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Organizational commitment among licensed practical nurses: exploring associations with empowerment, conflict and trust

Mary B. Carman-Tobin
University of Iowa

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**ORGANIZATIONAL COMMITMENT AMONG LICENSED PRACTICAL
NURSES: EXPLORING ASSOCIATIONS WITH EMPOWERMENT,
CONFLICT, AND TRUST**

by

Mary B. Carman-Tobin

An Abstract

Of a thesis submitted in partial fulfillment of the requirements
for the Doctor of Philosophy degree in
Educational Policy and Leadership Studies
in the Graduate College of The University of Iowa

December 2011

Thesis Supervisors: Professor Lelia B. Helms
Professor Alan B. Henkin

ABSTRACT

Healthcare organizational stability rests on organizational commitment. This study adds to the literature that demonstrates the mediating effects of empowerment on organizational commitment in a long understudied population of Licensed Practical Nurses (LPNs) employed full time. Organizational commitment encourages extra role behaviors, paramount in times of decreasing resources such as that facing all sectors of national health care. A 45-item work environment survey was distributed to all registered LPNs employed full time in one state (N = 5486) and 1164 (21%) responded. Data revealed that empowerment is associated with LPN organizational commitment and mediates effects of organizational conflict and trust on commitment to the organization. Further empowerment and organizational climate, especially organizational conflict and trust, matter to full-time LPNs. Results contribute to initial knowledge about linkages to organizational commitment among lower educated and less skilled nurses and have implications for managers in healthcare settings who employ full-time LPNs. LPNs may be more highly valued by scholars in nursing if LPN-sensitive research shows their continued value and cost effectiveness for specific and important organizational outcomes, especially in light of the growing geriatric population that will require increasingly chronic and routine care. As bedside RNs become more highly educated, they may increasingly disdain employment that involves the repetitive, low-risk patient care that LPNs currently provide. There is a real need to better understand the current work environment of those employees responsible for delivering low-risk repetitive healthcare to chronically ill and elderly patients. LPNs are key among those.

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CERTIFICATE OF APPROVAL

PH.D. THESIS

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TABLE OF CONTENTS

LIST OF TABLES	vi
LIST OF FIGURES	viii
CHAPTER	
1. INTRODUCTION.....	1
Statement of the Problem	16
Significance of the Study	16
Research Questions	17
Definition of Terms.....	18
Limitations of the Study.....	19
2. REVIEW OF THE LITERATURE AND CONCEPTUAL FRAMEWORK FOR THE STUDY	21
Introduction.....	21
Organizational Commitment: Conceptual Origins, Definitions, and Measures (Outcome Variable).....	21
Definition of Organizational Commitment	29
Measures of Organizational Commitment.....	29
Organizational Commitment in Health Care Workers.....	31
Organizational Commitment in Allied Health Care Delivery Groups.....	40
Organizational Commitment in Licensed Practical Nurses.....	44
Empowerment: Conceptual Origins and Definitions (Intervening Variable)	45
Structural Empowerment.....	46
Psychological Empowerment.....	47
Structural Empowerment: Evaluations.....	49
Psychological Empowerment: Evaluations.....	50
Empowerment: Approach and Measurement Used in This Study	50
Research on Empowerment in Nursing and Allied Healthcare Workers.....	51
Organizational Trust: Conceptual Origins, Definitions, and Measures (Independent Variable).....	55
Introduction	55
Definitions of Trust.....	56
Overview of Trust.....	56
Measures of Organizational Trust.....	58
Conflict (Independent Variable).....	59
Introduction	59
Definitions of Conflict.....	60
Overview of Conflict.....	60
Measurement of Conflict.....	62
Demographic Variables.....	63
Conclusion.....	64
3. METHODOLOGY.....	65
Introduction.....	65
Methodology	65
Population and Study Participants.....	68
Data Collection and Procedures	69

