WORK ENVIRONMENT AND THE EFFECT ON OCCUPATIONAL COMMITMENT AND INTENT TO LEAVE: A STUDY OF BEDSIDE REGISTERED NURSES

by

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ABSTRACT

The purpose of this research was to determine the effect work environment has on occupational commitment and intent to leave the profession for bedside registered nurses. Subscales of autonomy, control over the practice setting, nurse-physician relationship, and organizational support were incorporated into the analysis to determine which aspect of work environment most directly effects occupational commitment and intent to leave the profession. The research was undertaken in order to help administrators determine the ways in which work environment can be improved upon in order to retain bedside registered nurses in the profession.

An explanatory cross sectional survey was distributed to 259 direct care bedside registered nurses employed at a rural, system affiliated hospital in Central Florida. Human subject protection was assured through the University of Central Florida Institutional Review Board. A 77 item questionnaire containing 9 demographic questions, 57 questions from the Nursing Work Index- Revised (NWI-R), 8 questions from Blau's occupational commitment scale, and 3 questions from Blau's intent to leave scale was distributed to all direct care nurses. Subjects were also given the opportunity to complete 3 short answer questions. A 32.8 percent response rate was achieved for a total of 85 complete and usable surveys.

Data analysis showed that the work environment is positively related to occupational commitment and negatively related to intent to leave. In addition each of the four subscales (autonomy, control over the practice setting, relationship with physicians, and organizational support) were also positively related to occupational

commitment and negatively related to intent to leave the profession. Implications for organizations, public policy and future research are discussed.

This dissertation is dedicated to my husband, parents, and friends; each of you did your part to keep me sane during this process.

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CHAPTER ONE: INTRODUCTION

At 2.4 million, licensed registered nurses (RNs) are the largest number of healthcare professionals in the United States (American Association of Colleges of Nursing, 2004), and they account for one-third of the budget of a hospital (Dumpel, 2001). They perform a wide range of duties across the healthcare continuum, and few can argue with the importance of their services and their presence as an essential member of the healthcare team. However, the very healthcare system and organizations that depend so heavily on the work of nurses is driving them out of the field at an alarming rate (Borowski, Amann, Song & Weiss, 2007).

Hospitals are bearing the brunt of the most recent nursing shortage. In 1985, 73 percent of the 1.42 million nurses were employed in hospitals (Hirsh & Schumacher, 2005), thus giving hospitals the competitive advantage with respect to hiring nurses. However, over the last 20 years many factors including budget cuts, other employment opportunities for women, and cost shifting have affected the labor market for nurses (Greiner, 1995, Shui, 1996). Even for those nurses that remain in the profession, the availability of employment with consistent hours and preferable work environments in physician's offices and managed care organizations has drawn nurses out of the hospitals (Unruh, 2005). These factors and many others have led to a diminished advantage for hospitals when hiring nurses; in 2004, they employed only 62 percent of the 2.24 million (Hirst & Schumacher, 2005).

The shortage of nurses is nothing new; this is a problem that has plagued the United States healthcare system for over a century (Andrews, 2003). Nevertheless, this shortage is like none that we have ever seen before, primarily because of the large

numbers of nurses expected to retire and the limited number of graduate nurses to take their place (Buerhaus, Staiger, & Auberbach, 2004). There are a multitude of factors contributing to the dwindling supply of nurses and the increased demands being placed on the healthcare system.

Implications of the Nursing Shortage

Across the United States and in particular, the State of Florida it is widely accepted that we are experiencing a nursing shortage. In a survey of hospital administrators conducted by the Florida Hospital Association (2004), 93.1 percent of the hospitals administrators surveyed agreed that there is a nursing shortage, and of those, 79.2 percent rated the shortage as severe or moderate. The implications of this shortage are wide ranging. One dramatic impact is on the Emergency Department (ED) with 33.7 percent of hospitals indicating that ED overcrowding is a major issue. Overcrowding in the Emergency Department as a result of the nursing shortage has also been documented in other states including New York and Texas (Derlet, & Richards, 2002).

Issues regarding patient safety and quality of care have also been raised in the wake of the nursing shortage. Patient safety and quality concerns have primarily arisen out of increasing patient to nurse ratios. A cross sectional study on staff nurses and patient data found that each additional patient a nurse was responsible for resulted in a 7 percent increase in the likelihood of the patient dying within 30 days of admission. This same study also found that each additional patient per nurse was associated with a 23 percent increase in the odds of burnout and 15 percent increase in the odds of job dissatisfaction (Aiken, Clarke, Sloane, Sochalski & Sibler, 2002). Another study the

nurse to patient ratios currently used in hospitals is underestimated by not accounting for the severity of patients nurses are being asked to care for (Unruh & Fottler, 2006). In light of these findings, the results of the Aiken, et al (2002) study become take on increased relevance. This research indicates that not only is patient safety in jeopardy, so are the burnout rates, and thus retention of staff nurses in the profession.

Supply and Demand Issues

The US Department of Health and Human Services (DHHS, 2004) reported that if current trends continue, by 2020 the United States Registered Nurse (RN) supply will be able to meet only 64 percent of the demand, leaving 36 percent of the demand unmet (see figure 1) The projections for the State of Florida are even more disturbing. DHHS (2004) reported that Florida will lose only one percent of their baseline Full Time Equivalent (FTE) supply between 2000 and 2020, but their baseline FTE demand will increase 63 percent during that same timeframe. This means that Florida will be able to meet only 57 percent of the demand, leaving 43 percent of the population demand unmet. (Department of Health and Human Services, 2004)

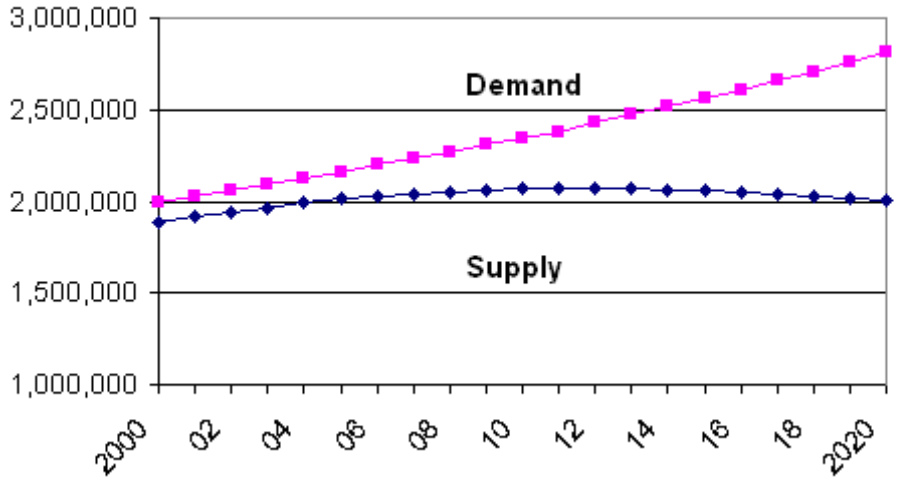


Figure 1: National Supply and Demand Projections for Full-Time Equivalent RNs, 2000 to 2020 (Source- Bureau of Health Professions, RN Supply and Demand Projections

These projections certainly paint a bleak picture for all citizens and particularly those residing in the State of Florida. However, there is some hope. Buerhaus, Staiger, and Auerback (2004) found that between 2001 and 2003 the nurse workforce increased 205,000, the largest increase since 1983 with most of that growth occurring in hospitals. They also found several factors that could have contributed to this increase, including a high unemployment rate, government and private sector initiatives, and increased wages (Buerhaus, et al, 2004). While these factors have certainly helped the workforce issues, in no way have they solved the nursing shortage. All of these factors are dynamic and depend on the state of the economy and government interest in nursing education; all could disappear as quickly as they arrived. (Unruh & Fottler, 2005)

The American Association of Colleges of Nursing (2004) reported a 14.1 percent increase in enrollment in baccalaureate nursing programs in 2004. This, coupled with the

increase in 2002 reported by Buerhaus, Staiger, and Auerbach (2004), appears to indicate a positive movement. However, the 2002 increase was a result of heavy reliance on older nurses reentering the workforce and foreign-born RNs, with 27 percent of hospitals in Florida actively recruiting nurses (FHA, 2006). This reliance on foreign born nurses raises some interesting ethical issues; a recent report points out that many of our foreign nurses are coming from countries that are experiencing nursing shortage themselves. These countries often subsidize the education of nurses in the hopes that they will alleviate their own shortage; therefore, when these nurses come to developed countries, such as the United States, those countries are losing the investment they have made (Arends-Kuenning, 2006; Aiken, 2007). The use of foreign-born RNs together with reentering nurses provides a short term solution for the shortage but this is not a viable long term strategy. Therefore, we must investigate alternatives to decrease the disparities between the supply and demand of nurses in the United States.

The obvious answer to increase the supply of nurses is to increase the number of nurses that are graduating from RN programs. However, despite the Nurse Reinvestment Act of 2002 which has funneled $323 million dollars into nursing education, colleges and universities cannot meet the demand for nursing students (Florida Center for Nursing, 2007). According to the American Association of Colleges of Nursing (AACN), nursing schools turned away nearly 32,797 applicants in the 2004-2005 academic year. There simply is not enough classroom space or professors to teach the increased number of students (Duff, 2002).

The nursing faculty population has seen a dramatic decline in the past years. The Southeastern Regional Education Board (2004) documents a 12 percent shortfall in the

number of nursing educators needed and is predicting that this will be a major threat to nursing education in the next five years. Nursing faculty might soon be feeling the effects of the baby boomers as well; the median age for all nursing faculty is now 46.8 years, but the average age for nurses with doctorate degrees, necessary to teach advanced courses, is 55.7 years (Florida Center for Nursing, 2007). The repercussion of not having enough doctoral prepared nurses is far reaching. Even if we can get enough nurses in the profession through Associates and Bachelors degrees, without nurses with advanced degrees we will not be able to educate the next generation.

Higher education is not the only place that the aging population is a concern; many of our current registered nurses are baby boomers and will also be retiring. In March of 2004 the average age of the RN population was 46.8 and the percentage of nurses over the age of 54 increased to 25.5 percent from 24.3 percent in 2000 making nursing the occupational group with the oldest members in the United States (Lynn & Redman, 2005). The graying of the nursing population together with the fact that the population of nurses under the age of 30 dropped 1 percent between 2002 and 2004 has created a bleak future for the nursing profession. (Department of Health and Human Services, 2004) This presents a significant problem in a profession that involves great physical demands; it is often not possible or desirable to work beyond one's mid-50s (Kovner, 2007; Kimball & O'Neil, 2002). As the baby boomers step out of the profession, there are few people waiting to fill their shoes.

Baby boomers are not only affecting the supply side of the nursing shortage but are a primary cause for concern on the demand side as well. As this vast generation ages, they will require more medical care for chronic and acute illnesses and more highly

trained staff to deliver that care (Watson, 2002). Officials from the Tenet Healthcare Corporation have begun to analyze the volume of patient-load growth they are experiencing by both services and age group. They have determined that during a six month time period ending November 30, 2000, patient-load volume at the company's hospitals grew 12 percent among 51 to 60 year olds (Kircheimer, 2001). This trend is expected only to increase in the next 20 years.

Since the demographic shifts are unlikely to reverse in the next 20 years, it becomes necessary to counteract the depleting supply of nurses in another manner. The changes in the managed care system and the shift to assistive personnel have not only affected the financial systems of the healthcare market, but they have also created a potentially hostile work environment for those nurses left in the profession. (Norrish & Rundall, 2001). The environment has become more demanding, stressful and less fulfilling, and in turn, impedes nurses from providing care that meets the standards necessary for safe, quality care and a positive work environment. This disillusionment has led to many nurses leaving the profession and to difficulty in recruiting new nurses (Kimball & O'Neil, 2002).

Why Wages Aren't Enough

Some evidence indicates that one of nurses' chief complaints is relatively low wages and some have indicated that increasing the average wages may indeed alleviate the shortage (Kimball & O'Neil, 2002). Nurses surveyed indicated that increasing wages was the number one way to retain nurses (Lynn, & Redman, 2006). In an attempt to test the impact of wages on retention, Ahlburg and Mahoney (1996) investigated the

independent decisions of remaining employed in nursing with respect to wages. In a study of 6,046 nurses in Minnesota, they determined that a 10percent increase in wages, relative to the anticipated wages in their next occupation, would increase the probability that they would remain a nurse by about two percent. Similar results found that the propensity of full-time, part time and casual nurses to leave increased only slightly if they were not satisfied with their pay (Zeytinoglu, Denton, Davies, Baumann, Blythe, & Boos, 2006).

This research indicates that while higher wages may increase retention rates of nursing in the profession, and have been successful in alleviating the shortage (May, Bazzoli, & Gerland, 2006) concerns about increasing hospital budgets and the long term sustainability of these practices have come into question. Ahlburg and Mahoney (1996) supported the assertion that systemic changes in hospital policies, such as increased activity in the decision making process, autonomy, and authority would be a more effective and efficient way to retain nurses. It is also important to note that since 2001 wages have increased steadily, but employment has dropped from 144,350 in 2001 to 130,410 in 2004 (Florida Center for Nursing, 2007)

In the past, many economists have based predictions of labor market shortages on the fact that a change in wages can bring a supply and demand cycle back into balance (Spetz, & Given, 2003), but as mentioned above, this principle is based on the assumption that we can retain nurses as well as produce more nurses through the education system. Spetz and Given (2003) did find that an increase of 3.2-3.8 percent in nursing wages in the United States from 2005-2016 and an increase in graduation rates could equalize the labor market by 2020.

The problem with this model is that several assumptions must be made to make this a plausible solution. First, this pay increase would create a 55-69 percent raise for RNs and double the total spending on RNs by 2016. Given the economic restrains of most hospitals, this is not a viable option. The second assumption is that nursing schools can produce 6.2 percent more graduates per year. This too is problematic based on the labor market issues occurring with nursing faculty as discussed above (Spetz & Given, 2003). While increasing wages is a key element of retention, it seems prudent to investigate increasing wages, and also attempt to retain nurses in their current occupation through a positive work environment.

Retention

Of the 2.4 million nurses in the United States, 16.8percent of them are not employed in nursing. Of those no longer working in nursing, 42.7percent claimed that they left for reasons connected with the workplace (Florida Center for Nursing, 2007). Since we cannot depend on a high unemployment rate or economic factors to force RNs back into the labor pool, recruitment and retention become tantamount in the fight against the nursing shortage. In 2002 while studying nurse staffing, Aiken, Clarke, Sloane, Sochalski, and Silber found that 40percent of the nurses they surveyed were planning on leaving the profession in the next year.

A meta analysis by Unruh and Fottler (2002) also provided insight into issues regarding retention. Recommendations were made to professionalize nursing in order to retain nurses at the bedside, in the organization and in the profession. These findings highlight the importance of staffing, wages, education, and career planning. These

hallmarks of professionalism are included in the NWI-R and are an important piece of retention of nurses.

Studies have also shown that the turnover rates for graduate nurses range from 35 percent-60 percent within the first year. The economic impact of this attrition rate is catastrophic when you consider that every nurse with less than one year in an organization costs the organization approximately $40,000 in hiring and orientation fees (Halfer & Graf, 2006). In 2006 the State of Florida hospital RN turnover rate was 10 percent and Florida hospitals spend about $147 million to replace nurses that have left (FCN, 2007)

A recent case study by Smith, Waldman, Hood & Fottler, 2007, evaluated the costs of turnover for a large academic medical center located in the Southwest area. These findings project an even greater turnover costs than are generally reported. This medical center reported spending almost 5percent of their annual operating budget on costs associated with turnover and failure to retain clinical personnel. These issues include not just hiring costs, which are most commonly reported, but also the cost of loss of productivity and training new employees. In total this medical center spends $17,251,000 to $29,312,000 annually on retention related costs. (Smith, et.al, 2007)

Work Environment and the Nursing Work Index:

The importance of work environment in the hospital setting first gained attention in the mid 1980s when a national shortage of nurses prompted the American Academy of Nursing (AAN) to look at certain hospitals that seemed resistant to the shortage. Upon investigation researchers discovered that these "magnet" hospitals (so dubbed because of

their magnetic properties to recruit and retain nurses) shared similar organizational characteristics. Through the use of interviews with nursing executives and staff nurses, researchers discovered that in addition to low nursing turnover rates, these hospitals also shared the following traits: "adequate staffing levels, flexible scheduling, strong supportive and visible nurse leadership, recognition for excellence in practice, participative management with open communication, good relationships with physicians, salaried rather than hourly compensation for nurses, professional development and career advancement opportunities." (Sovie, 1984, p 21)

In direct response to the AAN report, Kramer and Hafner (1989) developed a measurement tool based on the characteristics of magnet hospitals to determine job satisfaction and the ability to provide care called the Nursing Work Index. This instrument was used to determine that job satisfaction scores are highly negatively correlated with turnover, meaning that organizations employing nurses with higher job satisfaction had lower turnover rates.

When originally designed, the NWI's unit of measure was the hospital and was not intended for the nursing unit or individual nurse; so in response to the need to study nursing units and individuals, the Nursing Work Index Revised (NWI-R) was created to measure work environment. In 2000, Aiken and Patrician revised the highly used Nursing Work Index by re-examining the importance of each of the original 65 NWI items. The result was a 57 item survey that was composed of 55 of the original questions and one revised question; one question regarding team nursing was added. In addition to the changes in the questions, four subscales were also conceptually derived from the NWI-R; these subscales mirrored the organizational attributes present in the literature.

These subscales are autonomy, control over the practice setting, nurse-physician relationship, and organizational support (Aiken & Patrician, 2000).

The use of magnet hospital characteristics as a measure of work environment has been used in a variety of research to study hospital characteristics and mortality rates (Aiken, et al, 1994), dedicated AIDS units (Aiken & Sloane, 1997), and perceived work environment (Choi, Bakken, Larson, Du, & Stone, 2004). In all of these diverse studies the NWI or the NWI-R has proved to be a valid and reliable method of measuring the nurse's practice environment or the nurse's work environment. Therefore, for the purposes of this study the NWI-R will be used to measure the organizational characteristics (i.e. work environment) of the hospital.

Occupational Commitment:

In 1998 Blau made an interesting statement in his study of medical technologists. He noted that as we employ more temporary employees, and movement across organizations is becoming more commonplace, there has been a shift from commitment to an organization to commitment to the occupation. This observation is applicable to the current state of the Registered Nurse workforce where the use of traveling nurses and part time nurses has been used as a band aid for the current shortage. Even though commitment to an organization is important from a policy perspective, a more macro view of the situation indicates that current nurses are more likely to be committed to their occupation than their organization (Lu, Wu, Hsieh, & Chang, 2002) and policy research should reflect that assumption. This assessment of the situation led to the research questions listed below and is the focus of this study.

Researchers have found that commitment to one's profession indicates an employee's intention to remain in the profession, and can in turn influence the amount of effort he or she expends on the job and the level of satisfaction that the employee derives from his or her position (Blau, 1985, 1998; McGinnis & Morrow, 1990; Somers & Birbaum, 1998; Kieslier, 1971). The commitment that one has to his or her profession has been termed many things including occupational, career, and job commitment. For the purposes of this research the term occupational commitment will be used as it best describes the nursing profession, and has been previously used in nursing literature.

Regardless of the lack of a consistent use of terminology, there are several definitions of the term that are used widely and occasionally interchangeably. Blau (1985) defined occupational commitment as "one's attitude toward one's profession or vocation (p. 278); while Carson and Bedeian (1994) defined the term as "one's motivation to work in a chosen vocation" (p. 240). For the purpose of this study Blau's (1985) definition of occupational commitment will be used. More specifically, Blau (1985) developed an eight-item scale that operationalization attempts to gauge a person's commitment to his or her career. The focus of this eight-item Likert Scale questionnaire hinges on the extent to which someone identifies with his or her chosen profession and is used to measure occupational commitment for the purposes of this research.

Intent to Leave

In recent years, changing jobs or positions within the same profession has become increasingly common. Bolles (2006) found that employees under the age of 35 will look for a job in another organization every one to three years. Research has also

demonstrated that an individual is much less likely to change his or her career, only changing occupations an average of three times during their working lives (Becker, 1964; Bolles, 2006). In spite of these findings, career instability among professional nurses is not a new phenomenon to the literature, and in fact, has been cited several times as a major cause of the nursing shortages of the past (Aiken, Blendond, & Rogers, 1981; Laird, 1983; Link & Settle, 1980; Schoen & Schoen, 1985). A recent study demonstrated that between 1992 and 2000, there was a 28percent increase in the number of nurses leaving the profession due to factors regarding work environment (Lynn & Redman, 2005). Recent studies have also found that older (50 and older) nurses often cite that they have left the nursing workforce as a result of problems at work (Kovner, Brewer, Cheng & Djukic, 2007). Several studies have shown that inactive nurses would return to nursing if they were given more flexibility, respect, lower workloads, better pay and better administrative support (Fottler & Widra, 1995; Pierce, Freund, Luikart, & Fondress, 1991). Therefore, by improving these factors, as well as other factors relating to work environment, we can decrease the number of nurses intending to leave the profession.

