new and innovative ways to do their work.	☐
9.	Actively listens to diverse points of view.	☐
10.	Makes it a point to let people know about his/her confidence in their abilities.	☐
11.	Follows through on promises and commitments he/she makes.	☐
12.	Appeals to others to share an exciting dream of the future.	☐
13.	Searches outside the formal boundaries of his/her organization for innovative ways to improve what we do.	☐
14.	Treats others with dignity and respect.	☐
15.	Makes sure that people are creatively rewarded for their contributions to the success of projects.	☐
16.	Asks for feedback on how his/her actions affect other people's performance.	☐
17.	Shows others how their long-term interests can be realized by enlisting in a common vision.	☐
18.	Asks "What can we learn?" when things don't go as expected.	☐
19.	Supports the decisions that people make on their own.	☐
20.	Publicly recognizes people who exemplify commitment to shared values.	☐
21.	Builds consensus around a common set of values for running our organization.	☐
22.	Paints the "big picture" of what we aspire to accomplish.	☐
23.	Makes certain that we set achievable goals, make concrete plans, and establish measurable milestones for the projects and programs that we work on.	☐
24.	Gives people a great deal of freedom and choice in deciding how to do their work.	☐
25.	Finds ways to celebrate accomplishments.	☐
26.	Is clear about his/her philosophy of leadership.	☐
27.	Speaks with genuine conviction about the higher meaning and purpose of our work.	☐
28.	Experiments and takes risks, even when there is a chance of failure.	☐
29.	Ensures that people grow in their jobs by learning new skills and developing themselves.	☐
30.	Gives the members of the team lots of appreciation and support for their contributions.	☐

Leader you are evaluating: Current Clinical Instructor at the hospital

I (the observer) am ☐ Home Hospital Student ☐ Non-home Hospital Student

To what extent does this leader typically engage in the following behaviors? Choose the response number that best applies to each statement and record it in the box to the right of that statement.

He or She:

1. Sets a personal example of what he/she expects of others.

2. Talks about future trends that will influence how our work gets done.

3. Seeks out challenging opportunities that test his/her own skills and abilities.

4. Develops cooperative relationships among the people he/she works with.

5. Praises people for a job well done.

6. Spends time and energy making certain that the people he/she works with adhere to the principles and standards that we have agreed on.

7. Describes a compelling image of what our future could be like.

8. Challenges people to try out new and innovative ways to do their work.

9. Actively listens to diverse points of view.

10. Makes it a point to let people know about his/her confidence in their abilities.

11. Follows through on promises and commitments he/she makes.

12. Appeals to others to share an exciting dream of the future.

13. Searches outside the formal boundaries of his/her organization for innovative ways to improve what we do.

14. Treats others with dignity and respect.

15. Makes sure that people are creatively rewarded for their contributions to the success of projects.

16. Asks for feedback on how his/her actions affect other people's performance.

17. Shows others how their long-term interests can be realized by enlisting in a common vision.

18. Asks "What can we learn?" when things don't go as expected.

19. Supports the decisions that people make on their own.

20. Publicly recognizes people who exemplify commitment to shared values.

21. Builds consensus around a common set of values for running our organization.

22. Paints the "big picture" of what we aspire to accomplish.

23. Makes certain that we set achievable goals, make concrete plans, and establish measurable milestones for the projects and programs that we work on.

24. Gives people a great deal of freedom and choice in deciding how to do their work.

25. Finds ways to celebrate accomplishments.

26. Is clear about his/her philosophy of leadership.

27. Speaks with genuine conviction about the higher meaning and purpose of our work.

28. Experiments and takes risks, even when there is a chance of failure.

29. Ensures that people grow in their jobs by learning new skills and developing themselves.

30. Gives the members of the team lots of appreciation and support for their contributions.

Appendix F

Demographic Questionnaire
Registered Nurse

Instructions: Please tell me about yourself and the characteristics of your work setting.
Please complete all questions.

1. Gender
    a. Male _____
    b. Female _____

2. Age in Years:_____

3. Please specify your ethnicity.
    Hispanic or Latino _____
    Not Hispanic or Latino _____

4. Race
    American Indian or Alaska Native _____
    Asian _____
    Black or African American _____
    Native Hawaiian or Other Pacific Islander _____
    White _____

5. Highest level of nursing education:
    a. Diploma _____
    b. Associate degree _____
    c. BSN _____
    d. MSN/MS _____
    e. Doctorate _____

6. Highest degree of other education:
    a. Bachelor _____ Field _____
    b. Masters _____ Field _____
    c. Doctorate _____ Field _____

7. Years of work experience in nursing: _____ years

8. Current employment status:
    a. Part time _____
    b. Full time _____

9. Years employed at current hospital: _____ years

10. Type of position:
    a. Staff nurse _____
    b. Charge nurse _____
    c. CNS/Educator _____
    d. Administrative/manager _____

e. Other: please specify _____

The following questions relate to your experiences with the clinical instruction of nursing students.

11. Desert Springs Hospital partners with UNLV to provide clinical instruction to students completing the baccalaureate program. In the last year, have you worked with a student enrolled in the UNLV nursing program?
   a. Yes _____
   b. No _____ Skip question 12 if answer is no.

12. During a semester, how often do you typically work with a UNLV nursing student completing a clinical rotation?
   a. Never or almost never _____
   b. Seldom _____
   c. Sometimes _____
   d. Often _____
   e. Always or almost always _____

13. Desert Springs also supports instruction for nursing students from other academic programs. In the last year, have you worked directly with a student enrolled in a program other than UNLV?
   a. Yes _____
   b. No _____ Skip question 14 if answer is no.

14. During a semester, how often do you typically work with a nursing student from other academic programs (non-UNLV) completing a clinical rotation?
   a. Never or almost never _____
   b. Seldom _____
   c. Sometimes _____
   d. Often _____
   e. Always or almost always _____

THANK-YOU!

Appendix G

Demographic Questionnaire
Student

Instructions: Please tell me about yourself and the characteristics of your work setting.
Please complete all questions.

1. Gender
    a. Male _____
    b. Female _____

2. Age in Years:_____

3. Please specify your ethnicity.
    Hispanic or Latino _____
    Not Hispanic or Latino _____

4. Race
    American Indian or Alaska Native _____
    Asian _____
    Black or African American _____
    Native Hawaiian or Other Pacific Islander _____
    White _____

5. Highest Education in field other than nursing
    a. Associate degree _____ Field _____
    b. Bachelors degree _____ Field _____
    c. Masters degree _____ Field _____
    d. Doctorate degree _____ Field _____
    e. Other, please specify _____

6. Current Clinical Level:
    a. Level I _____
    b. Level II _____
    c. Level III_____
    d. Level IV _____

7. Do you currently participate in the Home Hospital Program?
    a. Yes _____
    b. No _____, if no skip question 8

8. If yes, please indicate your Home Hospital Clinical site.
    a. Desert Springs Hospital _____
    b. UMC _____

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