Hypotheses	71
Measures of Organizational Commitment	72
Measures of Empowerment.....	73
Measures of Organizational Trust.....	74
Measures of Conflict.....	74
Independent Demographic Control Variables.....	75
Validity, Reliability, and Construction of the Survey Instrument.....	76
Data Analysis and Statistical Methodology	77
4. ANALYSIS OF DATA AND FINDINGS	79
Assumptions.....	79
Response Rate and Representativeness.....	80
Demographic Characteristics of Survey Respondents	80
Validation and Construction of the Instruments	83
Reliability of the Instruments.....	84
Descriptive Statistics of Attitudinal Variables	85
Regression and ANOVA Analysis.....	86
Summary Regression and ANOVA Analysis	91
Hypothesis Testing.....	92
Hypothesis 1	92
Hypothesis 2.....	94
Hypothesis 3	95
Hypothesis 4.....	96
Structural Equation Modeling Results: Hypotheses 5, 6, and 7.....	99
Hypothesis 5	100
Hypothesis 6.....	102
Hypothesis 7.....	104
Summary of Structural Equation Modeling Results for Hypotheses 5, 6, and 7.....	106
5. DISCUSSION AND ANALYSIS.....	110
Model	110
Empowerment and Organizational Commitment.....	112
Relationship between Empowerment and Organizational Commitment with Indirect Effects of Demographic Variables.....	113
Relationship between Empowerment and Organizational Commitment with Indirect Effects of the Independent Variable Organizational Conflict	114
Relationship between Empowerment and Organizational Commitment with Indirect Effects of the Independent Variable Organizational Trust	117
Organizational and Policy Implications	119
Organizational and Policy Implications for Nursing.....	124
Introduction	124
Key Nursing Organizational and Policy Implications.....	126
Recommendations for Future Nursing Research	132
Conclusion.....	136
APPENDIX A. CONCEPTUAL FRAMEWORK: EMPOWERMENT, TRUST, CONFLICT, AND ORGANIZATIONAL COMMITMENT AMONG LICENSED PRACTICAL NURSES.....	139
APPENDIX B. COVER LETTER.....	141

APPENDIX C. LPN WORK ENVIRONMENT SURVEY	144
APPENDIX D. GIFT CARD	147
APPENDIX E. NON-RESPONSE POSTCARD	149
APPENDIX F. TWO TYPES OF ENTRY-LEVEL LICENSED NURSES IN THE UNITED STATES	151
APPENDIX G. IRB MATERIALS	153
APPENDIX H. NATIONAL, IOWA, AND VERMONT LPN DEMOGRAPHIC DATA COMBINING FULL- AND PART-TIME LPNS	156
REFERENCES	158

LIST OF TABLES

Table	
4-1. Nomenclature for Study Variables	79
4-2. Correlational Coefficients Matrix Among Variables in This Study.....	80
4-3. Full-Time LPN Respondent Demographics	82
4-4. Principal Component Analysis with Varimax Rotation	84
4-5. Comparison of Reliabilities by Factors (Cronbach's Alpha)	85
4-6. Descriptive Statistics of Attitudinal Variables	86
4-7. Statistically Significant Relationships Between the Continuous Demographics and Attitudinal Variables Using Ordinary Least Squares Techniques.....	86
4-8. Significant Difference of Attitudinal Variables by Gender Using ANOVA Techniques	87
4-9. Significant Difference of Attitudinal Variables by Married Using ANOVA Techniques.....	88
4-10. Significant Difference of Attitudinal Variables by Long-Term Relationship Using ANOVA Techniques	89
4-11. Significant Difference of Attitudinal Variables by Work Setting Category Using ANOVA Techniques.....	89
4-12. Significant Difference of Organizational Commitment by Organizational Trust Categories Using ANOVA Techniques	90
4-13. Significant Difference of Empowerment by Organizational Trust Categories Using ANOVA Techniques	91
4-14. Regression Model for Hypothesis 1	92
4-15. Contribution of Continuous Demographic Variables to Organizational Commitment.....	93
4-16. Regression Model for Hypothesis 2	94
4-17. Contribution of Organizational Conflict to Organizational Commitment.....	95
4-18. Regression Models for Hypothesis 4.....	97
4-19. Significant Contribution of Empowerment to Organizational Commitment	97
4-20. Significant Contribution of Empowerment Subcategories to Organizational Commitment.....	98
4-21. Regression Model for SEM for Hypothesis 5	101

4-22. Regression Model for Hypothesis 6	103
4-23. Regression SEM Model for Hypothesis 7	105
4-24. Estimated Regression Coefficients (β) from the Structural Model	107
4-25. Path Analysis Results: Estimated Regression Coefficients and Significance	109
5-1. Summary of Hypothesis Test Results.....	111
F-1. Contrast and Description of the Two Types of Entry-Level Licensed Nurses in the United States	152
H-1. National/State Demographic Data Combining Full- and Part-Time LPNs	157