Research Questions

1. What is the relationship between work environment factors and the occupational commitment of bedside registered nurses?
    a. What is the relationship between organizational characteristics measured by the NWI-R and the occupational commitment of bedside registered nurses?
    b. What is the relationship between the autonomy subscale measured in the NWI-R and the occupational commitment of bedside registered nurses?
    c. What is the relationship between control over the practice setting subscale measured in the NWI-R and the occupational commitment of bedside registered nurses?
    d. What is the relationship between nurse-physician relationship subscale measured in the NWI-R and the occupational commitment of bedside registered nurses?

e. What is the relationship between organizational support subscale measured in the NWI-R and the occupational commitment of bedside registered nurses?

2. What is the relationship between work environment and the intent to leave the profession of bedside registered nurses?
    a. What is the relationship between organizational characteristics measured by the NWI-R and the intent to leave the profession of bedside registered nurses?
    b. What is the relationship between the autonomy subscale measured in the NWI-R and the intent to leave of bedside registered nurses?
    c. What is the relationship between control over the practice setting subscale measured in the NWI-R and the intent to leave of bedside registered nurses?
    d. What is the relationship between nurse-physician relationship subscale measured in the NWI-R and the intent to leave bedside registered nurses?
    e. What is the relationship between organizational support subscale measured in the NWI-R and the intent to leave of bedside registered nurses?

Dependent Variables

Occupational commitment

For the purpose of this study occupational commitment is defined as "one's attitude toward one's profession or vocation" (Blau, 1985). The eight-item scale developed by Blau (1985) is a compilation of theoretical studies conducted by several researchers and includes professional commitment (Price & Muller, 1981), occupational commitment (Downing et al., 1978), and career orientation (Liden & Green, 1980). This assessment consists of the following items: 1) If I could get another job different from being a nurse and paying the same amount I would probably take it, 2) I definitely want a career for myself in nursing, 3) If I could do it all over again, I would not choose to work in the nursing profession, 4) If I had all the money I needed without working, I would probably still continue to work in the nursing profession, 5) I like this vocation too well to give it up, 6) This is the ideal vocation for a life work, 7) I am disappointed that I ever entered the nursing profession, 8) I spend a significant amount of personal time reading nursing-related journals or books. The eight-item scale has a range of potential values

from 8 to 40. Items 1,3, and 7 have been reverse coded so that a high score indicates a high occupational commitment. The chosen scale has been proven reliable (.67) in a test retest research design conducted with a sample of 119 registered nurses (Blau, 1985). In light of the difficulty of collecting data from those that have left the profession, the intent to leave the profession is the most commonly used measure of turnover (Blau, 2007)

Intent to Leave the Profession

The employee's intention to leave his or her profession will be defined as turnover intentions for the purpose of this study. Employees that have a lower degree of loyalty to their organization are more likely to leave their current job if a move to another organization will enhance their career (Gouldner, 1958). Career turnover intentions will be measured using three items, also used by Blau (1985). These three items are: 1) I am thinking about leaving the nursing profession, 2) I intend to look for a different profession, 3) I intend to stay in the nursing profession for some time. The survey will ask that these three items be ranked on a five-point Likert scale (1=never, 5=always).

The psychometric properties of both the occupational commitment and intent to leave scales were supported through a confirmatory factor analysis performed on pharmacists. This analysis determined that all factor loadings were statistically significant with small standard errors indicating validity of these scales. (Gaither, 1993)

Independent Variables

Work Environment

The Nurses Work Index- Revised (NWI-R) will be used to measure the work environment for the purposes of this study. Nurses with a high total score on the NWI-R

are more likely to be satisfied with their work environment and perceive it to be a positive place to work. The reliability of this measure has been established using a survey design method conducted in AIDS dedicated units (Conbach's alpha .96). The work environment as measured by the NWI-R also contains subscales that will be utilized. These subscales are autonomy (Cronbach's alpha .75), control over practice setting (Cronbach's alpha .79), nurse-physician relationship (Cronbach's alpha .76), and organizational support. (Aiken & Patrician, 2000) The reliability of this measure was further demonstrated in a study of nurses in Ontario Canada where the Alpha reliability was .87 for the total scale, .78 for the autonomy subscale, .75 for the control over the practice subscale, and .85 for the relationship subscale (Laschinger, Almost, & Tuer-Hodes, 2003).

Autonomy Subscale

Autonomy has been defined in numerous ways and for the purpose of this study will be defined as "socially granted and legally defined freedom to make practice decisions without technical evaluation from sources outside of the profession" (McKay, 1983, p21). The autonomy subscale of the NWI-R is designed to measure the extent to which nurses feel that they can practice their profession on their own. It has been noted in the literature that autonomy among nurses is related to magnet hospital status and that autonomy highly correlates with nurse job satisfaction (Kramer & Schmalenberg, 2003; Upenieks, 2002) and teamwork (Rafferty, Ball & Aiken, 2005).

Control over Practice Setting Subscale

Control over the practice setting has been defined as "a system that supports registered nurse control over the delivery of care and the environment in which care is

delivered (Hoffart & Woods, 1996 p 354). The NWI-R control over the practice setting subscale seeks to measure the extent to which nurses have the ability to control the delivery of care. Mark, Salyer, & Wan (2003) found in a study of 1,682 RNs that if the RNs perceived a high degree of control over the practice setting, job satisfaction would increase and turnover would decrease.

Nurse Physician Relationship Subscale

The Nurse Physician Relationship subscale is intended to measure the quality of the relationship, teamwork, and collaboration between the nurse and those physicians in which he or she most often comes in contact. It has been documented in the literature that the relationship with physicians can influence a graduate nurse's intent to stay in a position (Halfer & Graf, 2006) and job dissatisfaction, psychological empowerment, and intent to leave in professional nurses(Larrabee, Janney, Ostrow, Winthrow, Hobbs & Burant, 2003).

Organizational Support Subscale

The Organizational Support subscale measures the degree to which a nurse feels as though he or she is supported by their organization in terms of support services, staffing, assignments, and teamwork. Recently, Skytt, Ljunggren and Carlsson (2007) sound that one of the major reasons first-line nurse managers' turnover is the lack of organizational support including a lack of support from supervisors. Organizational support and structure was also seen to be a factor in attracting and retaining nurses (Stordeur, D'Hoore, & the NEXT-Study Group, 2006, Drach-Zahavy, 2004).

Hypotheses

Null Hypothesis Number One

Ho_1-There is no relationship between bedside registered nurses perceptions of work environment and occupational commitment

Rationale for Null Hypothesis Number One:

The Researcher feels that the NWI-R will measure the organizational characteristics that determine work environment for bedside registered nurses and since these characteristics mimic those present in magnet hospitals (Aiken & Patrician, 2000) these characteristics will prove to be positively related to occupational commitment of these nurses.

Null Hypothesis Number Two

Ho_2- There is no relationship between bedside registered nurses perceived autonomy and their occupational commitment.

Rationale Statement for Null Hypothesis Number Two:

According to the literature, autonomy is an essential element to job satisfaction of registered nurses (Kramer & Schmalenberg, 2003, Irvine& Evans, 2005). Autonomy is also theoretically linked to increased affective commitment (Meyer & Allen, 1991). The researcher believes that this aspect of work environment will be positively related to occupational commitment.

Null Hypothesis Number Three

Ho_3- There is no relationship between a bedside registered nurses control over their practice setting and occupational commitment.

Rationale Statement for Null Hypothesis Number Three:

Control over the practice setting is an essential element to RNs perception of recognition of excellence in practice which is a hallmark of magnet hospital status (Aiken & Patrician, 2000) and can also be an antecedent to the development of affective commitment (Meyer & Allen, 1991). Because of this link the Researcher believes that a higher score on the NWI-R subscale for control over the practice setting will indicate a heightened level of occupational commitment.

Null Hypothesis Number Four

Ho_4- There is no relationship between nurse physician relationships of bedside registered nurses and occupational commitment

Rationale Statement for Null Hypothesis Number Four:

Nurse-Physician relationships are an important determinant on an employee's job satisfaction (Skytt, Ljunggren, & Carlsson, 2007; Vahey, Aiken, Sloane, Clarke & Vargas, 2004) and are theoretically linked to commitment (Ashforth & Mael, 1989) therefore, the Researcher believes that the nurse physician relationship subscale will be positively related to the respondent's occupational commitment.

Null Hypothesis Number Five

Ho_5- There is no relationship between organizational support and occupational commitment of bedside registered nurses.

Rationale Statement for Null Hypothesis Number Five:

Organizational support has been indicated in the literature to be a predictor of magnet hospital status (Aiken, Patrician, 2000), and indicate a positive work environment

believed to be positively related to occupational commitment. It is also theoretically linked to the development of affective commitment to an occupation (Meyer & Allen, 1993).

Null Hypothesis Number Six

Ho_6- There is no relationship between nurses' intent to leave the profession and their perceived work environment.

Rationale Statement for Null Hypothesis Number Six:

Research has shown (Fottler & Widra, 1995; Lynn & Redman, 2005) that some nurses leave the profession due to negative aspects encountered in their work environment. Therefore the researcher believes that the measurement of work environment using the NWI-R will predict a nurse's intention to leave the profession.

Null Hypothesis Number Seven

Ho_7- No relationship exists between a bedside registered nurse's perceived autonomy and their intent to leave the profession.

Rationale Statement for Null Hypothesis Number Seven:

Researchers have found that autonomy is an important aspect of work environment (Aiken & Partician, 2000), and can contribute to turnover from the profession (Chapman & Hutchinson, 1982, Rafferty, Ball & Aiken, 2001). Therefore the researcher believes that a nurse who feels that they have a high degree of autonomy will have a lower intent to leave the profession.

Null Hypothesis Number Eight

Ho_8- There is no relationship between a bedside registered nurse's control over the practice setting and their intent to leave the profession.

Rationale Statement for Null Hypothesis Number Eight:

The researcher believes that since control over the practice setting has been negatively correlated with turnover (Mark, et al, 2003; O'Brien, Duffield & Hayes, 2006) that control over the practice setting and intent to leave the profession will also be negatively related.

Null Hypothesis Number Nine

Ho_9- No relationship exists between nurse physician relationships and a bedside registered nurse's intention to leave the profession.

Rationale Statement for NullHypothesis Number Nine:

Relationships at work, primarily nurse-physician relationships, have been linked to intentions to leave in the literature (Larrabee, Janney, Ostrow, Winthrow, Hobbs, & Burant, 2003); the researcher contends that the relationship between intent to leave and nurse-physician relationships will be negative.

Null Hypothesis Number Ten

Ho_{10}- No relationship exists between organizational support and a bedside registered nurse's intent to leave the profession.

Rationale Statement for Null Hypothesis Number Ten:

Organizational support has been determined to be a key indicator of magnet hospital status in the literature (Aiken & Patrician, 2000). In light of this research, the researcher believes that organizational support and intent to leave the profession will be negatively correlated.

Table 1: Definition of All Variables Used in This Study

Name	Definition	Operational Definition
Dependent Variables		
Occupational Commitment	"one's attitude toward one's profession or vocation" (Blau, 1985)	Measured using the Occupational Commitment scale developed by Blau (1985) and measured on a 5 point Likert Scale where 1=Never and 5= Always. The scale includes 8 items and the range of scores is 6 to 40. Scores were developed by summing all items, with equal weighting for each item.
Intent to Leave	The employee's intention to leave his or her profession	Measured using the 3 item Intent to Leave scale and measured on a 5 point Likert Scale where 1=Never and 5=Always. The range of scores is from 3 to 15. Scores were developed by summing all items with equal weighting for each item.
Independent Variables		
Work Environment	The environment in which a nurse functions including his/her autonomy, control over practice setting, organizational support, and physician relationships	Measured using all 57 questions on the NWI-R on a 4 point Likert Scale where 1= strongly disagree and 4= strongly agree and a higher score indicates a positive work environment. Range of scores is 57 to 228. Scores were developed by summing all items, with equal weighting for each item.
Autonomy	"Socially granted and legally defined freedom to make practice decisions without technical evaluations from sources outside the profession" (McKay, 1983, p 21)	Measured using the autonomy subscale of the NWI-R. All 5 items are measured on a 4 point Likert Scale where a 1= strongly disagree and 4= strongly agree and a higher score indicates a heightened sense of autonomy in the work environment. Range of scores is 5 to 20. Scores were developed by summing all items in the subscale, with equal weighting for all 5 items.

Independent Variables	Definition	Operational Definition
Control Over Practice Setting	"A system that supports registered nurse control over the delivery of nursing care and the environment in which care is delivered" (Hoffart & Woods, 1996, p 354)	Measured using the control over the practice setting subscale of the NWI-R. All 7 items are measured on a 4 point Likert Scale where 1= strongly disagree and 4= strongly agree, a higher score indicates greater control over the practice setting. The range of scores is 7 to 28. The scores were developed by summing all items in the subscale, with equal weighting for all 7 items.
Nurse Physician Relationship	The quality of the relationship, teamwork and collaboration between the nurse and those physicians in which he or she most often comes in contact.	Measured using the nurse-physician relationship subscale of the NWI-R. The 3 item subscale is measured on a 4 point Likert Scale and where 1= strongly disagree and 4 = strongly agree. The range of scores is 3 to 12. The scores were developed by summing all items in the subscale with equal weighting for all 3 items.
Organizational Support	The degree to which a nurse feels as though he or she is supported by their organization.	Measured using the organizational support subscale of the NWI-R. The 10 item subscale is measured on a 4 point Likert Scale where 1=strongly disagree and 4= strongly agree. The range of scores is 10 to 40. The scores were developed by summing all items in the subscale with equal weighting for all 10 items.

Control Variables	Definition	Operational Definition
Education	The highest degree each respondent has completed	Measured where: 0=Diploma 1=Associates Degree 2=Bachelor's Degree 3=Master's Degree or Doctorate
RN Tenure	The length of time a respondent has been a registered nurse	Measured in years by the open ended response to "How long have you been a Registered Nurse?"
Waterman Tenure	The length of time a respondent has been employed at Florida Hospital Waterman	Measured in years by the open ended response to "How long have your been employed at Florida Hospital Waterman?"
Shift	The shift (days, nights or rotating) that the respondent most often works.	Measured where: 0=Days 1= Nights or Rotating
Employment Status	If the respondent works full time or part time	Measured where: 0=Full Time 1= Part Time or Rotating
Marital Status	The marital status of each respondent	Measured where: 0=Single 1=Married 2=Divorced 3=Widowed or Separated
Family Obligations	The number of children and the age of youngest child	Measured by the number of children each respondent has and the age of the youngest child.
Age	The age of the respondent	0=18-25 years of age 1=26-33 years of age 2=34-40 years of age 3=41-48 years of age 4=49-56 years of age 5=57-64 years of age 6= 65 years of age and older

Table 1 outlines all variables included in this study as well as their definition, how they were scored and their significance to the study. Figure 2 shows the relationship between the dependent, independent and control variables to be used in this study. The dependent variables are occupational commitment and intent to leave the profession. The independent variables are work environment, organizational support, autonomy, control over the practice setting and nurse-physician relationship all measured using the NWI-R. The control variables include age, education, marital status, full time vs. part time, shift, RN Tenure, marital status, and obligations (number of children, children's age).

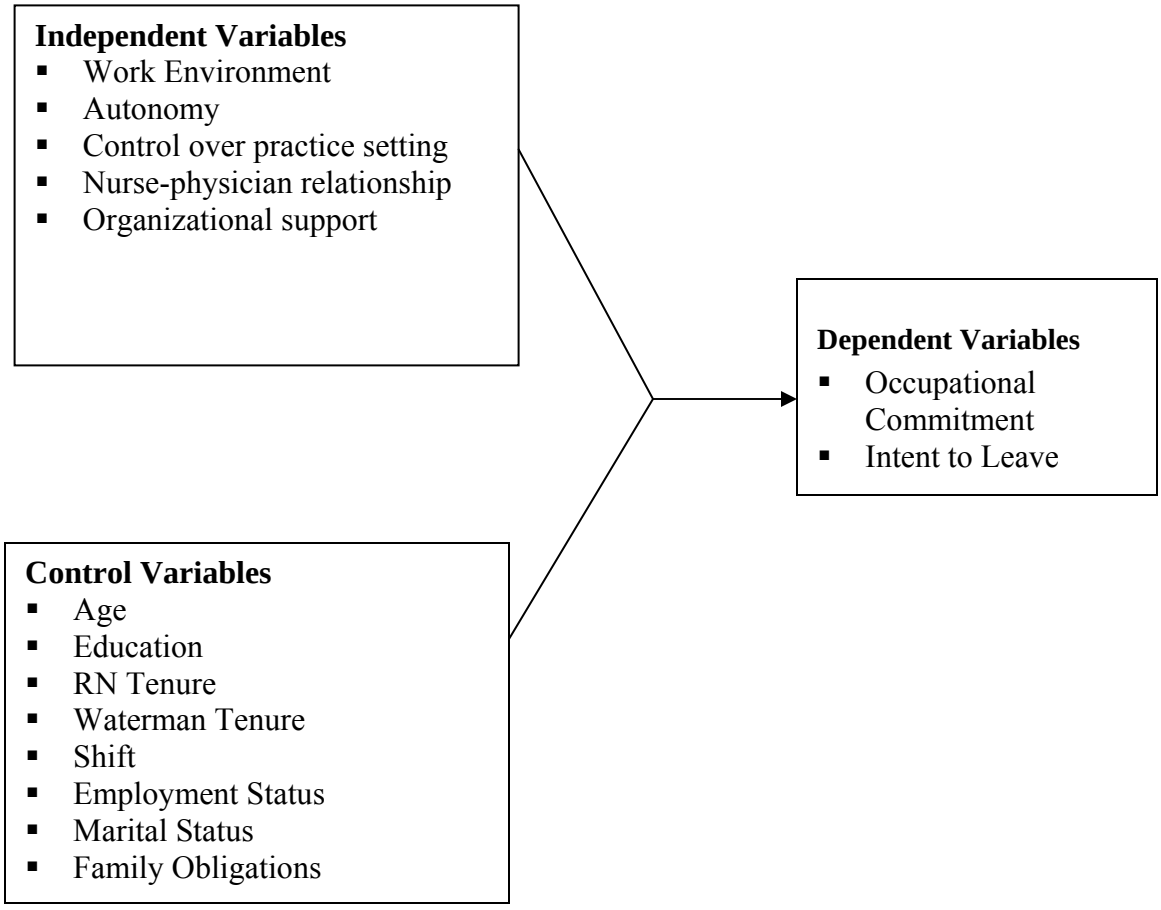


Figure 2: Research Model

Summary

The purpose of this research is to determine the impact of work environment on the occupational commitment of bedside registered nurses and, in turn, their intent to leave the nursing profession. This study attempts to significantly add to the limited amount of research on occupational commitment among nurses, and to expand on previous research by determining clear determinants of a strong occupational commitment. By focusing solely on the hospital bedside registered nurse, this study will also be able to isolate the aspects of the work environment that affect the nurses most at risk of leaving the profession.

By determining which aspects of Work Environment affect the occupational commitment of bedside registered nurses, managers and human resource professionals can use this information to improve their own work environment and retain nurses in the occupation. This research analyzes demographic characteristics of the respondents as well as their responses to the Nurses Work Index-Revised (NWI-R), which measures organizational attributes of the practice environments. It also investigates the intent to leave of these respondents with respect to perception of their work environment.

CHAPTER TWO: THEORETICAL FRAMEWORK

To discover the determinants of occupational commitment of hospital bedside registered nurses (RN) one must first determine what occupational commitment is and how it is fostered. Commitment theories have been popular in the literature for many years with a growing interest in the subject evident since the late 1970s (Angle & Perry, 1983). The first organizational behavior commitment theories (Buchanan, 1974; Mowday, Steers & Porter, 1979; Steers, 1977; Hall, 1971, London, 1983, Salancik, 1976) focused on organizational commitment, or one's commitment to his or her employing organization, and have proven to be influential in other behavioral theorists' works (Oliver, 1990). In response to employment shortages in the health professions as well as other professions, occupational commitment (also referred to as career and profession commitment) theories have abounded in the literature (Blau, 1985, 1998; Morrow, 1983, 1989; Morrow, McElroy, Elliott, 1994; Mowday, Portner & Steers, 1982). As Meyer, Allen, and Smith (1993) point out, these theorists often worked in separate silos with little regard for the research being conducted regarding other types of commitment and how these areas interact with one another.

Three Component Theory

In response to the lack of collaboration between these two schools of thought on commitment theories, Meyer, et al. (1993) modified the Three Component Theory (Meyer & Allen ,1991) on organizational commitment to apply to organizational and occupational commitment. The Three Component Theory of Organizational Commitment by Meyer and Allen (1991) is comprised of three types of commitment,

affective, normative, and continuance, and combines the different schools of commitment to theoretically explain the way in which an employee becomes committed to his or her organization and occupation and can be used to explain the way Registered Nurses can become committed to their occupation.

Affective Commitment

Historically, theorists studying both organizational and occupational commitment have seen an individual's commitment to his or her occupation or organization as a function of affective commitment (Meyer, et. al, 1993). Affective commitment describes the extent to which an employee is committed to his or her occupation (Meyer, et al, 1993) or organization (Meyer & Allen, 1991) because he or she wants to continue to work in this organization or occupation. This type of commitment is marked by an individual's desire to keep up with what is occurring within the occupation by reading journals or attending conferences (Blau, 1985; Meyer & Allen, 1991; Meyer, et. al, 1993) and is represented in Blau's (1985) eight item occupational commitment scale.

Most importantly, the antecedents to affective commitment also include work experiences such as the independent variables in this study. Meyer and Allen (1991) used a meta analysis of commitment literature to determine the work experiences that cause "comfort" or promote affective commitment. They determined that pre-entry expectations, equity in reward distribution, organizational dependency, organizational support, role support and freedom from conflict, and supervisor consideration positively supported the development of affective commitment. They also found that accomplishments, autonomy, fairness in performance reviews, job challenge, job scope,

opportunity for advancement, opportunity for self expression, participation in decision making, and personal importance to the organization are competency related attributes that contribute to affective commitment (Meyer & Allen, 1991). These antecedents are captured in the NWI-R and are directly related to the subscales which have been developed and tested in this model.

Normative Commitment

Much like affective commitment, normative commitment negatively correlated with intent to leave the profession (Meyer, et al, 1993). Normative commitment is primarily marked by an individual's commitment to either his or her occupation or organization because he or she has a sense of obligation to remain in his or her organization or occupation (Meyer & Allen, 1991). This obligation can be born from a variety of resources, but a primary example in the nursing profession would be tuition support or opportunities for continuing education. Theoretically, nurses receiving this type of support are committed to their occupation or organization because they have reaped the benefits or "had positive experiences as a result of engagement in the profession" (Nogueras, 2006 pg 87). Normative commitment is also marked by participation in the profession such as membership in a professional organization or reading journals related to the profession. These activities are reflected in Blau's (1985) Occupational Commitment Scale and are central to the research model.

Continuance Commitment

In contrast to affective and normative commitment, continuance commitment is based on negative consequences. Continuance commitment is common among

employees who recognize that they have a lot to lose if they leave their occupation or organization. Individuals who have non-transferable skills are in fear of losing attractive benefits (Borowski, Amann, Song & Weiss, 2007), or do not want to disrupt their families are all candidates for continuance commitment (Meyer & Allen,1991).

While those employees who display continuance commitment to their occupation or organization are likely to stay in their positions, they do not behave in the same way as those employees with affective or normative commitment. One of these behaviors, which has been noted primarily in nurses (Kimball & O'Neil, 2002) is the lack of inclination to promote their occupation to the public (Meyer, et al, 1993; Nogueras, 2006). This lack of promotion from within has been cited as an issue in the nursing shortage of today (Kimball & O'Neil, 2002)

In an attempt to measure continuance commitment, a variety of mechanisms have been used, with age and tenure in the profession being two of the most common (Shoemaker, Snizek & Byrant, 1977; Ritzer & Trice, 1969). For the purpose of this study, age, tenure, marital status, number of children, and the age of the youngest child will be used to measure this type of commitment.

Testing the Three Component Model

In order to test the Three Component Theory on occupational commitment, Meyer, et al (1993) used two samples of nurses, nursing students and currently employed registered nurses. The sample of student nurses was surveyed over two consecutive academic years and the researchers found that students have both positive and negative commitment correlations with age, years in their nursing program, satisfaction with the

program, nursing summer jobs, plans to get a nursing summer job, and their intent to remain in the program.

More recently, Nogueras (2006) studied a sample of 908 licensed RNs through the Nursing Spectrum website. These nurses were asked to complete 3 surveys: The Occupational Commitment Instrument, The Measure of Career Change and demographic information. This research indicated that there was a statistically significant relationship indicating that greater affective (r=-.31, p=0.00), normative (r=-.18, p=0.00), and continuance (r=-.14, p=0.00) commitments yielded less intention to leave the profession. It is also important to note that Jaros (1997) found that affective commitment was the only significant predictor of turnover intentions of MBA students.

The modified Three Component Theory demonstrates that commitment to the employing organization and commitment to the occupation correlate with occupation and organizational related activities. Of specific importance to this study was the discovery that the inclusion of occupational commitment into the original Three Component Theory better predicted intent to leave the nursing profession (Meyer, et. al, 1993).

These findings are especially important in the context of this study. Since occupational commitment is a combination of all three types of commitment, the focus on the work environment, which encapsulates the antecedents to all types of commitment, is an appropriate predictor of turnover intentions and occupational commitment. Also, as demonstrated by Nogueras (2006) and Zeytingolu, et. al (2006), the levels of commitment in nurses can be correlated with occupational commitment. Much like these two studies, the aim of this research is to take variables that have been linked to

predictors to leave the profession and attempt to correlate them with occupational commitment and intent to leave the profession.

An Integrated Model of Career Change

The intention of RNs to leave their career is a major component of this research study. In an attempt to develop the research model, the integrated model of career change provided this research with a theoretical basis for why individuals leave their occupation. In 1983 Rhodes and Doering found that career change theory suffered from the same disconnects that Meyer and Allen (1991) found in commitment literature. While research was progressing in this area, it lacked continuity and a theoretical base. In an attempt to develop a model that would look at occupational turnover, Rhodes and Doering (1983) integrated several existing theories into their integrated model of career change.

The integrated model of career change includes pieces of several theories on career change including the turnover models (Mobley, Horner, & Hollingsworth, 1978; Price, 1977; Steers & Mowday. 1981; Lodal & Kejner, 1965) as well as expectancy theory (Schneider, 1976), which was proved to be inconclusive. The primary purpose behind the integrated model is to identify the motivation one goes through when deciding to change occupations and takes into account personal, organizational and environmental determinants of this decision (Rhodes & Doering, 1983).

The integrated model is comprised of 17 interrelated boxes outlining the process one goes through in determining if one wants to change careers. The first three boxes are the independent and control variables of this study. Box 1 and 3, organizational factors

and personal factors, feed into box 2, perceived person/organizational correspondence (including person/work environment correspondence) which, in turn, is a determinant of job satisfaction. It is theorized that job dissatisfaction will produce thoughts of career change (box12) and career dissatisfaction (box 11). (See Appendix B)

One of the most important aspects of the integrated model is the theoretical linkage between work environment, job satisfaction and intent to leave. This linkage provides a basis for this research and allows us to investigate the relationship between work environment and intent to leave, and since work environment directly affects job satisfaction which can lead to intent to leave the profession.

The focus on the person-work environment correspondence is of particular interest to this study. Rhodes and Doering (1983) defined this term as "the match between the needs or desires of individuals and their perceptions of the work environment" (pg. 632). The factors that are used to make up this term are autonomy, pay, co-workers, responsibility and working conditions. The NWI-R will measure the respondents' perceived autonomy, relationship with co-workers, and responsibilities and, therefore, according to the integrated model, these variables should affect the intentions one has to leave the profession.

Testing the Integrated Model

Rhodes and Doering (1993) then tested their integrated model of career change on public school teachers in New York. The 180 respondents were given a variety of measurement tools to determine how well the integrated model predicted occupational turnover. They were able to explain 36percent of the variance in intention to change

career using their model which included work environment, labor market, and personal factors. While the findings with respect to work environment were not robust, the model does support the relationship between work environment and intent to leave the profession.

Blau (2007) also tested the integrated model using a sample of medical technologists. In this study he was able to differentiate between voluntary organizational turnover and occupational turnover. Blau (2007) was also able to draw the relationship between satisfaction as a driver for occupational commitment and the effect of work exhaustion stemming from work environment had on occupational commitment. The integrated model was also used in a study of psychologists. Researchers found that the integrated model of career change was supported, and the study revealed that those individuals who are unhappy with their current job are more likely to consider leaving the profession (Carless & Bernath, 2007)

This model incorporates the variables of interest to this research providing a theoretical link between the work environment and career change or intent to leave the profession. By linking these two constructs, this model provides theoretical backing for hypothesis 6-10 and the linkage between work environment and intent to leave the profession.

Summary

The Three Component Model and the Integrated Model of Career Change provide the theoretical base for this study. Both theories help to explain the development of occupational commitment as well as the determinants of intent to leave the profession.

Blau's occupational commitment scale directly reflects the theoretical components of the Three Component Model and therefore was chosen as the dependent variable in this model. The Integrated Model of Career Change demonstrates the direct linkage between work environment and intent to leave the profession. This theory helps to explain the relationship between work environment and intent to leave the profession and was used in the development of the model for this study.

CHAPTER THREE: LITERATURE REVIEW

There is no shortage of literature on the nursing shortage including the causes, effects, and potential solutions. However, few studies have been conducted on the hospital work environment related to bedside nurses, occupational commitment, and intent to leave the profession. Tables 2, 3 and 4 detail the interdisciplinary literature relevant to this study and draws together research that is often housed in discipline specific literature. By collecting the relevant literature from nursing, social science commitment research, health administration, and education one can begin to understand all of the different factors that affect the work environment, development of commitment and retention of nurses.

Characteristics of Work Environment

Table 2 outlines the relevant literature on work environment, including the problems most commonly cited by nurses and includes the study in which the NWI-R was created. It is important to note that while there is much literature on organizational commitment and work environment there is little concerning occupational commitment and work environment. Some literature on the relationship between work environment and organizational commitment has been included in the summary below in an attempt to more fully explore the relationship between work environment and the development of commitment.

Table 2: Summation of Work Environment Literature

Author/Year	Sample	Results
Kimball & O'Neil/2002	73 Acute Care Patient Nurses	• Nurses are generally dissatisfied with their current work environment.
Aiken & Patrician/2000	40 "scattered" & dedicated AIDS units in 20 hospitals	• The NWI-R is able to differentiate nurses who work within a professional practice environment and those that do not. • Reliability and validity of NWI-R was established
Buerhaus, Donelan, Ulrich, Norman & Dittas/ 2006	Longitudinal study of RNs in the US.	• RNs in 2002 and 2004 stated that the #1 way to improve shortage was to improve work environment • 2/3 of the increase in RN employment was accounted for by nurses over 50
Cimiotti, Quinlan, Pastor, Lin & Stone/2005	2,100 ICU RNs	• Nurses working in hospitals with magnet characteristics perceive their work environment as more positive.
Ulrich, Buerhaus, Donelan, Norman & Dittus/2005	National Survey of RNs	• Direct care nurses rate their perceptions of work environment lower than other RNs • Low perception of opportunity to influence patient care

In order to evaluate the theoretical and empirical evidence of the work environment construct, we must first determine the components of work environment. For the purposes of this study, magnet hospital characteristics will be considered, as well as what research has found to be the key components of work environment.

Since the AAN's report and the resulting development of the magnet hospital program in the 1980s, evidence has mounted that indicates a strong relationship between a poor work environment and low job satisfaction and increased nursing turnover. In 2005, a study compared the perceived work environment of nurses from magnet hospitals, hospitals in the process of achieving magnet status, and non-magnet hospitals.

This study surveyed 2,100 RNs in Intensive Care Units and discovered that nurses from magnet hospitals scored higher on all seven subscales of the Perceived Nursing

Work Environment Instrument: professional practice, staffing and resources adequacy, nursing management, nursing process, nurse-physician collaboration, nurse competence, and positive scheduling climate (Cimiotti, Quinlan, Larson, Pastor, Lin & Stone, 2005). These findings support the assertion that nurses working in hospitals with magnet hospital characteristics perceive their work environment as more positive. And the use of the magnet hospital characteristics as a model to measure work environment.

In 2004, most nurses were dissatisfied with many components of their work environment. Ulrich, Buerhaus, Donelan, Norman, and Dittus (2005) conducted a national survey following up on work environment issues first noted in 2002. On the whole, most nurses felt that the work environment had improved since 2002 but not drastically. The number one complaint as indicated in this survey was workplace health and safety with 53percent of the RNs agreeing that "My job is so stressful that I felt burned out" and with 96 percent of the nurses believing that the current shortage will lead to increased stress on current nurses.

These nurses also felt that they did not have control over patient care. Forty percent of the respondents indicated that their opportunity to influence patient care was fair or poor. The quality of the relationships between nurses, nurse management, and nurses and physicians was much improved in the 2004 survey versus the 2002, survey but direct care nurses continuously rated their perception of relationships lower than the other stakeholders (Ulrich, et al, 2005). This finding is of particular importance in the context of this study because it is an indication that direct care nurses, who are at the greatest risk of leaving the profession (Kimball & O'Neil, 2002), may find that their work environment is significantly different from others nurses in non-direct care positions.

Kimball and O'Neil, in the Robert Wood Johnson Foundation (2001) study, found that most nurses stated that there are four broad categories that must be addressed to alleviate the shortage and keep nurses in their jobs. The first is the work environment, specifically, decreasing individual workloads, providing support staff, empowering nurse managers, and listening and taking action regarding concerns nurses have in relation to their work environments. The second is financial, and simply put, increasing the salaries of all nurses. The third is respect and support for the nursing staff and treatment of nurses as colleagues, by doctors. Finally, facilitating education and professional development by improving the orientation process and providing paid continuing education can help to alleviate the shortage (Kimball & O'Neil, 2002).

One of the reoccurring themes in the work environment literature, as well as a common complaint for the nurses surveyed, is nurse to patient ratios. Much research has been conducted on nurse-to-patient ratios and how they have risen in recent years (Bond & Rahhl, 2000). However, a more in depth evaluation of the situation yields insight into the root of the problem. Unruh (2003) found that in fact licensed nurse (RNs and LPNs) to patient ratios have not increase significantly. Instead the acuity of the patients for which RNs care for has risen, thus creating a more challenging work environment. These results shed much light on the perception of increased nurse to patient ratios and potential burnout of Registered Nurses.

In a synthesis of the literature regarding RN employment conditions at the bedside, several key areas of improvement were suggested to increase the stability of the bedside registered nurse workforce (Unruh, 2005). Of particular interest to this study is the finding that improving working conditions, in particular increased staffing can help

alleviate the shortage of bedside registered nurses. These findings support the need for a healthy work environment and are one of the few studies that focus solely on the bedside registered nurse, a key piece of this research (Unruh, 2005)

Another finding in the Ulrich, et al (2005) study was the direct effect respect has on the retention of nurses. In 2004, 64 percent of respondents indicated that they intended to leave the profession stating that more respect from frontline management would cause them to reconsider leaving, while 65 percent said that administrative respect would have the same effect. This caused Ulrich, et al (2005) to delve more deeply into what a nurse considers respect. They determined that involvement in decision making, high value on nursing, including benefits and pay, manager's attention to their concerns, administration's intervention when it is perceived that nurses are being treated unfairly, adequate staffing levels, quality nursing care as a priority, and formal recognition of nurses as a part of the patient care team are some of the indicators of respect from nursing's point of view (Ulrich, et al, 2005). These findings, especially those regarding the indicator respect, are reminiscent of the components of the Nursing Work Index (NWI-R).

In 2004, the NWI-R was used to measure the work environment and the quality of care given in varying units within the same hospital (McCusker, Dendukuri, Cardinal, Laplante, & Bambonye, 2004). This research indicates that the work environment does in fact; affect the quality of care that a unit produces, especially with respect to resource adequacy and nurse-physician relations. Most importantly, with relation to this research, McCusker, et al, (2004) determined that the NWI-R and the subscales as defined by Lake (2002) can be used to measure hospital level characteristics.

Resource adequacy was also found to be an important aspect of empowerment as it is related to magnet hospital characteristics as measured by the NWI-R. In a secondary analysis of three datasets, Laschinger, Almost, and Tuer-Hodes (2003) found that total empowerment scores were similar to total NWI-R scores and these two combined explain 50 percent of the variance in job satisfaction. Similarly, in a previous study of 50 nursing units, researchers found that 49 percent of the variance in staff nurse retention could be explained by management style, job stress, organizational job satisfaction and professional job satisfaction (Leveck, & Jones, 1996). Organizational culture, which is similar to work environment has also been found to be an indicator of empowerment and magnet hospital characteristics (Klakovich, 1996)

In 1996, the nursing administration at Brigham and Women's Hospital (BWH) found that they suffered from these same issues and narrowly avoided a strike from their 2,000 nurses. They discovered that their staff nurses felt that the administrators were not responsive to the day to day problems of staff nurses, that they were not being fairly compensated with respect to administration, and there was a fear of change, resistance to unlicensed personnel, and work environment concerns. All of these factors led to a sense of toxic work environment at BWH and reflect national trends (Ponte, Fay, Brown, Doyle, Perron, Zizzi & Barrett, 1998). While BWH was able to avoid the strike, these findings show the extent to which Work Environment issues can affect nurses.

As more research is being conducted on the relationship among work environment, job satisfaction and nursing turnover, the aim of this study is to look at the relationships among work environment, career/occupational commitment, and intent to

leave the profession. By studying these factors, we can determine the linkages between these factors and postulate possible remedies.

Determinants of Occupational Commitment

While the determinants of organizational commitment have been discussed in length in current literature few studies have been conducted on the determinants of occupational commitment. Table 3 provides a synthesis of this literature including the original studies by Blau which provide the basis for the measurement instrument used in this study.

Table 3: Summation of Occupational Commitment Literature

Author/Year	Sample	Results
Blau/1985	119 Staff Nurses	• Occupational commitment is distinguishable from job involvement, job satisfaction and organizational commitment.
Blau/ 1998	484 Medical Technologists	• Professional behaviors were positively correlated to professional commitment.
Meyer, Allen & Smith/ 1993	603 Registered Nurses members of College of Nurses in Ontario	• Moderate correlation between occupational commitment and intent to leave profession
Zeytinoglu, Denton, Davies, Baumann, Blythe, & Boos, 2006)	1.396 RNs working in teaching hospitals in Ontario, Canada	• Relationship between occupational commitment, pay and stress was established

One of the seminal studies on occupational commitment and the effect it has on withdrawal was conducted by Gary Blau (1985), where he published a study attempting to measure and predict occupational commitment among nurses in a large urban hospital. Blau's (1985) main objectives for this occupational commitment study were to test the

validity of a measure of occupational commitment and differentiate it from the more commonly studied job involvement and organizational commitment. He also examined the extent to which relationships exist between occupational commitment, job involvement, and organizational commitment and the extent to which these correlate with an employee's consideration to leave the profession, which will be referred to as intent to leave for the purposes of this study (Mobley, 1978). Blau (1985) also attempted to differentiate which aspects of occupational commitment are based on one's personalities and which are based on the situation in which one works, an important aspect of this research.

The results of Blau's (1985) study are based upon the data collected from 119 repeat responders drawn from a population of 221 staff nurses which was representative of the nursing staff as a whole (Blau, 1985). Most importantly with respect to this study he found that "career (occupational) commitment is operationally distinguishable from job involvement and organizational commitment" (p. 284). He also differentiates the relationship between occupational commitment and intent to leave from the relationship of job involvement or organizational commitment from intent to leave and demonstrates that these relationships are explicitly different from one another. A high level of occupational commitment was found to generate low instances of intent to leave (Blau, 1985).

The study also revealed that those who have been nurses longer, are not married, have aspirations to progress up the career ladder, have a well defined role in the organization, have supervisors with clear direction and structure, and identify with their jobs and organizations have a higher level of occupational commitment (Blau, 1985). It

is important to note that Blau's findings regarding the determinants of occupational commitment are present in the NWI-R.

Blau's (1985) study adds to the body of existing research on commitment, the differentiating factors of occupational commitment from other types, specifically organizational commitment and job satisfaction. The study also operationalizes the way in which occupational commitment can be measured, allowing future research and standardized measurement of the term.

Blau then developed an eight item career/occupational commitment scale used to measure occupational commitment to encompass previous research on commitment, professional commitment (Price & Mueller, 1981), occupational commitment (Downing, Dunlap, Hadley & Ferrell, 1978), and career orientation (Liden & Green, 1980). These items were statements respondents rated on a five point Likert scale ranging from 1= strongly disagree to 5= strongly agree. (Blau, 1985).

Blau then used his eight item scale of occupational commitment to study the professional commitment of medical technologists in the first four years of their careers. Blau's (1998) goal in this analysis was to study the establishment stage of these medical technologists' careers as defined by several career development models (Greenhaus & Calahan, 1994; Hall 1971) and determine their occupational commitment from that point.

The personal variables that Blau (1998) controlled for included age, gender, marital status, and number of dependent children. The organizational context antecedents incorporated were workforce reductions, shift and schedule. The four socialization control variables were educational level, job preparation, expected job utility, and job change (Blau, 1998).

Occupational commitment was measured using a condensed version of Blau's (1985) eight-item occupational commitment scale. The measure contained five items measured on a four point Likert scale ranging from 1=strongly disagree to 4= strongly agree (Blau, 1998).