LIST OF FIGURES

Figure

1-1. Conceptual Framework.....	5
4-1. Path Model of Organizational Commitment	108
5-1. Conceptual Framework.....	110
A-1. Conceptual Framework.....	140

CHAPTER 1

INTRODUCTION

Organizational commitment is a critical element of staff retention and highly associated with intent to leave and actual turnover (Larrabee et al., 2003; Perrow, 2000; Porter-O'Grady, 2001; Price, 2009; Price & Mueller, 1981; Stearns & D'Arcy, 2008; Wolf, Boland, & Aukerman, 1994). Organizational commitment is a major challenge for American healthcare systems (Karsh, Booske, & Sainfort, 2005; Wilke, 2008). The development and maintenance of an organizationally committed workforce is a major concern in particular among Licensed Practical Nursing (LPN) staff (Aiken & Patrician, 2000; Buccini & Ridings, 1994; Buerhaus, 1994; Eriksen et al., 1992; Kenney, 2001). As healthcare costs soar, LPNs are employed in nearly all sectors of the American healthcare system to perform common and predictable patient care at lower cost. As the geriatric population increases, LPN staffing needs will also increase; thus, the retention of LPNs will become paramount (Stone, 2007). Although turnover is a multi-stage process, low organizational commitment has been shown to have a strong and direct impact on intent to leave and actual turnover in many occupational and healthcare delivery groups. However, this relationship has not been well studied with LPNs (Allen, 2003; Castle, 2006; Lambert, Hogan, & Griffin, 2007; McClure et al., 1983; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002; Nelson, 2002; Liou & Cheng, 2008; Way et al., 2007).

The focus of this study is on organizational commitment among LPNs. It should be understood that in the United States, when an individual is referred to as a "nurse," he or she may be either a registered nurse (RN) or an LPN. To become an RN requires at a minimum a 2-year degree, referred to as an Associate Degree in Nursing (ADN) registered nursing degree, which is generally obtained from a community college. To become an LPN requires at minimum a 1-year degree, which is also generally obtained from a community college. RNs and LPNs work together to staff almost all healthcare

settings and both are referred to as “staff nurses.” Because of the increasing complexity of patient care, many entry-level RNs today elect to obtain a 4-year bachelor’s degree in nursing or a BSN degree. Although LPNs do not perform many of the higher level nursing skills that RNs perform, LPNs are used frequently to deliver basic nursing cares at lower costs. There are also numerous advanced practice RN roles, such as the nurse practitioner or nurse midwife. Advance practice RN roles usually require at minimum a 3-year master’s or a doctoral degree beyond the BSN degree.

Both LPNs and RNs are licensed nurses. The entry-level RN degree is either the BSN or the ADN degree, and both types of graduates must pass the same national registered nursing licensure exam (NCLEX-RN) to practice as an RN. Students entering an LPN educational program must have a high school diploma or equivalent and must pass the NCLEX-PN exam to practice as an LPN. The NCLEX-PN is written at an estimated 11th grade reading level (Woo, Wendt, & Liu, 2009). See Table F-1 in Appendix F for a chart further differentiating entry-level RNs and LPNs.

Across the United States, fewer LPNs are employed than RNs, but LPNs are a vital component of the current U.S. healthcare system. LPNs work in almost all healthcare settings, usually under the direct supervision of RNs. LPNs perform nursing cares that require critical thinking and assessment skills, yet they generally deliver cares that are considered lower risk. LPN cares tend to be more routine and predictable than those delivered by RNs (Aiken & Patrician, 2000; Sohn, 1991).

Certified nursing assistants (CNAs) are not licensed practitioners, but they are also increasingly used in U.S. healthcare settings. Nursing assistants are “certified” by completing a national nursing assistant certification exam. The educational preparation to become a CNA does not require a high school diploma and generally takes 6 to 8 weeks to complete at a community college, although some high schools also offer CNA education. CNA skills are very specific, low risk, and basic. Certified nursing assistants are supervised by both RNs and LPNs (Paquay et al., 2007).

States generally regulate the practice of nursing. Under state LPN Practice Acts, LPNs perform nursing cares that typically include giving injections, taking vital signs, performing basic diagnostic tests, observing patients, dressing wounds, and administering medications (Eriksen et al., 1992; Kenney, 2001). LPNs assist patients with the activities of daily living such as eating, dressing, exercising, and bathing. In most states, LPNs are not allowed to administer intravenous medications without further training and certification (Prevosto, 2001).