After hierarchical regression analyses were performed on the data, it was determined that the number of organizational memberships as well as routine tasks were significantly, positively related to occupational commitment, and professional behavior is significantly negatively related. Thirty-eight percent of occupational commitment was explained by the factors studied. This is significant at $p<.01$ (Blau, 1998)

The research found that a mix of routine tasks and professional behaviors are responsible for motivating medical technologists through the early career development phases. These routine tasks may be appropriate for beginning professionals but have serious implications for nurses who find they still performing these tasks years into their tenure (Bailyn, 1981). In order to ensure that nurses are allowed to progress through the stages of career development, it is essential to study the professional aspect of Blau's findings, the amount of time they spend with patients and that reflection on their occupational commitment.

More recently Blau's eight item scale has been used in a study of retention strategies for nurses in Ontario, Canada (Zeytinoglu, Denton, Davies, Baumann, Blythe, & Boos, 2006). This study consisted of 1,396 nurses employed in teaching hospitals in Southern Ontario Canada. The responses were then divided into three employment categories for analysis; full time, part time and casual nurse. Subjects were asked questions regarding their inclination to leave both the hospital and the nursing profession,

symptoms of stress, organizational support, supervisor support, organizational commitment including affective, continuance, and normative commitment as well as Blau's scale of occupational commitment and demographic information (Zeytingolu, et. al 2006).

The results of this study with respect to occupational commitment demonstrate the relationship between intent to leave, occupational commitment, pay, and stress. The researchers determined through regression analysis that uncompensated over-time pay was a major cause of a nurse's intent to leave from the profession only for part time nurses. Another contributing factor for intent to leave was a high level of stress among full time and part time nurses. The relationship between occupational commitment and intent to leave was also supported as increased levels of occupational commitment indicated a decreased incidence of intent to leave. (Zeytingolu, et. al 2006)

While organizational commitment is not a focus of this study, another interesting finding of the Zeytingolu, et al (2006) study relates to the types of organizational commitment that relate to turnover from the organization. They found that affective and normative commitments were the only two variables in their study that are consistently associated with intent to leave the hospital. Affective commitment indicates the degree to which a nurse forms an emotional attachment to the hospital and normative commitment indicates a nurse's sense of obligation to the hospital. Noticeably missing from this list of statistically significant commitment types is continuance commitment which indicates that a nurse is committed to a hospital for no other reason than he or she feels that another employment option is not available or possible (Zeytingolu, et. al 2006).

These findings are intriguing given Nogueras' (2006) study of 908 licensed RNs, which found that affective commitment (r=-.31, p=0.00), normative commitment (r=-.18, p=0.00), and continuance commitment (r=-.14, p=0.00) were all statistically significant predictors of a nurse's intent to remain in the profession. These differences can be attributed to the differences in the dependent variables (organizational vs. occupational commitment) and lend support to the assertion that organizational and occupation commitment, while similar, are two distinct types of commitment (Meyer, Allen & Smith, 1993).

Determinants of Intent to Leave the Profession

Studies on intent to leave the profession are more common than those focusing on occupational commitment but still lack the focus on bedside nurses only. Table 4 demonstrates the relevant literature on intent to leave the profession. It is important to note the reliance on demographic characteristics as independent variables and the lack of predictor variables, that policy makers are capable of changing.

Table 4: Summation of Intent to Leave Literature

Author/Year	Sample	Results
Fottler & Widra/1995	1,009 Nurses no longer in profession	• The primary professional reasons for leaving the nursing profession are salary, inadequate staffing, scheduling, administrative support, lack of time for patient care.
Nogueras/ 2006	908 Registered Nurses	• RN Occupational Commitment appears to predict RN intent to leave the profession • RN age is positively correlated with RN occupational commitment • RN years of experience and RN occupational commitment are positively correlated

Author/Year	Sample	Results
Borowski, Amann, Song & Weiss/2007	284 Registered Nurses in the State of Florida	• 46 percent of the sample was considering leaving the profession • White non-Hispanic are more likely to leave the profession • Benefits (as a reason to stay) were statistically significant for white men but not women or minorities • Education was negatively correlated with intent to leave
Stone, Larson, Mooney-Kane, Smolowitz, Lin, Dick/2006	2,323 ICU Registered Nurses (NWI-R)	• 17 percent reported intent to leave the profession within one year, citing working conditions as a major reason • Control over practice setting and nurse competence are important factors in nurses' intent to leave the profession
Bowles & Candela/2005	352 RNs with <5 years experience	• 30 percent of respondents left profession in 1 year • 57 percent of respondents left profession in 2 years
Fimian, Fastenau & Thomas/1988	283 Nurses	• 60 percent of nurses has seriously considered leaving the profession • Nurses that experienced higher stress were also those more likely to leave the profession.
Rambur, McIntosh, Val Palumbo, & Reinier /2005	2,778 RNs from Vermont Board of Nursing	• BS educated nurses have more long term stability in the profession
Lynn & Redman/2005	787 RNs scattered across US	• Satisfaction in both work and professional areas predict intention to leave the nursing profession
Kovner, Brewer, Cheng, & Djukic /2007	1,348 RNs in 29 states	• Older RNs (50 and older) were more satisfied, had greater organizational commitment and less intent to leave the profession • No significant difference between older and younger RNs in terms of autonomy, mentor support

Researchers have demonstrated that the decision to leave one's profession is a much more difficult choice than the decision to leave an organization (Blau, 2000; Blau, Tatum, & Ward-Cook, 2003; Carson, Carson, & Bedeian, 1995; Cunningham & Sagas, 2004; Neapolitan, 1980, Cotton, 1986). Factors, such as the investment in education, the effect on their family and finding a new career have been cited as major roadblocks to career change (Blau, 2007).

These findings are consistent with a study of teachers conducted in an attempt to understand the educator's shortage in the 1980s. Researchers found that teachers that left education entirely cited salary, job responsibilities, job autonomy, the opportunity to learn new things and to contribute to decision making as their primary reasons for leaving the profession (Chapman & Hutchinson, 1982). It appears as though 25 years later we are dealing with similar issues in a similar profession.

Davidson, Folcarelli, Crawford, Duprat, and Clifford (1997) found that a nurse's intent to leave was related to many of the factors related to work environment including communications, opportunity for advancement, and the ability to make decisions on the job. Norson, Opladen and Quinn (1995) found a similar phenomenon and point out the importance of trust and respect when fostering communication.

In 2006, Stone, Larson, Mooney-Kane, Smolowitz, Lin, and Dick conducted a study of 2,323 RNs in 66 hospitals with similar results. Using the Perceived Nurse Working Environment, which was derived from the NWI-R, they found that professional practice and nursing competence were the strongest predictors of intent to leave the profession. In particular, a one unit increase of a nurse's perception of professional practice decreased the odds on intent to leave by 48 percent.

A more telling and somewhat disturbing finding of the Stone, et al (2006) study is the fact that 17 percent of the critical care nurses surveyed intended to leave their current job within one year. And of those intending to leave, over 50 percent of them indicated that poor work environment was a reason for their departure. Those respondents indicating that work environment contributed to their intent to leave also expressed the value of collaborations in a positive work environment (Meyer, et al, 1993).

Research on the relative importance of personal and professional reasons for leaving the nursing profession indicates that several factors contribute to a nurse's decision to turnover from the profession. Of the professional factors, 47.1 percent of respondents indicated that inadequate salary was of importance when deciding whether or not to leave the profession. Many reported that inadequate staffing (45.3 percent) affected their decision as did inflexibility of scheduling (44.3 percent). Lack of administrative support (32.6 percent) and insufficient time for patient care (28.1 percent) were also cited as major reasons for leaving the profession (Fottler & Widra, 1995).

While Fottler and Widra (1995) found that the primary reason for nurses leaving the profession was pregnancy and child-rearing concerns (34.5 percent), professional factors also contributed to turnover from the profession. These professional factors salary, staffing, scheduling, administrative support, and time for patient care, together account for 28.7 percent of the primary reason these nurses left the profession.

In contrast to professional factors, Borowski, Amann, Song and Weiss, 2007 focused on the demographic variables that affect a nurse's intent to leave the profession. In a sample of 284 nurses in the State of Florida, 46 percent of respondents indicated that they are considering leaving the profession; of those respondents 76.9 percent were

White-non-Hispanic. This represented a statistically significant difference between ethnic groups. Of these 100 respondents indicating a desire to leave, benefits was the only statistically significant variable they considered when deciding whether or not to pursue another career (Borowski, et. al, 2007).

Male nurses, who represent only 5.7 percent of the nurses currently working in the profession (Borowski, et al, 2007), consistently rate their job satisfaction as lower than their female colleagues (Sochalski, 2002; Farella, 2000; Hilton, 2001) and were found to be at the greatest risk of leaving the profession. In the Borowski et al (2007) study 39 percent of the male respondents indicated that they would leave the profession and they were more likely to cite benefits as an important factor to consider before leaving the profession.

Borowski et, al (2007) also found that educational level is a significant variable when evaluating a nurse's intent to leave but not the reasons behind this intent. The study determined that 49.6 percent of baccalaureate prepared nurses intended to leave the profession as opposed to 27.6 percent of nurses holding a masters degree or higher. However, there was no statistically significant variable that either group could pinpoint as being a factor to consider when leaving the profession. (Borowski, et al, 2007) These findings are mirrored in numerous studies including Blau's (1985) study of medical technologists and Nogueras (2006) and Rambur, McIntosh, Val Palumbo, and Reinier (2005) studies of nurses.

Summary of Literature

Upon synthesis of the above referenced literature it became apparent that the work environment in which a nurse functions has a variety of effects on the nurse, the patient and the organization. Combining the findings of Blau (1985), who defined and conceptualized occupational commitment, with the more recent findings on work environment (Aiken, 2001) and determinants of intent to leave the profession (Borowski, 2007; Nogueras, 2006; Zeytinoglu, 2006), one can postulate that if a nurse feels as though they have a positive work environment with respect to autonomy, control over the practice setting, nurse-physician relationship and organizational support, he or she will be more committed to the nursing profession and less likely to leave it.

One component of the literature that is missing is the focus on bedside RNs only. Many recent studies, while focusing on nursing retention and commitment, fail to concentrate on hospital bed-side nurses only. By narrowing the focus of these past studies to include only this population group, this study will be able to more clearly define how to retain the nurses most at risk for leaving the profession and determine which pieces of work environment most directly affect occupational commitment and intent to leave the nursing profession of bedside registered nurses.

By focusing on the effect of the work environment on development of commitment and retention in the profession, this study also provides policy makers with tools to retain nurses in the profession. Many previous studied have focused on the demographic determinants of occupational commitment; however the need to focus on

determinants that can be changed and improved upon, such as work environment, is apparent.

CHAPTER FOUR: METHODOLOGY

Developing and sustaining occupational commitment in nurses is an integral part of retaining those nurses already in the profession. As the literature review establishes, it is believed that a highly sustained level of occupational commitment will decrease turnover intentions and the number of nurses leaving their profession. It is then important to define the determinants of occupational commitment for nurses and determine a viable way to increase and sustain occupational commitment and reduce turnover from the nursing profession. Given the theoretical underpinnings, it is apparent that work environment can help us to better understand how to develop and foster occupational commitment.

This study attempts to significantly add to the limited research on occupational commitment among nurses and to expand on previous research by identifying clear determinants of a strong occupational commitment, and intent to leave as well as the effect work environment has on occupational commitment and intent to leave the profession of bed-side Registered Nurses. It analyzes several demographic characteristics of the respondents, as well as the work environment measured by the Nursing Work Index- Revised (NWI-R) and the correlations of theses variables with intent to leave, and occupational commitment of respondents.

Research Design

This study utilizes a survey, cross-sectional research design and is quantitative in nature augmented by several qualitative, free response questions. The research took place at Florida Hospital Waterman located in Tavares, Florida using established scales

to measure all variables. The results of these surveys were analyzed using ordinary least squared regression.

The survey instrument is a combination of the 57 item NWI-R, the 8 item occupational commitment scale and the 3 item intent to leave scale as well as demographic information. The first section of the survey asks respondents for demographic information (see Appendix A), this information was used to determine if the sample could be representative of a population of hospital bedside nurses. The second section includes the 57 item NWI-R. In this section respondents were asked to indicate on a 4 point Likert scale, to what degree they agreed that the items are present in their current job. These items were totaled and used as the measurement of work environment, and the subscales scores were also derived from these survey items. The third portion of the survey asked respondents to indicate how they feel about their profession on a five point Likert scale and includes both the occupational commitment and intent to leave scales. The final section is a free response section comprised of three questions. Appendix K details the components of the survey as well as the items representing the four subscales of the NWI-R.

Survey Administration

January 2007 marked the beginning of the survey process. During this month the research study was presented at both Charge Nurse Meetings as well as Nurse Practice Council in an effort to inform and gain support from charge nurses as well as nursing management for the upcoming study. In February 2007, survey distribution to all direct

care units began. The nurses were given time during these staff meetings to complete the survey and submit it to a locked dropbox in the nursing education department.

The aggregate data is available to both Florida Hospital Waterman Nursing Administration and the survey respondents. All surveys were used by the Researcher only and were destroyed after the data has been recorded.

Institutional Review Board approval was obtained from the University of Central Florida. Florida Hospital Waterman agreed to accept approval from the Institutional Review Board at UCF in lieu of another review by Florida Hospital. All participants will be adults (< 18 years of age) and no compensation will be offered for completion of surveys.

Surveys were distributed to nurse management who in turn distributed the surveys to direct care nurses during unit staff meetings. All nurse managers provided their staff with an overview of the study and informed them of the process to return the survey. Of the 259 surveys distributed, 57 were returned, on the first round of surveying for a 22 percent response rate.

Due to the low response rate and small sample size the Dillman (2000) technique was employed and in an effort to achieve more responses a second round of surveys were distributed through the Nursing Education office. Since there were no identifying marks on the surveys, it was not possible to target the portion of the sample that had not returned their survey so another round of surveys were distributed with an additional note on the instruction page indicating that each nurse should complete only one survey and to disregard this survey if they had already completed one. The second round yielded 20 more surveys for a total of 77 or a 29.7 percent response rate.

Since the expected sample size of 100 was not reached a third and final round of surveys were distributed and yielded 8 more surveys for a total of 85 or a 33 percent response rate. While Dillman's (2000) research pertains primarily to mail and internet based surveys some principles such as repeated surveying are applicable here and were used to increase response rate.

Participants

Participants included all bed-side registered nurses employed at Florida Hospital Waterman between February 2007 and June 2007. Florida Hospital Waterman is a 204 bed non-profit facility located in Tavares, Florida and currently employs 259 direct care Registered Nurses working on 13 direct care units. Waterman is a rural hospital that became a part of the Adventist Healthcare System in 1992. Many hospitals in the Central Florida region have been heavily surveyed by their administration as well as researchers from the University making the likelihood of survey fatigue high. Florida Hospital Waterman is unique in the respect that unlike many Florida Hospitals Institutions, it has not been surveyed recently regarding nursing satisfaction, retention, or other employee level variables.

Personal Characteristics

Table 5 details the personal characteristics of the sample and indicates that the largest single age group (32.9 percent) of respondents is between 49 and 56 years of age, 41.2 percent of the sample is 40 and younger and 58.8 percent 49 and older. This is consistent with licensure data which demonstrates that 35.5 percent of licensed Florida RNs that work at the bedside in a hospital are 40 and younger. Similar comparisons can

be drawn at the national level as well, where 43.5% of the bedside hospital nurses are 40 and younger. Based on the age of respondents these data indicate that this sample is representative of bedside, hospital based RNs in the State of Florida and at the national level.

When compared to the population of bedside, hospital based Registered Nurses in the State of Florida and the United States; this sample is representative of all educational levels except Diploma nurses. According to this data statistically significantly more bedside hospital based RNs have a Diploma degree as their highest educational attainment. The difference between these demographic variables can be explained by the way in which this question was asked. In this study, nurses were asked for the highest degree that they have attained while in the licensure data nurses were asked for the highest nursing degree they have attained. Because of this difference, a diploma nurse that also completed a bachelors degree in another field would respond to the two questions differently.

This sample of nurses are also primarily married (61.2 percent),which is consistent with the national sample indicating that 69.9 percent of nurses are married. This demographic characteristic also indicates that our sample is representative of the Florida Hospital Waterman nursing population as 65 percent of currently employed RNs are married as well as the data available from the State of Florida (64.2 percent). The sample also have an average of 1.6 children with an average age of 12.61, while these demographic characteristics are not available from Florida Hospital Waterman, they are believed to be representative.

A comparison of the personal factors of this sample against data from Florida Hospital Waterman, State of Florida Licensure and National Licensure indicates that this sample is representative of bedside hospital based Registered Nurses currently working. Table 5 demonstrates the comparison of these factors.

Table 5: Comparison of Personal Factors

	Sample N=85	Florida Hospital Waterman N=339	Significance	Florida Licensure Data N=447	Significance	National Licensure Data N=12,507	Significance
Age							
18-40	41.2 %			35.5 %	.164	43.5%	.336
41-56	44.7%			50.1%	.434	47.6%	.298
57 and older	14.1%			14.1%	.053	9%	.097
Average		43	N/A				
Education							
Diploma	6.6%	N/A		15.7 %	.000*	14.3%	.002*
Associates	55.3%	N/A		50.8 %	.224	42.9%	.012*
Bachelors	35.3%	N/A		30 %	.163	39.4%	.217
Masters/Doctorate	3.6%	N/A		3.6 %	.50	3%	.384
Marital Status							
Single	18.8%	35%	.260	11.9%	.087	12.6 %	.074
Married	61.2%	65%	.260	64.2%	.302	69.9 %	.052
Divorced	14.1%	*included in single		23%	.266	16.8 %	.232
Widowed	5.9%	*included in single				*included in divorced	
Number of Children							
Average	1.59	N/A					
Maximum	8	N/A					
Minimum	0	N/A					
Age of Children							
Average	12.61						
Maximum	40						

Minimum	N/A	
children under 6		28.3 %
children 6-18		65.2 %

*indicates a statistically significant difference

Professional Characteristics

The research sample has an average of 13.4 years as a registered nurse including a maximum number of years as 40 and a minimum of .07 (see table 4). The respondents have been employed an average of 6.9 years at Florida Hospital Waterman with a maximum value of 28 and a minimum of .01 years. This is comparable to the average years of licensure for RNs in the State of Florida are (13.03 years). (Florida Center for Nursing, 2007). The respondents primarily work full time (94.1 percent) which is an overrepresentation when compared to the national data, which shows that only 64.4 percent of nurses in the State of Florida work full-time as well as Florida Hospital Waterman data which indicates that 70.2 percent of nurses at Florida Hospital Waterman work full time. This sample of nurses also primarily work on the day shift (82.4 percent), indicating that the sample is over representative of the day shift given that only 67 percent of all nurses at Florida Hospital Waterman work on the day shift only and therefore these findings cannot be generalized to the night shift nurses.

Table 6: Comparison of Professional Factors

	Sample	**Florida Hospital Waterman N=339**	**Significance**	**Florida Licensure Data N=447**	**Significance**	**National Licensure Data N=12,507**	**Significance**
Employment Status							
Full Time	94.1%	70.2%	.001*	77%	.001*	64.4%	.001*

	Part Time	4.7%	9.4%	.047*	22.8%	.001*	28.1%	.001*
	Depends	1.2%	20.4%	.001*				
Shift								
	Days	82.4%	66.9%	.001*				
	Nights	15.3%	33.1%	.001*				
	Rotating	2.4%	*included in nights					
RN Tenure								
	Average	13.45 years	N/A	N/A	13.03 years	.584	13.90 years	.884
	Maximum	40						
	Minimum	0.07						

*indicates a statistically significant difference

These results are generalizable to the population of bedside registered nurses in the United States in spite of the fact that the professional characteristics of this sample are not representative of the Florida or National Sample. This is based on the lack of statistically significant differences in the personal factors of this sample and the Florida and National data. All research regarding intent to leave the profession and occupational commitment show a relationship between demographic characteristics, not professional characteristics.

Data Analysis

For the purposes of this study ordinary least squared (OLS) multiple regression analysis was chosen to answer all research questions. Two models were run for each hypothesis, the first model includes only the dependent and independent variable, the second or "full model" is comprised of the independent and dependent variables along with the control variables mentioned earlier. OLS was chosen because of the interest in the relationship between variables and the small sample size of 85. In an attempt to

determine if OLS was indeed the correct statistical tool, several common issues with the use multiple regression analysis were tested including insufficient power, collinear variables, lack of normality of dependent variable, non-continuous dependent variable.

Insufficient Power

A power analysis was conducted on all 10 full model regression equations where the significance level is .050 and there are 17 variables in the equation. The results of this analysis demonstrate that sufficient power exists for all equations. (see Appendix I) with power scores ranging from 72 percent to 99 percent. This indicates that there is a low likelihood of these models producing a Type II error, or failing to reject the null hypothesis.

Collinear Variables

An independent variable that is perfectly correlated with, or almost perfectly correlated with, another independent variable can mask the relationship between the independent variable and the dependent variable and create multicollinearity. In a situation where one is trying to determine the effect of one independent variable on a dependent variable it is important to determine if your independent variable of interest is correlated with any other independent or control variable (Gujarati, 2003). This allows the researcher to better isolate the effect the independent variable, in this case work environment and its subscales, on the dependent variable, occupational commitment and intent to leave.

In order to ensure that multicollinearity does not exist, correlations between the control variables and the independent variables were drawn. It was noted that several

control variables were highly correlated with one another. In an attempt to rectify this situation the following control variables were removed from the model: number of children, age of children, age, interaction effects between marital status, number of children and tenure at Florida Hospital Waterman. Education, employment status (full time vs part time) shift, RN tenure, and marital status were retained as control variables because of past studies and strong theoretical underpinnings. The interaction effect between RN tenure and number of children was retained as a control variable in an attempt to control for how the family obligations placed on the respondent and their experience interact with occupational commitment and intent to leave.

Lack of Normality of Dependent Variable

In order for ordinary least squared regression analysis to be a viable statistical technique, the dependent variable must be normally distributed. To ensure that occupational commitment and intent to leave are normally distributed, descriptive statistics were performed. Both dependent variables were found to be normally distributed, the skewness and kurtosis divided by standard error for occupational commitment were -2.01 and .129 respectively, within the limits of normality. The results for intent to leave were similar with values of 1.11 and -.419 for skewness and kurtosis both divided by the standard error again indicating that the dependent variable is normally distributed.

Non-Continuous Dependent Variable

One of the assumptions of ordinary least squared analysis includes the continuous nature of the dependent variable. The use of Likert scale data as a dependent variable,

which is measured at the ordinal level, as opposed to the nominal level, is a violation of this assumption. However, the use of Likert scale data in multiple regression analysis where the dependent variable is normally distributed, as it this one, is prevalent in the literature; most notably Blau used this same statistical technique during the development of the occupational commitment scale. Zeytinoglu (2006) also used ordinary least squared analysis with the occupational commitment scale. It is also worth noting that Jaccard and Wan (1996) found assuming that Likert scale data is in fact nominal "does not greatly increase the occurrence of Type I and Type II errors".

In order to determine the effect that work environment characteristics have on the occupational commitment of individual nurses, the following multiple regression model will be utilized.

$$Y_1=B_0 + B_iX_i + \xi$$

In order to determine the effect that work environment characteristics have on the intent to leave the profession of individual nurses, the following multiple regression models will be utilized.

$$Y_2=B_0 + B_iX_i + \xi$$

$Y_{1=}$Dependent variables of occupational commitment determined by the Blau (1985) occupational commitment scale

Y_2= Dependent variables of intent to leave determined by the Blau (1988) intent to leave scale

$B_{0=}$ intercept for the model

B_i= resultant coefficient for the independent variables

X_1= Nursing Work Environment/Organizational Characteristics as measured by the NWI-R

ξ= Error Term

Limitations and Delimitations

While this study adds considerable insight into the occupational commitment of bedside registered nurses, and the effect that work environment has on this commitment, several limitations are present in this study. The first limitation that should be considered is the nature of the hospital in which this study was conducted. Florida Hospital Waterman proved an ideal population of nurses because they have not been routinely surveyed and the researcher was given full access to all bedside nurses. However, the hospital is located in a rural area of Central Florida with few other occupational opportunities. With the relatively low educational level, and lack of economic diversity in Tavares, nurses that are not satisfied with their occupation may be displaying continuance commitment to the occupation. These factors may bias results and make it difficult to generalize these findings to other organizations and locations that do not have the similar economic characteristics. It is also important to note that due to the relatively small, close knit group of nurses working in this organization, some fear of reprisal for completing the survey may have biased the results.

While a larger sample size would be preferable in understanding the effect work environment has on occupational commitment, a response rate of 33 percent is average according to Dillman (2000). Given the small sample, 85 returned and usable surveys proved to limit the rigor of the statistical techniques used.

The generalizabiltiy of the findings to another population could be a concern as well. While the sample of nurses is representative in many demographic areas, the sample has an overrepresentation of day shift, full time bedside nurses when compared to the population data from Florida Hospital Waterman. It is important to note that not all demographic variables were attainable from Florida Hospital Waterman due to insufficient employee information. Comparing this data to other demographic sources may prove difficult because the population of interest in this study is specific to bed-side registered nurses only. Demographic data for this population is not routinely collected, making comparisons problematic.

Another potential limitation of this study is the use of the NWI-R as a measure of work environment. After this study was approved, some issues were raised pertaining to the validity of this instrument in measuring magnet hospital characteristics (Cummings, Hayduk, & Estabrooks, 2006). However, in this research the reliability was established through robust Cronbach alpha levels and the validity of the study was supported by the findings and their consistency with previous research. These findings including the results of the regression analysis and the descriptive statistics of the sample are included in the next chapter.

CHAPTER FIVE: FINDINGS

Descriptive Statistics

Preliminary data analysis indicates that the sample demonstrates a fairly high occupational commitment to the nursing profession where the mean score on the eight-item Blau occupational commitment scale is 28.52 where 40 is the highest possible commitment and 5 is the lowest. One can also infer from these statistics that the sample demonstrates a low intent to leave the profession. The mean score on the three-item intent to leave scale is 5.45 (2.89), where the lowest possible score of 5 would indicate a respondent's desire to remain in the profession and the highest score of a 15 would indicate intent to leave. These numbers were robust indications that the sample would remain in the profession for some time. The low standard deviations indicate that this group of participants is fairly homogeneous and few respondents deviated from the mean. It is important to notice that it is not possible to compare these mean scores with precious research. This is a product of the inconsistent use of these scales in the nursing literature. Much data on occupational commitment scores are available for sports professions but it is lacking in nursing literature and in other comparable professions. Table 7 includes the mean scores and standard deviations for each of the variables in the study.

Table 7: Descriptive Statistics of Sample

	Mean/ Frequency	Standard Deviation	Possible Values
Dependent Variables			
Occupational Commitment	28.52	6.629	6-40
Intent to Leave	5.45	2.889	3-15
Independent Variables			
Autonomy Subscale	14.59	2.96	5-20
Control Over Practice Subscale	20.08	4.29	7-28

Nurse-Physician Relationship Subscale	9.02	1.88	3-12
Organizational Support Subscale	29.07	5.51	10-40
Work Environment Total	163.15	28.34	57-228

The item from the occupational commitment scale with the highest mean score is the reverse coded statement "I am disappointed that I ever entered the nursing profession", the mean score for this statement is 4.35 out of a possible 5 indicating a very high commitment to the occupation. 61.2 percent (n=85) of respondents felt as though they were never disappointed that they entered the nursing profession.

The lowest mean score on the occupational commitment scale is "If I had all of the money I needed without working I would probably still continue to work in the nursing profession". The mean score for this statement is 2.96 (SD=1.45) out of a possible 5, with only 37.7 percent of the respondents indicating that this statement is often or always true, and most respondents (64.3 percent) indicating that it is never, sometimes or occasionally true.

Other indications of the high level of occupational commitment for this sample include that 70.6 percent of respondents indicated that they often or always feel as though they want a career for themselves in nursing and report a mean score of 3.89 (SD=1.23) . 55.3 percent also report feeling always or often that nursing is their ideal vocation with a mean score of 3.62 (SD=1.25). Appendix D demonstrates the frequencies, means and standard deviations of the questions included in the occupational commitment scale.

Appendix E shows the frequencies, means and standard deviations for the Intent to Leave scale. The item with the lowest mean score (mean=1.65, SD=.972), indicating a low intention to leave the profession is the statement "I intend to look for a different

profession". 78.8 percent responded that they never or only sometimes considered looking for another profession indicating that these nurses intend to remain in the nursing profession.

"I intend to stay in the nursing profession for some time" has the highest mean score of 2.02 (SD=1.17). While mean score for this statement is slightly higher than the previous 2 items, the low mean still indicates a low intention to leave the profession. After this item was recoded only 70.6 percent indicated that they do not intend to stay in the profession for some time.

When the comparing the mean differences in occupational commitment (see Appendix F) and intent to leave (see appendix G) with the demographic characteristics of the sample, no statistically significant results were found, indicating that changes in occupational commitment and intent to leave remained consistent across demographic groups.

The nurses also indicated that they are somewhat satisfied with their work environment as measured by the Nurses Work Index- Revised. Table 7 shows the mean, standard deviation, and theoretical values for the NWI-R and related subscales. The mean 163.15, (SD=28.34) for the overall score on the NWI-R (range 57 to 228) indicates that respondents are somewhat satisfied with their work environment. Nurses felt the least satisfied with their control over the practice setting (total score mean=20.08, SD=4.29 out of a possible 28)) and the support they receive from the organization (total score mean =29.07, SD=5.51 out of a possible 40). Nurse-Physician relationships had the greatest level of satisfaction (total score mean=9.02, SD=1.88 out of a possible 12) followed closely by autonomy (total score mean=14.59, SD=2.96 out of a possible 20).

Appendix C shows the frequencies, means and standard deviations for each of the 57 questions in the NWI-R. Of particular interest, this research found that 92.9 percent of respondents agree or strongly agree that high standards of nursing care are expected by the administration. 89.5 percent of respondents also agreed or strongly agreed that standardized policies and procedures are present in their work environment. In addition 88.2 percent agreed or strongly agreed that nurses and physicians have a good working relationship in their organization.

In contrast only 49.4 percent agreed that the salaries in their organization were sufficient. The data indicate that the nurses feel as though good career development ladder is not in place (53 percent), that they do not have the opportunity to become involved in policy decisions (59 percent), lack the freedom to make necessary decisions (52.3 percent), and do not have enough Registered Nurses to get their work done (47.1 percent)

These findings indicate that overall this sample of nurses feel as though they have a positive work environment and are committed to the occupation of nursing. However, the respondents are more satisfied with some aspects of the work environment than others. For example, an analysis of the NWI-R items specifically addressing the adequacy of staff indicates that this is an area of particular concern in the work environment. However, the collegial relationships among the medical staff indicate an area of great satisfaction. Using the scales from the NWI-R we can determine that overall the nurses have a low level of intentions to leave the profession as shown in Appendix H which details the mean scores for work environment and the four subscales.

The Cronbrach's Alpha for the NWI-R was .947 indicating that this instrument is reliable. The Cronbrach's Alpha was also determined for each of the subscales autonomy (.78), control over practice setting (.82), nurse-physician relationship (.80), organizational support (.86) and they too were found to be reliable.

Tables 8 through 17 detail the results of the regression equations and include the Beta value, standard error and significance for each variable. The beta weights were chosen for this study to so that the relative importance of each of the independent variables could be assessed. Since each variable was measured on a different scale, this reporting is appropriate.

Qualitative Data

In addition to the statistical data offered, respondents were given the opportunity to complete a free response portion. In this portion, the nurses were asked 1) Are there any specific concerns that cause you dissatisfaction? 2) What would be the one thing that you would change about your employment? 3) Are there specific attributes of your unit that cause you satisfaction? Of the 85 returned surveys 62 answered the free response section. Several themes emerged from these free responses. First, nurses are generally dissatisfied with the nurse/patient ratios, and several referred to the patient load as a potential safety issue as well as a leading cause of burnout. These findings mirror the findings of Aiken, et al. (2002) which found that patient safety and burnout are major concerns for hospital based nurses

Salary was also a major area of concern for nurses and was cited as a potential precursor to a career change. Respondents cited issues such as pay inequities with

graduate nurses as well as relatively low wages for the hospital in general as a major cause for dissatisfaction. Of those nurses answering the free response section, most listed teamwork and relationships with co-workers as their greatest source of satisfaction. (See Appendix D). Vahey, et. al (2004) also found similar results including adequacy of staff, administrative support, and improved relationships with physicians affect the rate to which nurses experience professional burnout.

Quantitative Data Analysis

Impact of Work Environment on Occupational Commitment

Ho_1-There is no relationship between bedside registered nurses perceptions of work environment and occupational commitment.

Table 8 details the results of the standard multiple regression analysis that was performed and demonstrates the statistically significant positive relationship that was found between a positive work environment and a high level of occupational commitment. The full model, including all questions on the NWI-R and control variables, accounts for 22 percent of the change in occupational commitment. The full model was found to be statistically significant at the .05 level and the variable of interest, work environment, is significant at the .001 level. The beta value indicates that there is a statistically significant positive relationship between work environment and occupational commitment. Having a masters or doctorate degree was also found to be statistically significant related to occupational commitment at the .10 level. While the effect of work environment on occupational commitment is small, the relationship is significant therefore; we will reject the null hypothesis and conclude that bedside registered nurses

with a higher perception of their work environment demonstrate a higher level of occupational commitment.

Table 8: Impact of Work Environment on Occupational Commitment

Occupational Commitment

	Model 1 Beta (Std. error)	**Full Model** Beta (Std. error)	**Significance**
Independent Variable			
Work Environment	.331 (.024)	.362 (.025)	0.001***
Control Variables			
Associates Degree		.139 (3.559)	.606
Bachelors Degree		.207 (3.551)	.427
Masters/Doctorate Degree		.270 (4.959)	.055*
Full Time		-.106 (2.929)	.316
Day Shift		-.008 (1.918)	.941
RN Tenure		-.048 (.087)	.751
Married		.004 (1.954)	.980
Divorced/Widowed		.205 (2.366)	.157
Interaction Effect between RN Tenure and number of children		-.073 (.031)	.620
R^2	0.109	0.22	
N	85	85	
F	10.144	2.087	
Significance	0.002**	.036**	
***significant at .001			
** significant at .05			
* significant at .10			

Impact of Autonomy on Occupational Commitment

Ho_2- There is no relationship between bedside registered nurses perceived autonomy and their occupational commitment.

Again, a standard multiple regression was performed and a statistically significant, positive relationship was found between autonomy and occupational commitment. The full model, including the NWI-R autonomy subscale and control variables account for 19.1 percent of the variance in occupational commitment. The full model was found to be statistically significant at the .01 level; and the variable of interest, autonomy, was significant at the .05 level and having a masters or doctorate degree was also significant at the .10 level. The results of the regression equation indicate that there is a positive statistically significant relationship between autonomy and occupational commitment. These findings indicate that the higher a nurse's perceived autonomy, the higher their occupational commitment; therefore we reject the null hypothesis. The results of this regression analysis are included in Table 9.

Table 9: Impact of Autonomy on Occupational Commitment

Occupational Commitment

		Model 1 Beta (Std. error)	**Full Model** Beta (Std. error)	**Significance**
Independent Variables				
	Autonomy	.309 (.234)	.322 (.248)	.005**
Control Variables				
	Associates Degree		.154 (3.623)	.575

		.202	
Bachelors Degree		(3.628)	.449
		.280	
Masters/Doctorate Degree		(5.058)	.052*
		-.106	
Full Time		(2.948)	.323
		-.046	
Day Shift		(1.952)	.685
		.019	
RN Tenure		(.088)	.903
		-.007	
Married		(1.988)	.960
		.163	
Divorced/Widowed		(2.396)	.255
Interaction Effect between RN Tenure and number		-.066	
of children		(.032)	.660
R^2	0.096	.191	
N	85	85	
F	8.784	1.743	
Significance	0.004**	.087*	
***significant at .001			
** significant at .05			
* significant at .10			

Impact of Control Over the Practice Setting on Occupational Commitment

Ho_3- There is no relationship between a bedside registered nurses control over their practice setting and occupational commitment.

A standard ordinary least squared analysis determined that there is a positive statistically significant relationship between nurses' control over the practice setting and occupational commitment. Table 10 details the results of the full model, including the control over the practice setting subscale of the NWI-R and control variables, explains 18 percent of the variance in occupational commitment. The beta value indicates that there is a positive statistical significant relationship between control over the practice and

occupational commitment. Given these results, we will reject the null hypothesis number three and conclude that nurses that have more control over their practice setting have a greater occupational commitment to the nursing profession.

Table 10: Impact of Control Over the Practice Setting on Occupational Commitment

Occupational Commitment

	Model 1 Beta (Std. error)	**Full Model** Beta (Std. error)	**Significance**
Independent Variable			
Control Over Practice Setting	.289 (.162)	.293 (.167)	.008**
Control Variables			
Associates Degree		.169 (3.644)	.541
Bachelors Degree		.264 (3.624)	.321
Masters/Doctorate Degree		.230 (5.092)	.111
Full Time		-.085 (3.005)	.429
Day Shift		-.045 (1.965)	.692
RN Tenure		-.030 (.089)	.849
Married		.037 (2.032)	.805
Divorced/Widowed		.212 (2.441)	.156
Interaction Effect between RN Tenure and number of children		-.104 (.032)	.494
R^2	0.083	.180	
N	85	85	
F	7.583	1.624	
Significance	0.007**	.116	

***significant at .001
** significant at .05
* significant at .10

Impact of Nurse Physician Relationships on Occupational Commitment

Ho_4- There is no relationship between nurse physician relationships of bedside registered nurses and occupational commitment

An ordinary least squared analysis was performed and indicates that there is a statistically significant relationship between nurse-physician relationship and occupational commitment of bed side registered nurses. The full model (see table 11), including the variable of interest, relationship with physicians, and control variables indicates that nurse-physician relationships and control variables account for 15.4 percent of the variance in occupational commitment. Having a masters or doctorate degree was also found to be statistically significantly related to occupational commitment at the .10 level. The beta value indicates that there is a positive statistically significant relationship between nurse physician relationship and occupational commitment. Because of this finding, we reject the null hypothesis and we can conclude that all other things held constant, nurses who perceived the nurse-physician relationship to be positive have an increase occupational commitment to nursing.

Table 11: Impact of Nurse-Physician Relationship on Occupational Commitment

Occupational Commitment

	Model 1 Beta (Std. error)	**Full Model** Beta (Std. error)	**Significance**
Independent Variable			
Relationship with Physicians	.227 (3.76)	.254 (.404)	.030*
Control Variables			
Associates Degree		.195 (3.697)	.487
Bachelors Degree		.295 (3.675)	.275

		.285	
Masters/Doctorate Degree		(5.185)	.053*
		-.075	
Full Time		(3.063)	.496
		. 028	
Day Shift		(2.044)	.816
		.003	
RN Tenure		(.090)	.987
		.013	
Married		(2.052)	.931
		.188	
Divorced/Widowed		(2.465)	.213
Interaction Effect between RN Tenure and number		-.100	
of children		(.033)	.516
R^2	0.051	0.154	
N	85	85	
F	4.505	1.350	
Significance	0.037**	.221	
***significant at .001			
** significant at .05			
* significant at .10			

Impact of Organizational Support on Occupational Commitment

Ho_5- There is no relationship between organizational support and occupational commitment of bedside registered nurses.

Table 12 details the results from the ordinary least squared analysis conducted on organizational support and occupational commitment. This analysis concluded that there is a statistically significant positive relationship between organizational support and occupational commitment. The full model including the variable of interest, organizational support, and control variables account for 17.7 percent of the variance in occupational commitment. Having a masters or doctorate degree was again found to be statistically significant related to occupational commitment at the .10 level. In light of

these findings, null hypothesis five will be rejected and we can infer that an increased perception of the support from the organization is positively related to occupational commitment.

Table 12: Impact of Organizational Support on Occupational Commitment

Occupational Commitment

	Model 1 Beta (Std. error)	**Full Model** Beta (Std. error)	**Significance**
Independent Variable			
Organizational Support	.287 (.127)	.289 (.131)	.010**
Control Variables			
Associates Degree		.183 (3.649)	.508
Bachelors Degree		.256 (3.634)	.337
Masters/Doctorate Degree		.264 (5.093)	.068*
Full Time		-.083 (3.012)	.443
Day Shift		-.026 (1.967)	.822
RN Tenure		-.022 (.089)	.888
Married		.009 (2.015)	.950
Divorced/Widowed		.189 (2.427)	.203
Interaction Effect between RN Tenure and number of children		-.074 (.032)	.625
R^2	0.082	.177	
N	85	85	
F	7.44	1.590	
Significance	0.008**	.126	

***significant at .001
** significant at .05
* significant at .10

Impact of Work Environment on Intent to Leave

Ho_6- There is no relationship between nurses' intent to leave the profession and their perceived work environment.

An ordinary least squared analysis was performed on intent to leave and work environment as measured by the NWI-R (table 13). The analysis concluded that there is a statistically significant, negative relationship between work environment and intent to leave ($p<.001$). The full model indicates that work environment ($p>.001$), having advanced education, masters degree and higher, ($p>.10$) and marital status ($p>.05$) are statistically significantly negatively related to intent to leave, while the interaction effect between RN tenure and number of children are statistically, positively related to the dependent variable at the .05 level. These findings indicate that a nurse's intent to leave the profession is attributable to aspects of his or her work environment; therefore, null hypothesis six is rejected.