LPN educational programs blossomed in the post-World War II era when vast shortages of nurses plagued the nation. Although LPNs organized politically as the National Federation of Licensed Practical Nurses (NFLPN) as early as 1949, there is an absence of literature about the efficient utilization or retention of the contemporary licensed practical nurse. There also is little guidance about how to make effective use of these lower skilled nurses to enhance patient care and augment the RN workforce (Seago & Ash, 2002). Although LPNs may be used to augment the workforce during RN shortages, the role of LPNs is limited by each state's LPN Scope of Practice Act. During cycles of RN shortages in the U.S., there is typically a renewed interest in LPNs as potential workers to augment the RN workforce and as potential substitutes for RNs (Molzahn, 1992). In 1998, LPNs accounted for 39% of licensed nurses in hospitals and 46% of licensed nurses in long-term care settings (Bureau of Labor Statistics, 2002; Foster, 2001).

Reported annual turnover rates for LPNs in nursing homes average 32%, but relatively little is known about the current LPN workforce in the United States (Seago & Ash, 2002). Only one national survey of LPNs was identified, and it was conducted in 1983 (Bentley, Campbell, Cohen, McNeill, & Paul, 1984; Bureau of Labor Statistics, 2002; Kenney, 2001). Although demand for LPNs is growing, poor wages, mandatory overtime, physically demanding work, and controversy and stigma regarding their lesser nursing status are thought to contribute to high LPN turnover rates (Kenny, 2001; Stone,

2007). Over the next 15 years, as the baby boom generation ages and increasing numbers of nurses themselves near retirement, the demand for LPNs is projected to significantly outstrip supply (Barber, Bland, Langdon, & Michael, 2000; Buerhaus & Staiger, 1996; Eriksen et al., 1992). Thus, although organizational commitment and retention of LPNs are increasing concerns for the nation's healthcare system, no studies to date have explored the relationship of organizational conflict, trust, and empowerment to organizational commitment specifically among contemporary LPNs employed full time.

A major conditioning variable of organizational commitment among RNs and other healthcare personnel is empowerment (Curtin, 1994; Henkin & Marchiori, 2003; Larrabee et al., 2003; Laschinger, Finegan, Shamian, & Wilk, 2003; McClure & Hinshaw, 2007; Spreitzer, 1995a). Empowerment as a broad measure and concept contains both a macro focus of structural (contextual) conditions that enable empowerment and a micro focus on the psychological experience of empowerment at work. Empowerment has yet to be studied as a conditioning variable specifically among LPNs, although it has been studied in some staff nurse samples that combined RNs and LPNs (Laschinger & Wong, 1999). This study addresses this gap and examines the conditioning relationship of empowerment as well as organizational conflict and trust to organizational commitment specifically in an all LPN sample.

This study tests the following conceptual model (see Appendix A) by using data from surveys mailed to LPNs in one Midwestern state. In addition, it employs psychometrically valid tools to measure empowerment and organizational commitment. Data from this survey will provide a regional profile on the relationship of empowerment, organizational conflict, and trust to organizational commitment among LPNs. The conceptual model for this study examines the relationship between exogenous independent demographic variables and the work environment independent variables of conflict and trust. In addition, the model includes the mediating variable of empowerment and the outcome variable of organizational commitment. Although

reciprocal causal effects are possible, the preponderance of empirical research suggests that levels of organizational conflict, trust, and empowerment predict organizational commitment (Currivan, 1999; Kim, Price, Mueller, & Watson, 1996; Laschinger et al., 2003; Price & Mueller, 1981). The research questions in this study are derived from previous empirical studies that have shown this predictive relationship, but this is the first study to examine whether levels of organizational conflict, trust, and empowerment also predict organizational commitment among an all-LPN sample. Figure 1-1 illustrates the research variables explored in this study.