Table 13: Impact of Work Environment on Intent to Leave

	Intent to Leave		
	Model 1 Beta (Std. error)	**Full Model** b (Std. error)	**Significance**
Independent Variable			
Work Environment	-.313 (.011)	-.352 (.010)	.001***
Control Variables			
Associates Degree		-.219 (1.483)	.396
Bachelors Degree		-.186 (1.480)	.455
Masters/Doctorate Degree		-.250 (2.067)	.064*
Full Time		.088 1.220)	.380

		.040	
Day Shift		(.799)	.705
		-.088	
RN Tenure		(.036)	.545
		-.327	
Married		(.814)	.021**
		-.410	
Divorced/Widowed		(.814)	.004**
Interaction Effect between RN Tenure and number		.371	
of children		(.013)	.010**
R^2	0.098	.287	
N	85	85.000	
F	9.039	2.975	
Significance	.003**	.003**	

***significant at .001
** significant at .05
* significant at .10

Impact of Autonomy on Intent to Leave

Ho_7- No relationship exists between bedside registered nurses perceived autonomy and their intent to leave the profession.

An ordinary least squared analysis was performed on intent to leave and the autonomy subscale of the NWI-R (see table 14). The findings indicated that there is a statistically significant, negative relationship between autonomy and intent to leave. Autonomy ($p<.05$), having a masters degree or higher, ($p<.10$)marital status ($p<.05$) and the interaction effect between RN tenure and number of children ($p<.05$) were all found to be statistically significant. Of these variables all were negatively related except for the interaction between RN tenure and the number children, which was positively related. The regression equation indicates that the full model accounts for 25.8 percent of the variance in intent to leave the profession. Due to these findings, null hypothesis seven

will be rejected and we can conclude that all things held constant, an increased in perceived autonomy by a bed side registered nurse indicates a low intention to turnover from the profession.

Table 14: Impact of Autonomy on Intent to Leave

Intent to Leave	Model 1 Beta (Std. error)	Full Model Beta (Std. error)	Significance
Independent Variables			
Autonomy	-.304 (.102)	-.312 (.103)	.004**
Control Variables			
Associates Degree		-.234 (1.511)	.374
Bachelors Degree		-.181 (1.513)	.477
Masters/Doctorate Degree		-.259 (2.110)	.060*
Full Time		.089 (1.245)	.387
Day Shift		.077 (.814)	.479
RN Tenure		-.153 (.037)	.301
Married		-.316 (.829)	.028**
Divorced/Widowed		-.373 (.999)	.009**
Interaction Effect between RN Tenure and number of children		.364 (.013)	.013**
R^2	0.092	0.258	
N	85	85	
F	8.443	2.578	
Significance	0.005**	.010**	
***significant at .001			
** significant at .05			
* significant at .10			

Impact of Control Over the Practice Setting on Intent to Leave

Ho_8- There is no relationship between a bedside registered nurse's control over the practice setting and their intent to leave the profession.

An ordinary least squared analysis was performed on intent to leave and the control over the practice subscale of the NWI-R (see table 15). This regression analysis indicates that there is a statistically significant ($p<.05$), negative relationship between control over the practice setting and intent to leave the nursing profession. The control variables, marital status ($p<.05$), and the interaction effect between RN tenure and number of children were all statistically significant, with the interaction effect being the only positively related variable. In addition the independent variable control over the practice setting is significant at the .05 level. With all other things held constant, the full model accounts for 23.2 percent of the variance in intent to leave the profession. This indicates that we will reject the null hypothesis and conclude that nurses with a great control over the practice setting with have a lower intent to leave the profession.

Table 15: Impact of Control Over the Practice Setting on Intent to Leave

Intent to Leave	**Model 1** Beta (Std. error)	**Full Model** Beta (Std. error)	**Significance**
Independent Variable			
Control Over Practice Setting	-.213 (.072)	-.312 (.070)	.019*
Control Variables			
Associates Degree		-.234 (1.537)	.347
Bachelors Degree		-.181 (1.529)	.339

Masters/Doctorate Degree		-.259 (2.148)	.127
Full Time		.089 (1.267)	.501
Day Shift		.077 (.829)	.500
RN Tenure		-.153 (.038)	.467
Married		-.316 (.857)	.018**
Divorced/Widowed		-.373 (1.029)	.006**
Interaction Effect between RN Tenure and number of children		.364 (.014)	.008**
R^2	0.046	0.232	
N	85	85	
F	3.958	2.233	
Significance	0.050**	.025**	
***significant at .001			
** significant at .05			
* significant at .10			

Impact of Nurse-Physician Relationships on Intent to Leave

Ho_9- No relationship exists between nurse physician relationships and a bedside registered nurse's intention to leave the profession.

Table 16 shows the results of the ordinary least squared analysis performed on intent to leave and the nurse-physician relationship subscale of the NWI-R. This analysis revealed a statistically significant, negative relationship ($p<.05$) between nurse physician relationships and intent to leave the nursing profession. Relationship with physicians ($p<.05$), advanced education ($p<.10$) and martial status ($p<.05$) were all negatively statistically significantly related to intent to leave, while the interaction effect between RN tenure and number of children was positively statistically significantly related ($p<.05$). The regression equation indicates that 22.7 percent of the variation in intent to leave can be explained by relationship with physicians. These findings indicate that the

null hypothesis nine should be rejected and that a positive relationship between nurses and physicians decreased a nurse's intent to leave the profession.

Table 16: Impact of Nurse Physician Relationship on Intent to Leave

Intent to Leave	Model 1 Beta (Std. error)	Full Model Beta (Std. error)	Significance
Independent Variable			
Relationship with Physicians	-.201 (.376)	-.253 (.168)	.024**
Control Variables			
Associates Degree		-.273 (1.540)	.309
Bachelors Degree		-.272 (1.531)	.293
Masters/Doctorate Degree		-.265 (2.160)	.060*
Full Time		.058 (1.276)	.581
Day Shift		.004 (.852)	.971
RN Tenure		-.137 (.038)	.363
Married		-.337 (.855)	.023**
Divorced/Widowed		-.394 (1.027)	.007**
Interaction Effect between RN Tenure and number of children		.397 (.014)	.008**
R^2	0.051	.227	
N	85	85	
F	4.505	2.173	
Significance	.037**	.029**	
***significant at .001			
** significant at .05			
* significant at .10			

Impact of Organizational Support on Intent to Leave

Ho_{10}- No relationship exists between organizational support and a bedside registered nurse's intent to leave the profession.

An ordinary least squared analysis was performed on intent to leave and the organizational support subscale of the NWI-R. This analysis, indicates that, there is a statistically significant negative relationship ($p<.05$) between organizational support and intent to leave the profession. In addition to the variable of interest, organizational support, advanced education ($p<.10$) and marital status are negatively statistically significantly ($p<.05$) related to intent to leave. The interaction effect between RN tenure and number of children was also found to be statistically significant ($p<.01$), but in this instance the relationship is positive. The regression equation demonstrates that, 23.6 percent of the variable in intent to leave can be attributed to the full model outlined in table 17. The results indicate that we must reject the null hypothesis number ten that a higher perception of organizational support will indicate a lower intent to leave the profession.

Table 17: Impact of Organizational Support on Intent to Leave

Intent to Leave	**Model 1** b (Std. error)	**Full Model** b (Std. error)	**Significance**
Independent Variable			
Organizational Support	-.249 (.056)	-.262 (.055)	.015**
Control Variables			
Associates Degree		-.263 (1.532)	.324
Bachelors Degree		-.238 (1.526)	.356
Masters/Doctorate Degree		-.243 (2.138)	.081*
Full Time		.067 (1.265)	.518
Day Shift		.058 (.826)	.601

RN Tenure		-.115 (.037)	.443
Married		-.329 (.846)	.025**
Divorced/Widowed		-.392 (1.019)	.007**
Interaction Effect between RN Tenure and number of children		.374 (.014)	.012**
R^2	.062	.236	
N	85	85	
F	5.479	2.286	
Significance	.022**	.021**	

***significant at .001
** significant at .05
* significant at .10

The next section will outline the discussions and conclusions that can be garnered from this research including specific recommendations for organizations, public policy, and future research.

CHAPTER SIX: DISCUSSION AND CONCLUSIONS

Work Environment and Occupational Commitment

Work environment, as measured by the NWI-R, demonstrated a statistically significant positive relationship with occupational commitment. These findings indicate that a nurse who works in a positive work environment is more likely to demonstrate occupational commitment to the profession and supports previous research on this area. These findings also support the Three Component Model of commitment by demonstrating that factors relating to organizational and work experiences effect an employee's affective commitment and if these experiences are positive, increase the commitment one feels toward their profession.

The results of the correlation analysis show that the correlation of occupational commitment and work environment, autonomy, control over the practice setting, and organizational support are all positively statistically significant at the .05 level. (See Appendix E) This indicates that there is a linear relationship between work environment and the derived subscales and occupational commitment and that a correlation does exist. It is also interesting to note that there is no statistically significant correlation between nurse-physician relationship and occupational commitment.

The results of the regression analysis on the subscales mimic that of the analysis performed on the variable work environment as a whole. Work environment as a whole and all subscales were statistically significant in model 1, work environment was the only full model regression analysis that was statistically significant at the .05 level. Each produced an R squared between 15 percent and 22 percent indicating that between 15 percent and 22 percent of the variance in occupational commitment can be attributed to

each of the full models. The R squared and regression coefficients indicate that little of the variability in occupational commitment can be attributed to the independent variables which indicate that while the relationships are statistically significant there may be other predictors of occupational commitment.

Only one of the control variables which consist of education, full time versus part time, shift, length of time as a nurse, marital status, and interaction between length of time as an RN and number of children was found to be statistically significant ($p<.10$) in the regression analysis. Having advanced education (masters degree of higher) was statistically significant in all but one regression analysis indicating that higher education does positively effect occupational commitment. The lack of relationship between age and RN tenure was surprising given previous findings that these variables are positively associated with occupational commitment (Nogueras, 2006). This may be a result of the relationship between age and education.

In this sample, of the 28 (32.9 percent) respondents age 49-56, 15 (54 percent) had earned only an Associates degree in nursing. This is by far the age group with the lowest educational level and when all nurses 49 and older are included, 55 percent of the respondents indicated that they have obtained an associate's degree or lower. To further investigate this phenomenon, correlation analysis was performed and education and occupational commitment were found statistically significantly positively correlated with one another ($r=.219$, $p<.05$). Because of these findings, one can theorize that the high educational attainment of the sample is a better negative predictor of occupational commitment.

Work Environment and Intent to Leave the Profession

Work environment was also a statistically significant predictor of a bedside registered nurse's intent to leave the nursing profession. The relationship between these two variables is negative and indicates that a nurse with a more favorable work environment is less likely to leave the nursing profession. These findings are consistent with previous research that indicate that nurses leave the profession for numerous reasons, often citing work environment as a primary concern (Kovner, et. al, 2007; Kimball & O'Neil, 2002, Fottler & Widra, 1995, Chapman, & Hutchinson, 1982).

Correlation analysis demonstrated a statistically significant negative linear correlation between intent to leave and work environment, autonomy, control over the practice setting and organization support. These correlations are somewhat weak but do demonstrate the direction of the relationship and indicate that the relationship does exist.

The regression analysis produced regression coefficients that are statistically significant at the .05 level. The independent variables in all equations are also statistically significantly negatively ($p<.05$) related to intent to leave the profession. Each regression equation can account for 22 percent to 28 percent of the variability in intent to leave the profession.

Three control variables were found to be statistically significant, advanced education, marital status and the interaction effect between RN tenure and number of children. Marital status indicates that being married or divorced/widowed is negatively related to intent to leave. The relationship between intent to leave and education indicates that those nurses with a higher educational attainment level are less likely to leave the profession.

The interaction between RN tenure and number of children was positively related to intent to leave the profession, indicating that nurses that have been in the profession longer and have children are more likely to remain in the profession. There is limited literature regarding this interaction, therefore, this is an interesting area for further analysis.

In order to further investigate this relationship, a correlation analysis was performed and it is note worthy that both the interaction effect between RN tenure and number of children and marital status are both highly correlated with age ($p<.05$). This could indicate that since age was not included in the regression analyses (to combat multicolliniarity), that these two variables are in fact representing the relationship between age and intent to leave.

Table 18: Hypothesis Summary Table

Hypothesis	**Decision**
Ho_1-There is no relationship between bedside registered nurses perceptions of work environment and occupational commitment	Reject Null Hypothesis
Ho_2- There is no relationship between bedside registered nurses perceived autonomy and their occupational commitment.	Reject Null Hypothesis
Ho_3- There is no relationship between a bedside registered nurses control over their practice setting and occupational commitment.	Reject Null Hypothesis
Ho_4- There is no relationship between nurse physician relationships of bedside registered nurses and occupational commitment	Reject Null Hypothesis
Ho_5- There is no relationship between organizational support and occupational commitment of bedside registered nurses.	Reject Null Hypothesis
Ho_6- There is no relationship between nurses' intent to leave the profession and their perceived work environment.	Reject Null Hypothesis
Ho_7- No relationship exists between a bedside registered nurses perceived autonomy and their intent to leave the profession.	Reject Null Hypothesis
Ho_8- There is no relationship between a bedside registered nurse's control over the practice setting and their intent to leave the profession.	Reject Null Hypothesis
Ho_9- No relationship exists between nurse physician	Reject Null

relationships and a bedside registered nurse's intention to leave the profession.	Hypothesis
Ho_{10}- No relationship exists between organizational support and a bedside registered nurse's intent to leave the profession.	Reject Null Hypothesis

Implications for Organizations

As indicated in the literature review, nurse retention is an essential piece of organizational survival. With vacancy rates climbing and the average cost to replace a nurse at an all time high, retention of nurses is a financial necessity. This study demonstrates the importance of fostering a positive work environment in the retention of nurses in the nursing profession and creating commitment to the profession. If organizations are going to decrease vacancy rates and alleviate the current nursing shortage, changes in the work environment are necessary.

While the nurses in this sample appear to be somewhat committed and generally happy with their work environment, several areas for improvement were exposed. One area of specific dissatisfaction is salary with 50.6 percent of the respondents indicating they were not satisfied with their salary. After analyzing the qualitative results it became apparent that the concern over salary goes deeper than simple dissatisfaction with how much they are paid. The nurses in this sample felt as though their experience was being undervalued because new nurses were given large signing bonuses and made salaries equal to nurses with seniority. This is a common complaint from more experienced nurses (Kovner, 2007; Kimball & O'Neil, 2002) and indicates that a policy change regarding salary inequities should be addressed. While salary increases across the board are likely not a viable option in today's budget conscious time, communication regarding the salary process could improve this area of dissatisfaction among nurses.

Another area of specific concern for these nurses was that of nurse to patient ratios and lack of staff necessary to get the work done. The issue of nurse patient ratios has been popular in the mainstream press as well as academic literature (Fottler & Widra, 1995; Unruh, 2005; Unruh & Fottler, 2006; Ulrich, et. al, 2005; Aiken, 2002) for some time and has yet to be resolved. 47.1 percent of the respondents indicated that they do not have enough registered nurses to provide quality care and 49.4 percent indicated that there is not enough staff to complete the workload. In the qualitative portion of this study it was revealed that not only are nurses concerned about burnout, but patient safety as a result of the short staffing is also considered an issue. While there currently no immediate solution to this problem, it is important from a policy perspective that administration recognizes this issue and improve communications with nurse managers as well as bedside nurses regarding potential safety issues.

Promotion of professional practice environments is another example of how organizations can promote occupational commitment and decrease turnover in their nurses. By changing the organizational culture to reflect the importance of nursing and reflect the skill level of Registered Nurses, hospitals can better retain nurses and increase autonomy and control over the practice settings. Fostering professional nurse-physician relationships will also foster a work environment conducive to promoting occupational commitment

Implications for Public Policy

The education of healthcare professionals such as physicians, nurses, and allied health professionals can improve the work environment, especially at the bedside in a

hospital. The new model of medical education in which healthcare professionals share learning space including labs, and classrooms lends itself well to improving the work environment. By working together while obtaining their education, healthcare providers will be more aware of the functions performed by each member of the healthcare team. This increased knowledge has the potential to increase autonomy, relationship with physicians and control over the practice setting therefore increasing occupational commitment and reducing intent to leave for nurses.

This research can also be useful in the education of nurse managers. Management techniques such as how to create commitment in employees and improve work environment should be included in nursing curriculum as well as be included in the Continuing Education process.

Much like Blau's studies on occupational commitment cross the boundaries of professions, these findings can be applied to other allied health professionals as well. While nurses may make a popular study group because of the national attention placed on the nursing shortage, but many other allied health professionals are facing shortages themselves. For example, the demand for Registered Respiratory Therapists (RRT) is expected to grow 2.8 percent nationally and 3.5 percent in the state of Florida generating a shortage much like the current nursing shortage. (Bureau of Labor Statistics, 2007) The work environments for RRT is similar to bed side nursing in that they work with patients individually and are subject to the same stressors that nurses often do. By applying the findings of this study to other allied health professionals like RRT, we can attempt to improve the work environment in all areas and prevent a more severe shortage of other professionals.

Future Research

In an attempt to better understand the relationship between occupational commitment and work environment future research is needed. The researcher has begun the process to conduct this same research at Florida Hospital DeLand. An adequate sample at this institution will allow further investigation into the study variables as well as compare the occupational commitment and work environment at two similar hospitals.

A statewide replication of this study would also prove invaluable in determining the way that work environment effects the occupational commitment and intent to leave of bedside registered nurses. This would help to better explain the implications of rural vs. urban hospitals and can control for issues regarding other employment opportunities and educational levels of the surrounding communities. A statewide study would also control for hospital level characteristics such as religious affiliations.

Another important aspect open for future study is the rate at which nurses are leaving the bedside. While this study focused on bedside nurses and their occupational commitment and intent to leave the profession, the intent to leave the bedside was not measured. This area of research may lend even more results regarding the effect work environment has on bedside registered nurses.

The application of this model to other allied health professionals is of particular interest. The shortage of other healthcare professionals, while smaller in numbers can be just a devastating to the healthcare team. Research on retaining these other professionals needs to be forthcoming to avoid a global shortage.

In future research, age will be an open ended question and thus producing a continuous variable. This will aid in better understanding the effect age has on

occupational commitment and intent to leave. In the current research this variable was excluded because of the categorical nature of the question and limited degrees of freedom.

Determining the effect of the three component model of commitment on occupational commitment and intent to leave as well as how work environment effects these types of commitment could be another interesting area for research. By using the Meyer and Allen (1993) affective, normative and continuance commitment scale as either the dependent or independent could produce interesting results.

The monetization of turnover from the profession as well as a cost benefit analysis of actual costs of replacing nurses could offer more insight for administrators regarding how improving work environment could improve the financial health of their organization and therefore increase the interest in improving work environment.

Conclusions

This research demonstrated that a work environment that allows nurses to feel autonomous, have control over their practice, fosters positive relationships with physicians and provides organizational support can lead to an increase occupational commitment and decrease nurses' intent to leave the profession. The environment in which this research was conducted proved to be a positive work environment and therefore the nurses studied had a high commitment to nursing as an occupation. The literature and theory support these findings and this study has provided policy makers, administrators, and educators with new insight into the retention of bedside registered nurses.

APPENDIX A: COVER LETTER AND SURVEY INSTRUMENT

Dear Professional Registered Nurse,

I am Doctoral Student at the University of Central Florida pursing a degree in Public Affairs. As a part of this degree I am completing research regarding work environment and the effect that it has on the length of time a registered nurse practices in the nursing field. You have been selected to participate in this study and your input is highly valued. The survey will take approximately 30 minutes to complete. By participating in this study you will be taking part in discovering what needs to be done to better retain registered nurses.

This survey consists of four sections:

1) Demographic Information- this information is for statistical purposes only and will not be used to identify you in any way
2) Work Environment- in this section please indicate the degree to which each item is present in your current position.
3) Career Commitment- in this section please indicate how often you feel each statement about your nursing profession is true.
4) Free Response- please answer each question as honestly as possible.

Participation in this study is completely voluntary and anonymous. Data will be available only in the collective form and no individual responses will be shared. If you chose to participate please complete the attached survey and return it to the designated box in Nursing Education. Your completion of this survey serves as your consent to participate in this study.

Thank you in advance you're your participation in this study. If you have any questions regarding this research please feel free to contact me at kcortely@mail.ucf.edu or 407-823-2639. You may also contact my faculty advisor, Myron D. Fottler, PhD, at 407-823-5531. If you have questions regarding participant's rights you may contact the UCF Institutional Review Board at 407-823-2901.

Thank you

Kendall H. Cortelyou-Ward
Doctoral Candidate, Public Affairs
University of Central Florida

Survey of Work Environment and Career Commitment of Bedside Registered Nurses at Florida Hospital Waterman

This portion of the survey is designed to obtain information about you. Please select the answer that most accurately describes your current situation.

1. What is your age?
    a. 18-25
    b. 26-33
    c. 34-40
    d. 41-48
    e. 49-56
    f. 57-64
    g. 65 and older

2. Do you work full time?
    a. Yes
    b. No
    c. Sometimes

3. What shift do you normally work on?
    a. Days
    b. Nights
    c. Rotating

4. What is your highest degree held?
    a. Diploma
    b. Associates Degree
    c. Bachelor's Degree
    d. Master's Degree
    e. Doctorate

5. How long have you been a Registered Nurse? _____

6. How long have you been at Florida Hospital Waterman? _____

7. What is your marital status?
    a. Single
    b. Married
    c. Divorced
    d. Widowed
    e. Separated

8. How many children do you have? _____

9. What is the age of your youngest child? _____ (please indicate either months or years)

For each item in this section, please indicate the extent to which you agree that the following items are present in your current job. Indicate your degree of agreement by circling the appropriate number.

Present in Current Job	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
1. Adequate support services allow me to spend time with my patients	1	2	3	4
2. Physicians and nurses have good working relationship	1	2	3	4
3. A good orientation program for newly employed nurses	1	2	3	4
4. A supervisory staff that is supportive of nurses	1	2	3	4
5. A satisfactory salary	1	2	3	4
6. Nursing controls its own practice	1	2	3	4
7. Active inservice/continuing education programs for nurses	1	2	3	4
8. Career development/clinical ladder opportunity	1	2	3	4
9. Opportunity for staff nurses to participate in policy decisions	1	2	3	4
10. Support for new and innovative ideas about patient care	1	2	3	4
11. Enough time and opportunity to discuss patient care problems with other nurses	1	2	3	4
12. Enough registered nurses on staff to provide quality patient care	1	2	3	4
13. A nurse manager who is a good manager and leader	1	2	3	4
14. A Chief Nursing Officer is highly visible and accessible to staff	1	2	3	4
15. Flexible or modified work schedules are available	1	2	3	4
16. Enough staff to get the work done	1	2	3	4
17. Freedom to make important patient care and work decisions	1	2	3	4
18. Praise and recognition for a job well done	1	2	3	4
19. Clinical Nurse Specialists who provide patient care consultation	1	2	3	4
20. Team nursing as the nursing delivery	1	2	3	4

system				
21. Total patient care as the nursing delivery system	1	2	3	4
22. Primary nursing as the nursing delivery system	1	2	3	4
23. Good relationships with other departments such as housekeeping and dietary	1	2	3	4
24. Not being placed in a position of having to do things that are against my nursing judgment	1	2	3	4
25. High standards of nursing care are expected by the administration	1	2	3	4
26. A chief nursing officer is equal in power and authority to other top	1	2	3	4
27. Much teamwork between doctors and nurses	1	2	3	4
28. Physicians give high quality medical care	1	2	3	4
29. Opportunities for advancements	1	2	3	4
30. Nursing staff is supported in pursuing degrees in nursing	1	2	3	4
31. A clear philosophy of nursing pervades the nursing environment	1	2	3	4
32. Nurses actively participate in efforts to control costs	1	2	3	4
33. Working with nurses that are clinically competent	1	2	3	4
34. The nursing staff participate in selecting new equipment	1	2	3	4
35. A nurse manager backs up the nursing staff in decision making even if the conflict is with a physician	1	2	3	4
36. An administrator that listens and responds to employee concerns	1	2	3	4
37. An active quality-assurance program	1	2	3	4
38. Staff nurses are involved in internal governance of the hospital (e.g. practice and policy committee)	1	2	3	4
39. Collaboration (joint-practice) between nurses and physicians	1	2	3	4
40. A preceptor program for new RNs	1	2	3	4
41. Nursing care is based on nursing rather	1	2	3	4

than a medical model				
42. Staff nurses have the opportunity to serve on hospital and nursing committees	1	2	3	4
43. The contributions that nurses make to patient care are publicly acknowledged	1	2	3	4
44. Nurse managers consult with staff on daily concerns and problems	1	2	3	4
45. The work environment is pleasant, attractive, and comfortable	1	2	3	4
46. Opportunity to work in a specialized unit	1	2	3	4
47. Written up to date nursing care plans for all patients	1	2	3	4
48. Patient assignments foster continuity of care (i.e. the same nurse cares for the same patient from one day to the next)	1	2	3	4
49. Regular, permanently assigned nurses never have to float to another unit	1	2	3	4
50. Staff nurses actively participate in developing their work schedules (i.e. what days they work, days off, etc.)	1	2	3	4
51. Standardized policies, procedures and ways of doing things	1	2	3	4
52. Use of nursing diagnosis	1	2	3	4
53. Floating so that staff is equalized among units	1	2	3	4
54. Each nursing unit determines its own policies and procedures	1	2	3	4
55. Use of problem-oriented medical record	1	2	3	4
56. Working with experienced nurses that "know" the hospital	1	2	3	4
57. Nursing care plans are verbally transmitted from nurse to nurse.	1	2	3	4

For each item in this section, please indicate how you feel about your profession as a nurse. Indicate your feelings by circling the appropriate number.

How often do you feel that the following are true?

	Never	Sometimes	Occasionally	Often	Always

If I could get another job different from being a nurse and paying the same amount I would probably take it	1	2	3	4	5
I definitely want a career for myself in nursing	1	2	3	4	5
If I could do it all over again I would not choose to work in the nursing profession	1	2	3	4	5
If I had all of the money I needed without working, I would probably still continue to work in the nursing profession	1	2	3	4	5
I like this vocation too much to give it up	1	2	3	4	5
This is the ideal vocation for my life work	1	2	3	4	5
I am disappointed that I ever entered the nursing profession	1	2	3	4	5
I spend a significant amount of personal time reading nursing-related journals or books	1	2	3	4	5
I am thinking about leaving the nursing profession	1	2	3	4	5
I intend to look for a different profession	1	2	3	4	5
I intend to stay in the nursing profession for some time	1	2	3	4	5

For each item in this section, please answer in the space provided and use the back if necessary.

1) **Are there specific concerns that cause you dissatisfaction?**

_____
_____
_____
_____

2) **What would be the one thing you would change about your employment?**

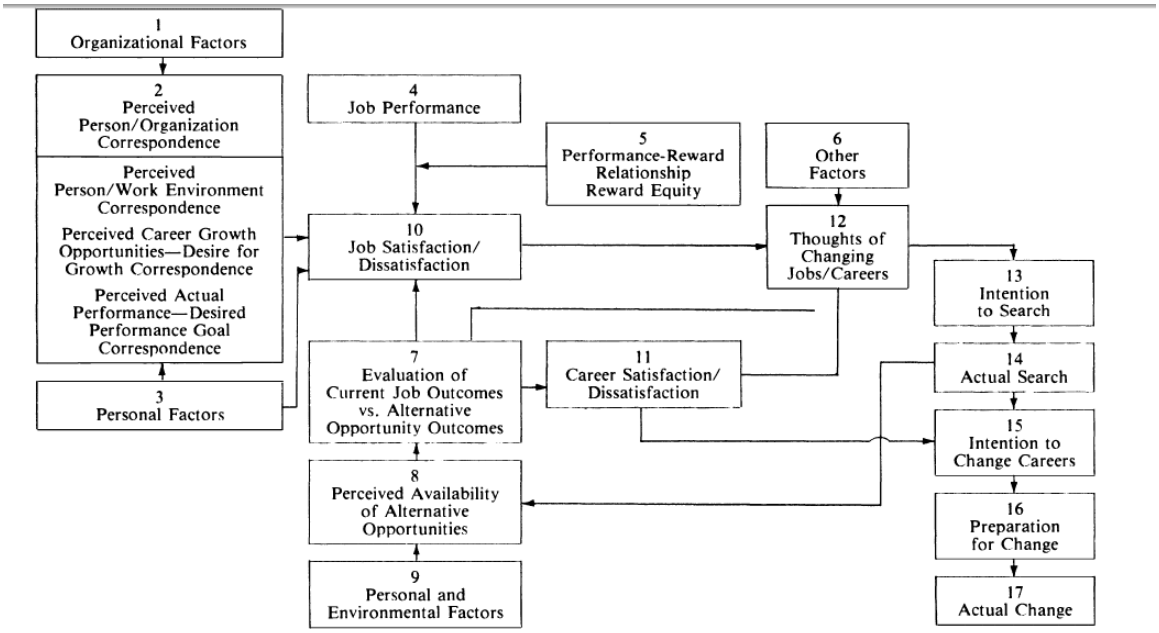
_____
_____
_____
_____

3) **Are there specific attributes or your unit that cause you satisfaction?**

_____
_____
_____

Thank you for your time and input on this very important project. Feel free to add any comments or suggestions that you would like the researchers to consider.

APPENDIX B: INTEGRATED MODEL OF CAREER CHANGE


1
Organizational Factors
2
Perceived
Person/Organization
Correspondence
Perceived
Person/Work Environment
Correspondence
Perceived Career Growth
Opportunities—Desire for
Growth Correspondence
Perceived Actual
Performance—Desired
Performance Goal
Correspondence
3
Personal Factors
4
Job Performance
5
Performance-Reward
Relationship
Reward Equity
6
Other
Factors
10
Job Satisfaction/
Dissatisfaction
12
Thoughts of
Changing
Jobs/Careers
13
Intention
to Search
7
Evaluation of
Current Job Outcomes
vs. Alternative
Opportunity Outcomes
11
Career Satisfaction/
Dissatisfaction
14
Actual Search
15
Intention to
Change Careers
8
Perceived Availability
of Alternative
Opportunities
16
Preparation
for Change
9
Personal and
Environmental Factors
17
Actual Change

APPENDIX C: NURSING WORK INDEX-REVISED FREQUENCIES

NWI-R Frequencies

	Strongly Agree		Somewhat Agree		Somewhat Disagree		Strongly Disagree		Mean (Standard Deviation)
	Frequency	%	Frequency	%	Frequency	%	Frequency	%	
Adequate support services allow me to spend time with my patients	17	20	38	44.7	21	24.7	9	10.6	2.73 (.931)
Physicians and nurses have good working relationship	28	32.9	47	55.3	10	11.8			3.21 (.638)
A good orientation program for newly employed nurses	29	34.1	37	43.5	16	18.8	3	3.5	3.08 (.820)
A supervisory staff that is supportive of nurses	33	38.8	32	37.6	17	20	3	3.5	3.12 (.851)
A satisfactory salary	8	9.4	34	40	25	29.4	18	21.2	2.38 (.926)
Nursing controls its own practice	11	12.9	33	38.8	29	34.1	12	14.1	2.51 (.895)
Active inservice/continuing education programs for nurses	29	34.1	26	30.6	24	28.2	6	7.1	2.92 (.954)
Career development/clinical ladder opportunity	12	14.1	28	32.9	26	30.6	19	22.4	2.39 (.989)
Opportunity for staff nurses to participate in policy decisions	9	10.6	26	30.6	35	41.2	15	17.6	2.34 (.894)
Support for new and innovative ideas about patient care	14	16.5	45	52.9	19	22.4	7	8.2	2.78 (.822)
Enough time and opportunity to discuss patient care problems with other nurses	18	21.2	40	47.1	24	28.2	3	3.5	2.86 (.789)
Enough registered nurses on staff to provide quality patient care	16	18.8	29	34.1	26	30.6	14	16.5	2.55 (.982)

A nurse manager who is a good manager and leader	40	47.1	34	40	7	8.2	4	4.7	3.29 (.814)
A Chief Nursing Officer is highly visible and accessible to staff	26	30.6	21	24.7	22	25.9	16	18.8	2.67 (1.106)
Flexible or modified work schedules are available	28	32.9	42	49.4	12	14.1	3	3.5	3.12 (.778)
Enough staff to get the work done	12	14.1	31	36.5	30	35.3	12	14.1	2.51 (.908)
Freedom to make important patient care and work decisions	14	16.5	52	61.2	18	21.2	1	1.2	2.93 (.651)
Praise and recognition for a job well done	19	22.4	44	51.8	18	21.2	4	4.7	2.92 (.790)
Clinical Nurse Specialists who provide patient care consultation	9	10.6	34	40	23	27.1	19	22.4	2.39 (.952)
Team nursing as the nursing delivery system	16	18.8	41	48.2	14	16.5	14	16.5	2.69 (.964)
Total patient care as the nursing delivery system	20	23.5	33	38.8	19	22.4	13	15.3	2.71 (.998)
Primary nursing as the nursing delivery system	21	24.7	32	37.6	18	21.2	14	16.5	2.71 (1.021)
Good relationships with other departments such as housekeeping and dietary	34	40	41	48.2	5	5.9	5	5.9	3.22 (.807)
Not being placed in a position of having to do things that are against my nursing judgment	30	35.3	41	48.2	12	14.1	2	2.4	3.16 (.754)
High standards of nursing care are expected by the administration	51	60	28	32.9	6	7.1			3.53 (.628)
A chief nursing officer is equal in power and authority to other top	20	23.5	47	55.3	15	17.6	3	3.5	2.99 (.748)

Much teamwork between doctors and nurses	21	24.7	44	51.8	16	18.8	4	4.7	2.96 (.749)
Physicians give high quality medical care	16	18.8	53	62.4	15	17.6	1	1.2	2.99 (.645)
Opportunities for advancements	15	17.6	40	47.1	24	28.2	6	7.1	2.75 (.830)
Nursing staff is supported in pursuing degrees in nursing	23	27.1	40	47.1	19	22.4	3	3.5	2.98 (.801)
A clear philosophy of nursing pervades the nursing environment	22	25.9	38	44.7	23	27.1	2	2.4	2.94 (.792)
Nurses actively participate in efforts to control costs	18	21.2	45	52.9	17	20	5	5.9	2.89 (.802)
Working with nurses that are clinically competent	31	36.5	33	38.8	19	22.4	2	2.4	3.09 (.826)
The nursing staff participate in selecting new equipment	4	4.7	35	41.2	34	40	12	14.1	2.36 (.784)
A nurse manager backs up the nursing staff in decision making even if the conflict is with a physician	23	27.1	35	41.2	20	23.5	7	8.2	2.87 (.910)
An administrator that listens and responds to employee concerns	21	24.7	39	45.9	16	18.8	9	10.6	2.85 (.919)
An active quality-assurance program	21	24.7	49	57.6	11	12.9	4	4.7	3.02 (.756)
Staff nurses are involved in internal governance of the hospital (e.g. practice and policy committee)	12	14.1	38	44.7	26	30.6	9	10.6	3.08 (4.462)
Collaboration (joint-practice) between nurses and physicians	16	18.8	44	51.8	21	24.7	4	4.7	2.85 (.779)
A preceptor program for new RNs	40	47.1	30	35.3	11	12.9	4	4.7	3.25 (.858)

Nursing care is based on nursing rather than a medical model	17	20	46	54.1	20	23.5	2	2.4	2.92 (.727)
Staff nurses have the opportunity to serve on hospital and nursing committees	15	17.6	50	58.8	17	20	3	3.5	2.91 (.718)
The contributions that nurses make to patient care are publicly acknowledged	10	11.8	41	48.2	24	28.2	10	11.8	2.60 (.848)
Nurse managers consult with staff on daily concerns and problems	30	35.3	36	42.4	11	12.9	8	9.4	3.04 (.932)
The work environment is pleasant, attractive, and comfortable	38	44.7	39	45.9	4	4.7	4	4.7	3.31 (.772)
Opportunity to work in a specialized unit	39	45.9	34	40	9	10.6	3	3.5	3.28 (.796)
Written up to date nursing care plans for all patients	16	18.8	42	49.4	20	23.5	7	8.2	2.79 (.846)
Patient assignments foster continuity of care (i.e. the same nurse cares for the same patient from one day to the next)	21	24.7	43	50.6	9	10.6	12	14.1	2.86 (.953)
Regular, permanently assigned nurses never have to float to another unit	24	28.2	19	22.4	15	17.6	27	31.8	2.47 (1.211)
Staff nurses actively participate in developing their work schedules (i.e. what days they work, days off, etc.)	25	29.4	39	45.9	11	12.9	10	11.8	2.93 (.949)
Standardized policies, procedures and ways of doing things	36	42.4	40	47.1	6	7.1	3	3.5	3.28 (.750)
Use of nursing diagnosis	13	15.3	47	55.3	18	21.2	7	8.2	2.78 (.807)
Floating so that staff is equalized among units	9	10.6	42	49.4	17	20	17	20	2.51 (.934)

Each nursing unit determines its own policies and procedures	9	10.6	36	42.4	22	25.9	18	21.2	2.42 (.943)
Use of problem-oriented medical record	10	11.8	49	57.6	19	22.4	7	8.2	2.73 (.777)
Working with experienced nurses that "know" the hospital	26	30.6	47	55.3	11	12.9	1	1.2	3.15 (.681)
Nursing care plans are verbally transmitted from nurse to nurse.	15	17.6	38	44.7	23	27.1	9	10.6	2.69 (.887)

APPENDIX D: FREQUENCIES AND DISTRIBUTIONS FOR OCCUPATIONAL COMMITMENT SCALE

Occupational Commitment:	Never		Sometimes		Occasionally		Often		Always		Mean (standard deviation)
	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	
If I could get another job different from being a nurse and paying the same amount I would probably take it *	7	8.2	14	16.5	23	27.1	18	21.2	23	27.1	3.42 (1.28)
I definitely want a career for myself in nursing	6	7.1	7	8	12	14.1	25	29.4	35	41.2	3.89 (1.23)
If I could do it all over again I would not choose to work in the nursing profession*	7	8.2	10	2	15	17.6	17	20	36	42.4	3.76 (1.33)
If I had all of the money I needed without working, I would probably still continue to work in the nursing profession	19	22.4	15	11.8	19	22.4	14	16.5	18	21.2	2.96 (1.45)
I like this vocation too much to give it up	7	8.2	11	12.9	23	27.1	23	27.1	21	24.7	3.47 (1.23)
This is the ideal vocation for my life work	6	7.1	10	11.8	22	25.9	19	22.4	28	32.9	3.62 (1.25)
I am disappointed that I ever entered the nursing profession*	1	1.2	5	5.9	9	10.6	18	21.2	52	61.2	4.35 (.97)
I spend a significant amount of personal time reading nursing-related journals or books	8	9.4	20	23.5	27	31.8	22	25.9	8	9.4	3.02 (1.12)
Total Score for Occupational Commitment											28.52 (6.63)

*Question has been recoded

APPENDIX E: FREQUENCIES AND DISTRIBUTIONS FOR INTENT TO LEAVE SCALE

Intent to Leave:	Never		Sometimes		Occasionally		Often		Always		Mean (standard deviation)
	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	
I am thinking about leaving the nursing profession	53	6.4	14	16.5	7	8.2	9	10.6	2	2.4	1.74 (1.14)
I intend to look for a different profession	55	64.7	12	14.1	10	11.8	6	7.1	2	2.4	1.65 (.972)
I intend to stay in the nursing profession for some time *	39	45.9	21	24.7	11	12.9	12	14.1	2	2.4	2.02 (1.17)
Intent to Leave Total	147	47.9	47	15.3	28	9.1	42	13.7	43	14.0	5.45 (2.89)

*Question has been recoded

APPENDIX F: OCCUPATIONAL COMMITMENT SCORES AND DEMOGRAPHICS

Occupational Commitment Scores

Personal Characteristics		Mean	Standard Deviation
Age			
	18-33	29.52	6.16
	34-48	27.68	7.04
	49 and older	28.40	6.74
Education			
	Diploma	24.50	6.45
	Associates Degree	27.94	7.25
	Bachelors Degree	29.39	5.45
	Masters and Higher	34.00	5.57
Marital Status			
	Single	28.69	6.37
	Married	27.85	5.94
	Divorced, Widowed, Separated	30.41	8.66
Number of Children			
	0	28.89	6.17
	1	29.31	4.57
	2 or more	28.05	7.46
Age of Children			
	.01- 5 year	30.92	5.07
	5-18 years	25.21	8.00
	18 and older	28.74	6.64

Professional Characteristics		Mean	Standard Deviation
Hours			
	Full Time	28.38	6.67
	Part Time	31.67	7.77
	Depends	34.00	N/A
Shift			
	Days	28.37	6.46
	Nights	29.85	4.88
	Rotating	25.00	N/A
Tenure as RN			
	less than 1 year	30.00	7.47
	1-5 years	30.00	5.19
	5 years and more	27.83	6.73
Tenure at Waterman			
	less than 1 year	29.77	7.14
	1-5 years	26.70	6.95
	5 years and more	29.33	5.76

APPENDIX G: INTENT TO LEAVE SCORES AND DEMOGRAPHICS

Intent to Leave Scores

Personal Characteristics		Mean	Standard Deviation
Age			
	18-33	4.96	2.57
	34-48	5.41	2.63
	49 and older	5.75	3.21
Education			
	Diploma	7.75	3.30
	Associates Degree	5.49	2.99
	Bachelors Degree	5.26	2.73
	Masters and Higher	3.67	1.16
Marital Status			
	Single	6.31	2.70
	Married	5.38	2.77
	Divorced, Widowed, Separated	4.82	3.36
Number of Children			
	0	5.04	2.44
	1	4.46	2.07
	2 or more	6.00	3.26
Age of Children			
	.01- 5 year	4.58	2.11
	5-18 years	6.50	3.41
	18 and older	5.68	3.21

Professional Characteristics		Mean	Standard Deviation
Hours			
	Full Time	5.53	2.94
	Part Time	3.00	N/A
	Depends	6.00	N/A
Shift			
	Days	5.47	2.98
	Nights	5.08	2.59
	Rotating	7.00	1.41
Tenure as RN			
	less than 1 year	5.23	2.95
	1-5 years	4.07	1.69
	5 years and more	5.38	3.03
Tenure at Waterman			
	less than 1 year	5.32	3.06
	1-5 years	5.83	3.05
	5 years and more	5.18	2.66

APPENDIX H: MEAN WORK ENVIRONMENT SCORES

Work Environment	Mean (standard deviation)	Theoretical Values
Autonomy Subscale	14.59 (2.96)	4-20
Control Over Practice Subscale	20.08 (4.29)	7-28
Nurse-Physician Relationship Subscale	9.02 (1.88)	3-12
Organizational Support Subscale	29.07 (5.51)	10-40
Work Environment Total	163.15 (28.34)	57-228

APPENDIX H: QUALITATIVE DATA

1) **Are there specific concerns that cause you dissatisfaction?**
   - Lack of respect
   - No
   - Lack of staff/pay rate/patient load
   - Nurses lack of cohesiveness- they don't stick together and stand up for their rights
   - Short staffing- there are times when I'm so busy that I am afraid I'll make an error. On the weekends the charge nurse seems to make unfair assignments I have been very upset over this
   - Nursing as a whole dissatisfies me
   - lack of progressive and current ideas, short staff, too much charting not enough time for hands on care
   - High volume of new inexperienced nurses, high volume of agency personnel, rapid turnover
   - For nurses to be more accountable for their job performance
   - stress and decrease staffing to patient ratio
   - The reasons why younger men and women are coming into the nursing field
   - insufficient staffing
   - Low pay, increased patient load and unnecessary float
   - nursing shortage decrease the nurse/patient ratio- patient safety should be #1 but increase patient load and longer working hours lead to higher errors
   - Floors are understaffed, people work too many 12 hour shifts
   - profit is more important than patient care staffing ratios are an afterthought except as it pertains to budget
   - The pay is considerably low when you take into consideration the amount of responsibility nurses have especially in highly specialized areas
   - Nurse to patient ratio too high- need standards. Doctors who regularly treat nurses like they are idiots and are useless. Bad communication- hospital wide. Nurses who sleep on night shift; chart checks that aren't done; "missed" orders
   - some physician's attitudes
   - Unsafe staffing is the norm
   - I am burnt out. Not enough patient contact need to get charting done continuously
   - Nurse-patient ratio too many patients to care for. Nurses moved from the floor have no sympathy for floor nurses- they are just too happy to be one of the stress. You are just given more patients than what was agreed on without anyone discussing it
   - the lack of nurses. Staffing is very tight. If you have a very sick group of patients there is not enough time to get everything done. I do not like to go home with that feeling.
   - It seems many facilities do not respect the nurse's time and effort. Everyone else's needs and wants come before the nurse Re: Pharm Physicians they want you to leave patient and solve their problems or make their lives simpler
   - Nursing is teamwork. One of the most dissatisfies to me is the blame that I get because of other people's mistakes. That is the nurse's wok work on previous shift.