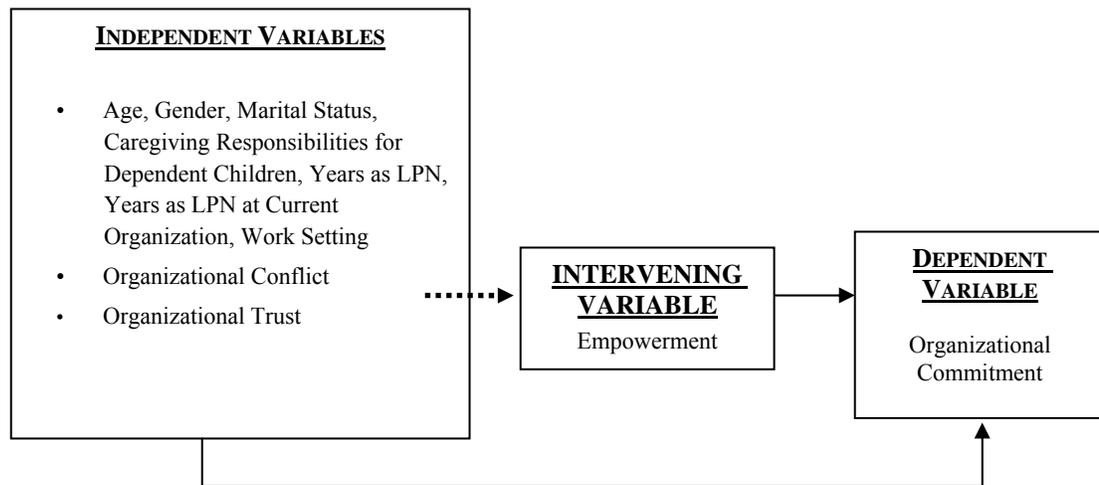


Figure 1-1. Conceptual Framework

Healthcare organizations are social institutions that depend on LPNs to provide direct service to patients. Shortages of LPNs reportedly have reached crisis levels, especially in long-term care environments (Kenney, 2001; Needleman et al., 2002). Retention of LPNs by the healthcare organizations that employ them is crucial to delivering future health care. One potential solution to the crisis is a better understanding of the major factors that are associated with or that modify organizational commitment specifically among LPNs. Research on organizational commitment is of importance to

healthcare agencies that strive for a competitive advantage. LPNs work long hours and experience frequent shift changes as well as other unique stressors, such as threats to personal safety. Work as an LPN requires autonomous, independent decision making in direct patient care, all for a modest amount of pay (Barber et al., 2000; Buerhaus & Staiger, 1996). The fact that many LPNs persist in healthcare agencies despite such hardships may be explained in part by the relationship of empowerment and organizational commitment. Empowerment is known to modify organizational commitment in RN samples, in mixed staff nurse samples including both RNs and LPNs, and in other occupational and allied healthcare delivery groups, but this relationship has not been studied among an all-LPN sample (Agho, Mueller, & Price, 1993; Anderson, Corazzini, & McDaniel, 2004; Curtin, 1994; Lambert et al., 2007; Larrabee et al., 2003; Laschinger & Finegan, 2008; McClure & Hinshaw, 2007; Price, 2009; Spreitzer, 1995a, 1995b; Squillace, Remsberg, Bercovitz, Rosenoff, & Branden, 2009; Wagner, 2007; Weiner & Vardi, 1980).

Empowerment mediates organizational commitment (Avolio, Zhu, Koh, & Bhatia, 2004; Koberg, Boss, Senjem, & Goodman, 1999; Liden, Wayne, & Sparrowe, 2000). Organizational commitment mediates intent to leave among RNs and in mixed staff nurse samples (Curtin, 1994; Lambert et al., 2007, Laschinger, Finegan, Shamian, & Casier, 2000; Price, 2009; Spreitzer, 1995a, 1995b; Wagner, 2007). Studies also show that empowerment is highly associated with transformational leadership style, trust, and conflict (Bess & Dee, 2007; Huber, 2000; Larrabee et al., 2003; Laschinger et al., 2003; Moye, 2003). However, full-time LPNs specifically are a relatively unstudied population. No empirical work exists that describes the relationship of empowerment, organizational trust, and conflict to organizational commitment in a large sample of contemporary LPNs employed full time (Schirm, Albanese, Garland, Gipson, & Blackmon, 2000).