- Sometimes the case load so too heavy and I am unable to give the patient/family the time they deserve
- inadequate nurse staff numbers, communication between physicians and patients could be better
- I am always very stressed. I haven't grasped the ideas of being in control of another's life/health yet; although it is getting better
- After 35 years I don't feel I can increase my salary even though I'm working on my masters degree
- The disrespect from the patients and some physicians the way patient make me feel like a waitress, maid, etc. "I am a nurse" not a servant
- The way the hospital looks at "money" and "how to save money" as the big picture and not worrying how it affects nursing
- Floating after 2 days with same assignment
- I work as an RNFA in the OR. I HATE call
- seeing patients struggle with healthcare costs. Seeing people put their own personal needs in front of the patient or medical team. Decrease respect for nursing as a profession (by nurses() less advancement in the profession
- Long hours, being forced to stay late because there is no one to relieve me
- Occasionally I get frustrated with things related to the nursing progression as a whole but I believe everyone in any career field does from time to time
- I am at max burnout. I am tired of the interpersonal politics
- Surgeons with God syndrome. General public paranoia of medical errors and increase desire to sure if outcome not to patient perceived level of outcome
- Leadership with significantly less education or experience. No compensation for certifications or degrees 20-30 percent difference in pat for other FH facilities Call offs- high agency staff
- The only concern if any is the lack of increases in pay for registered nurses. This seems to be a national problem
- need higher pay rates
- not always having the supplies needed for the patient at hand
- I think people (nurses) forget that it is a privilege to work in a critical unit and they become whiny/lazy
- Lack of continued support with floors and ER in bed situation
- No managerial support- Gallop scores and money are focus too much work not enough money un-kept promises by managers
- some parts of management
- I've worked in approximately 25 different hospitals and FH Waterman is the LOWEST paying facility I've been in
- Waterman is the lowest paying facility in this area
- Usually work overloaded- too many patients for each nurse, ratio high and unsafe sometimes. Pay scale low for saving lives
- Legal responsibilities and litigation concerns cause me significant anxiety requiting extra work while coping, to the point of wanting leave hospital nursing.
- Occasionally short staffed

- Not all staff reacts quickly enough to non-reassuring patient symptoms
- workload
- Yes: salary, support, staffing
- lack of respect for new people and seasoned need for nurses and how we train new ones
- Not enough respect and money for what we do. New nurses come in do not have enough training and not enough emphasis on detail of skills

2) **What would be the one thing you would change about your employment?**
   - Have nurses stand up for one another instead of jumping at the opportunity to condemn or criticize another nurse.
   - Nothing
   - Pay rate
   - Lack of pay- Benefits and representative
   - Staffing
   - I would like to work more than one area
   - That I did not have to do it
   - More staff, progressive ideas and up to date practices
   - More cooperation between nurses and techs so that more care be accomplished in one shift. Also 12 hour shifts can be too long
   - improve RN to patient ratio
   - Nothing
   - increase pay, decrease nurse/patient ratios
   - More control in nursing policies, control on patient load, more pay for special certifications
   - Go back to 8 hour shifts for regular staff nurses
   - The hierarchy between doctors and nurses should be flatter. Educators would be at staff's fingertips.
   - Management would listen to the people that work night shift and involve them more in decisions made for them
   - I entered nursing school as a young single mom, with a toddler. I thoroughly enjoyed nursing school. I moved out of the stat the day after graduation to take Florida Stat Boars and to take a job in South Florida. After one year, I took a $1.00/hour pay cut to attend a critical care internship- and then to take a job in ICU in Orlando. I loved ICU Nursing. I transferred to PACU after 6.5 years and absolutely love PACU. After 9 years, I went back to staff nurse- or per diem status. Nursing has been a perfect career for me- it has been rewarding- I have always felt that I am making a real difference in people's lives. It has allowed me to financially care of my son as well. I have made wonderful nursing friends and would choose nursing all over again.
   - My salary
   - The attitudes of the doctors- they belittle nurses and act like they don't make mistakes. They are rude (not all of them but about 75 percent) especially in surgical/radiology areas.
   - the amount of money the employer offers an RN to further education more money for additional schooling

- I would offer salary/benefits to attract new nurses and retain current nurses so that safe staffing could be achieved and maintained
- Decrease computer time
- Having fewer patients so one can handle the job load well and feel comfortable focus on taking care of patients safely.
- Patient to nurse ratio
- Wages in the south are horrible. Staffing issues are always a problem and with an extremely heavy workload it is very difficult to satisfy many clients
- Salary
- The patient to nurse ratio
- Nothing
- Increase salary
- The change salary for those with experience- especially change the rates because new hires are starting out just under a nurse that has been working for 13 years with only 3 percent merit raises
- Pay the nurses and keep their salaries competitive to help maintain seasoned nurses
- Every other weekend for nurse
- Surgeons should understand team work. Fewer work hours, no call
- staying late to finish cases and being on cal for extended periods of time after already working 40 hours is very tiring it affects patient safety and staff morale and personal health and well being
- Forced overtime
- hours down to 6 hours day with full benefits more vacation time, better retirement, cheaper benefits
- increased sick and vacation time better retirement and decrease in cost of health insurance
- I would make more money or the amount and work one less day a week in an ideal world
- More income less titles
- Less call for staff. Salary at same levels as Orlando Surgery staff. Acknowledge increased educational levels with salary and title reflected
- Location- currently doing that
- Nothing, my career brings me much personal satisfaction
- need more nurses
- More team nursing, We have a pretty good group here and it continues to get better but improvement can always be made
- More money come to raise time especially in ER we re constantly on the go and it would help
- Decrease work hours 12 too long, patient education- ER not primary care physician, decrease staff/patient ratios, incentive pay, encourage continuing education, throw gallop scores out the window.
- Decrease the amount of “chiefs” and increase the number of “Indians”
- Night shift cohesiveness
- I think we need more bonuses for working extra and more pay increases.

- more money
- Better staffing to safely and adequately (ALWAYS) care for patients
- Physicians held to the same behavior standard as staff
- Physicians and midwives take fetal monitoring courses like nurses do
- more staff
- The day/ hourly wage/salary/ holiday pay differentials
- Money- more of it
- More money

3) **Are there specific attributes or your unit that cause you satisfaction?**
   - Yes
   - Nurses and other staff are very friendly and make me feel like part of the family
   - Everyone gets along and helps each other when needed
   - My co-workers are great
   - The people, well most of them
   - Most staff members work as a team
   - Clean pleasant atmosphere
   - Working with mothers and their new babies
   - I have only been in this unit for about 2 years and am very happy with my working situation this time for my job, family. Yes, there are days but I keep coming back and I do feel satisfied at the end most of the time
   - nurse/patient ratios too high for intermediate care unit
   - Teamwork ☺
   - Seeing the increased complaining about core measures and data abstracts
   - The people that I work with are for the most part dedicated and care about the patients.
   - I feel satisfied with I know we potentially saved a sudden cardiac death due to the procedures done in our lab. I am satisfied in knowing people trust me to be a good job.
   - Good/nice manager. Most people have good attitudes. 8 hour sift. Flexibility with doctor's appointment/time off. Specialized area (cath /angio) less stress than floor nursing.
   - The teamwork and caring manager who looks out for the staff and listens to their concerns.
   - I love working for the patient
   - Would like to join with nurses who are willing to stand up and make a difference. Most nurses are fearful to speak out and just grumble about the work load- thus turning their frustrations on each other.
   - Patient gratitude
   - The nurses I work with regularly you can always depend on them
   - The staff is all very supportive of each other. It is very satisfying when I an or another staff member can assist to complete a goal for the patients benefit. It also is satisfying when a doctor compliments the nursing staff for their hard work and dedication.
   - Yes- teamwork and lost of help with questions.
   - Good nurses and physicians. Good communication

- Friendly staff
- I like the unit that works together as a team will help each other without pitching a fit. A unit that plays well together and works together
- Sometimes inappropriate language from employees and no repercussions for offenders :
- We are a close knit unit- relying on each other
- I have a very goal oriented "fix it" mentality the OR gives me a lot of satisfaction because of that.
- We are like a family we work together as a team and we are all very close
- no
- the nursing staff are more than employees they are caring supportive and love not only their patients but each other and the patients family
- I enjoy my job a great deal and I like my co-workers I work in this department specifically because I enjoy this nursing job
- No
- Comradry of staff and management. Beautiful facility up to date equipment
- Challenge- skill level to function variety of patient needs personal satisfaction through teaching and mentoring
- My job in the ED brings me great satisfaction. The fast pace always changing environment is highly challenging
- teamwork
- I love to stay busy that is why I love the ER. I like to see changes in patient from start to finish. I like the fast pace.
- Camaraderie with co-workers we work as one until Wonderful open door policy
- My co-workers make this the best job in the world. Being able to educate patients makes me happy
- good teamwork
- Night shift cohesiveness
- good working team- dependable reliable peers
- No!
- Great team in OB with manager support
- At times but only because of workload for the most part we have a dedicated team which is actively involved in patient safety ad satisfaction.
- caring staff
- Nurses on this unit are pleasant my NM and Asst mgr are the strongest most supportive of them all here but they can't do much. Nursing here is treated like an ancillary dept
- Working with highly skilled people daily and the job of sharing a personal experience with patients.
- I love most of my coworkers and the quality of nursing skills

APPENDIX I: POWER ANALYSIS

Multiple linear regression

	Occupational Commitment					Intent to Leave				
	Ha_1	Ha_2	Ha_3	Ha_4	Ha_5	Ha_6	Ha_7	Ha_8	Ha_9	Ha_{10}
Test significance level, α	0.050	0.050	0.050	0.050	0.050	0.050	0.050	0.050	0.050	0.050
Number of variables, k	10	10	10	10	10	10	10	10	10	10
Squared multiple correlation, R^2	.22	.191	.180	.154	.177	.287	.258	.232	.227	.236
n	85	85	85	85	85	85	85	85	85	85
Power (percent)	91	84	81	72	80	98	96	93	92	94

APPENDIX J: CORRELATIONS: OCCUPATIONAL COMMITMENT AND INTENT TO LEAVE

	Occupational Commitment			Intent to Leave		
	Pearson Correlation	Significance	r2	Pearson Correlation	Significance	r2
Work Environment	0.292	0.007**	0.085	-0.313	0.003**	0.098
Autonomy	0.262	0.015**	0.069	-0.304	0.005**	0.092
Control Over Practice Setting	0.257	0.017**	0.066	-0.213	0.05**	0.045
Nurse/Physician Relationship	0.189	None	0.036	-0.201	none	0.041
Organizational Support	0.241	0.026**	0.058	-0.249	0.22**	0.062

	Occupational Commitment			Intent to Leave		
	Spearman's rho	Significance	Level	Spearman's rho	Significance	Level
Work Environment	0.306	0.004	0.01	-0.249	0.022	0.05
Autonomy	0.308	0.004	0.01	-0.296	0.006	0.01
Control Over Practice Setting	0.274	0.011	0.05	-0.185	0.089	N/A
Nurse/Physician Relationship	0.228	0.036	N/A	-0.174	0.111	N/A
Organizational Support	0.259	0.017	0.05	-0.228	0.036	0.05

APPENDIX K : SURVEY QUESTIONS AND SUBSCALE COMPONENTS

In order to determine the overall score for Occupational Commitment after reverse coding items 1,3,and 7, the following eight items will be summed and the total score will be represented as Y_1 in the regression model.

Occupational commitment	Survey Questions
#1	If I could get another job different from being a nurse and paying the same amount I would probably take it
#2	I definitely want a career for myself in nursing
#3	If I could do it all over again I would not choose to work in the nursing profession
#4	If I had all of the money I needed without working, I would probably still continue to work in the nursing profession
#5	I like this vocation too much to give it up
#6	This is the ideal vocation for my life work
#7	I am disappointed that I ever entered the nursing profession
#8	I spend a significant amount of personal time reading nursing-related journals or books

In order to determine the overall score for Intent to Leave after reverse coding item 3, the following three items will be summed and the total will be determined and represented as Y_2 in the regression model.

Intent to leave	Survey Questions
#9	I am thinking about leaving the nursing profession
#10	I intend to look for a different profession
#11	I intend to stay in the nursing profession for some time

In order to determine the overall score for Organizational Characteristics the following 57 items will be summed and the total score will be determined and represented as B_1 in the regression model.

Organizational Characteristics	Survey Questions
	Adequate support services allow me to spend time with my patients
	Physicians and nurses have good working relationship
	A good orientation program for newly employed nurses
	A supervisory staff that is supportive of nurses
	A satisfactory salary
	Nursing controls its own practice
	Active inservice/continuing education programs for nurses
	Career development/clinical ladder opportunity
	Opportunity for staff nurses to participate in policy decisions
	Support for new and innovative ideas about patient care
	Enough time and opportunity to discuss patient care problems with other nurses
	Enough registered nurses on staff to provide quality patient care
	A nurse manager who is a good manager and leader
	A Chief Nursing Officer is highly visible and accessible to staff
	Flexible or modified work schedules are available
	Enough staff to get the work done
	Freedom to make important patient care and work decisions
	Praise and recognition for a job well done
	Clinical Nurse Specialists who provide patient care consultation
	Team nursing as the nursing delivery system
	Total patient care as the nursing delivery system
	Primary nursing as the nursing delivery system
	Good relationships with other departments such as housekeeping and dietary
	Not being placed in a position of having to do things that are against my nursing judgment
	High standards of nursing care are expected by the administration

A chief nursing officer is equal in power and authority to other top
Much teamwork between doctors and nurses
Physicians give high quality medical care
Opportunities for advancements
Nursing staff is supported in pursuing degrees in nursing
A clear philosophy of nursing pervades the nursing environment
Nurses actively participate in efforts to control costs
Working with nurses that are clinically competent
The nursing staff participate in selecting new equipment
A nurse manager backs up the nursing staff in decision making even if the conflict is with a physician
An administrator that listens and responds to employee concerns
An active quality-assurance program
Staff nurses are involved in internal governance of the hospital (e.g. practice and policy committee)
Collaboration (joint-practice) between nurses and physicians
A preceptor program for new RNs
Nursing care is based on nursing rather than a medical model
Staff nurses have the opportunity to serve on hospital and nursing committees
The contributions that nurses make to patient care are publicly acknowledged
Nurse managers consult with staff on daily concerns and problems
The work environment is pleasant, attractive, and comfortable
Opportunity to work in a specialized unit
Written up to date nursing care plans for all patients
Patient assignments foster continuity of care (i.e. the same nurse cares for the same patient from one day to the next)
Regular, permanently assigned nurses never have to float to another unit
Staff nurses actively participate in developing their work schedules (i.e. what days they work, days off, etc.)
Standardized policies, procedures and ways of doing things
Use of nursing diagnosis

Floating so that staff is equalized among units
Each nursing unit determines its own policies and procedures

	Use of problem-oriented medical record
	Working with experienced nurses that "know" the hospital
	Nursing care plans are verbally transmitted from nurse to nurse.

In order to determine the overall score for Autonomy the following 5 items will be summed and the total score will be determined and represented as B_2 in the regression model.

Autonomy	Survey Questions
#4	A supervisory staff that is supportive of nurses
#6	Nursing controls its own practice
#17	Freedom to make important patient care and work decisions
#24	Not being placed in a position of having to do things that are against my nursing judgment
#35	A nurse manager backs up the nursing staff in decision making even if the conflict is with a physician

In order to determine the overall score for Control Over the Practice Setting the following 7 items will be summed and the total score will be determined and represented as B_3 in the regression model.

Control Over the Practice Setting	Survey Questions
#1	Adequate support services allow me to spend time with my patients
#11	Enough time and opportunity to discuss patient care problems with other nurses
#12	Enough registered nurses on staff to provide quality patient care
#13	A nurse manager who is a good manager and leader
#16	Enough staff to get the work done
#46	Opportunity to work in a specialized unit
#48	Patient assignments foster continuity of care (i.e. the same nurse cares for the same patient from one day to the next)

In order to determine the overall score for Nurse-Physician Relationship the following 3 items will be summed and the mean score will be determined and represented as B_4 in the regression model.

Nurse-Physician Relationship	Survey Questions
#2	Physicians and nurses have good working relationship
#27	Much teamwork between doctors and nurses
#39	Collaboration (joint-practice) between nurses and physicians

In order to determine the overall score for Organizational Support the following 10 items will be summed and the total score will be determined and represented as B_5 in the regression model.

Organizational Support	Survey Questions
#1	Adequate support services allow me to spend time with my patients
#2	Physicians and nurses have good working relationship
#6	Nursing controls its own practice
#11	Enough time and opportunity to discuss patient care problems with other nurses
#12	Enough registered nurses on staff to provide quality patient care
#13	A nurse manager who is a good manager and leader
#17	Freedom to make important patient care and work decisions
#24	Not being placed in a position of having to do things that are against my nursing judgment
#27	Much teamwork between doctors and nurses
#48	Patient assignments foster continuity of care (i.e. the same nurse cares for the same patient from one day to the next)

APPENDIX L: INSTITUTIONAL RESEARCH BOARD APPROVAL

University of Central Florida

Office of Research & Commercialization

January 17, 2007

Kendall Cortelyou- Ward
102 Brushcreek Drive
Sanford, FL 32771

Dear Ms. Cortelyou-Ward:

The University of Central Florida's Institutional Review Board (IRB) received your protocol IRB #06-4102 entitled, "The Effect of Work Environment on Career Commitment of Registered Nurses in Florida: A Sample of Hospital Bedside Nurse." The IRB Chair reviewed the study on 1/13/2007 and did not have any concerns with the proposed project. The Chair has indicated that under federal regulations (Category #4, collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves) this research is **exempt** from further review by our IRB, so an approval is not applicable and a renewal within one year is not required.

Please accept our best wishes for the success of your endeavors. Should you have any questions, please do not hesitate to call me at 407-823-2901.
Cordially,

Joanne Muratori
(FWA00000351 Exp. 5/13/07, IRB00001138)

Copies: IRB File
Myron Fottler, Ph.D.

JM:jt

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