Nationally, “magnet hospitals” employ this relationship between empowerment and organizational commitment and offer extensive RN internships to boost empowerment as a strategy to reinforce the organizational commitment and retention of RNs (Bhatnager, 2007; Brown, McWilliam, & Ward-Griffin, 2006; Butts, Vandenberg, DeJoy, Schaffer, & Wilson, 2009; McClure, Poulin, Sovie, & Wandelt, 1983; McClure & Hinshaw, 2007). To acquire a “magnet hospital” status, a hospital must apply for the magnet accreditation title and be found to possess the qualities of magnetism. Magnetism qualities include high-quality nursing leadership, participative organizational structure and management style, high-quality personnel policies and programs, professional models of nursing care, quality improvement programs, high-quality consultation and resources, staff nurse autonomy, community and the hospital nurses as teachers, satisfactory image of nursing, effective interdisciplinary relationships, and integrated professional development mechanisms (McClure & Hinshaw, 2007). Magnet hospitals encourage hiring mainly RNs as staff nurses. The magnet hospital accreditation literature maintains that LPNs have not received the leadership curriculum that magnet hospitals expect of all staff nurses (McClure & Hinshaw, 2007). Nonetheless, LPNs are still a vital component of the current U.S. healthcare system, and they are especially used in rural, non-acute, office, and long-term care settings. LPNs are used less frequently in hospitals because of increasing patient acuity levels, and LPNs are especially rare as staff nurses in magnet hospitals.

Organizational commitment is strongly associated with intent to stay (Price, 2009), quality (Curtin, 1994; McClure, 2005), and productivity in education, hospitals, and health education staff (Dee, Henkin, & Singleton, 2006; McNeese-Smith, 2001). Factors associated with organizational commitment have been studied in many healthcare settings and occupational groups such as assisted living (Sikorska-Simmons, 2006; 2008), counselors (Mitus, 2006), health profession faculty (Henkin & Marchiori, 2003), registered nurses and mixed staff nurse samples (Jalonen, Virtanen, Vahtera, Elovainio,

& Kivimaki, 2006; Liu, Chang, Li, Liao, & Lin, 2006; Lou et al., 2007; Wakefield et al., 1988), police and social workers (Lambert et al., 2007), professionals and non-professionals (Mathieu, Deshon, & Bergh, 2008), radiographers (Akroyd, Legg, Jackowski, & Adams, 2009), occupational therapists (Painter, Akroyd, Barefoot, Schemedeke, & Daniels, 2000), military (Allen, 2003), occupational groups (Mathieu & Zajac, 1990), and temporary workers (Chiu & Ng, 1999). Although organizational commitment has been studied among all these groups, it has yet to be studied in a large, strictly LPN sample.

Research describing conditioning variables and factors associated with organizational commitment among LPNs can enhance understanding of these relationships in the U.S. healthcare system. Although long-term care accreditation agencies require facilities to explore methods to increase LPN retention, few agencies have resources to engage in such research. National healthcare LPN staffing shortages and burgeoning geriatric populations leave most agencies struggling to maintain adequate LPN staff coverage (Anderson et al., 2004; Barber et al., 2000; Browne, 1997; Buerhaus & Staiger, 1996; Goodstein, 1983; Ingersoll, 1995; Kash, Castle, Naurai, & Hawes, 2006).

The body of research on organizational commitment is well established, and tools to measure organizational commitment are characterized by sound psychometric properties (Allen & Meyer, 1996; Mowday, 1998; Mowday, Steers & Porter, 1979). The literature contains several organizational commitment meta-analyses with evidence-based antecedents and consequences of commitment across occupational groups (Cohen, 1993; Mathieu, & Hamel, 1989; Mathieu & Zajac, 1990). Empirical research and structural models have shown that organizational commitment is tied to both direct and indirect predictors and is highly associated with intent to leave and actual turnover (Hinshaw, Gerber, Atwood, & Allen, 1983; Mobley, Griffeth, Hand, & Meglino, 1979; Parasuraman, 1989; Porter, Steers, Mowday, & Boulian, 1974; Price & Mueller, 1981;

Wagner, 2007). Larrabee et al. (2003) found robust predictability of organizational commitment on intent to leave and turnover among staff nurses. She found greater predictability of organizational commitment versus job satisfaction on intent to leave and actual turnover of staff nurses.

It cannot be assumed that factors associated with organizational commitment among RNs are the same for LPNs. The unique and limited job scope, context, culture, and work of LPNs suggest that different factors may be associated with organizational commitment. The etiology of organizational commitment depends on the nature of the job and the organizational context. Thus, job-specific research is needed with LPNs. Patients with chronic health issues or terminal illnesses are often dependent on LPN staff care for extended periods of time, frequently until death. Many patients cared for by LPNs are often physically and/or mentally disabled, requiring routine ongoing help with activities of daily living and creating incentives for continuity in care giving. A distinctive characteristic of the care delivered by LPNs is that it is frequently delivered to patients with terminal illnesses, chronic conditions, or severe disabilities, although some LPNs do practice in acute settings such as intensive care units (Ingersoll, 1995). Research on organizational commitment among LPNs could provide healthcare managers with insight on factors strongly associated with LPN organizational commitment, thus reducing turnover, cutting costs, and improving employee performance.

Empowerment among LPNs is also explored in this study. Empowerment appears to be important to commitment and is often targeted by organizations as a strategy for boosting retention (McClure, 2005). According to Lawler (1996), 70% of organizations use some kind of empowerment intervention with at least some of their workforce. However, no studies exist that specifically examine empowerment, organizational trust, and conflict in a structural model among LPNs.

There are two classic approaches to empowerment: a structural (macro contextual) focus and a psychological (micro) focus. Empowerment as a broad construct

and measure incorporates these two related dimensions. According to Kanter (1987), structural empowerment contains four core components: access to opportunity, information, support, and resources. Structural empowerment refers to the process through which leaders redistribute power and resources to lower levels in the organization. According to Spreitzer (1995b), the psychological empowerment dimension contains four core components: meaning, competence, self-determination, and impact. Empowerment as a psychological state refers to “a subjective state of mind where an employee perceives that he or she is exercising efficacious control over meaningful work” (Potterfield, 1998, p. 51).

Spreitzer’s (2007) conceptualization of psychological empowerment as an integrated set of cognitive states is used in this study. According to Spreitzer, psychological empowerment is not conceptualized as a gestalt but rather as an integrated set of cognitive states. Although Spreitzer (2007) argued that her tool has construct validity and generalizes across different work contexts, it has not been tested in a strictly LPN population. No universally accepted measure of the macro-level structural empowerment dimension exists; thus, Spreitzer’s (1995a) tool was used in this study to measure empowerment. Factor analysis was employed to explore the underlying factor structure among the LPN population. Factor loadings are presented along with a discussion of whether the loadings support measurement of only psychological empowerment.

Structural empowerment components supply subordinates with the ability to influence and share leadership. Structural empowerment is highly associated with psychological empowerment. Psychological empowerment is considered a mediator between structural empowerment (macro dimension) and organizational outcomes (Laschinger, Sabiston, & Kutzcher, 1997; Morgeson & Campion, 2003, Spreitzer, 2007). Spreitzer (2007) argued that psychological empowerment is increasingly cited as the explanation for how structural empowerment improves outcomes for the organization.

Research suggests that both structural and psychological empowerment are conditional variables that contribute to higher commitment to the organization (Avolio et al., 2004; Laschinger, Finegan, & Shamian 2001; Liden et al., 2000; Morgeson & Campion, 2003; Spreitzer, 2006; Thomas & Velthouse, 1990).

The macro structural empowerment dimension is difficult to define but is based on social exchange and social power theories. Kanter (1987) argued that the four structural empowerment “power tools” are access to opportunity, information, support, and resources. He stated that all employees may be empowered structurally in the organization if given the “power tools” that match their jobs. Structural empowerment involves arranging for power sharing between supervisors and subordinates so that decisions fit the scope and domain of their work (Spreitzer, 2007). Structurally, empowered organizations are seen as high-involvement organizations that do not employ top-down control systems (Bowen & Lawler, 2006). High-involvement systems involve five aspects: participative decision making, skill/knowledge-based pay, open flow of information, flat organizational structures, and training (Lawler, 1996). High-involvement systems increase the availability of Kanter’s “power tools.”

Bowen and Lawler (2006) argued that a marginal effect would occur if only some of the high-involvement aspects are employed. They suggested that it is key to employ all five of the high-involvement aspects to achieve Kanter’s structural empowerment “power-tool” components. Structural empowerment should be conceptualized as limited and organizationally centric because some structurally empowered employees still feel disempowered. This limitation led to the conceptualization of the second related dimension of empowerment: psychological empowerment. Conger and Kanungo (1988) reported that structural empowerment practices are ineffectual if the employee lacks a sense of self-efficacy and control. Thomas and Velthouse (1990) expanded on Conger and Kanungo’s ideas and argued that empowerment leads to increased task motivation.

Spreitzer (1995a, 1995b) has conducted the bulk of theoretical and empirical work on psychological empowerment. She referred to psychological empowerment not as a gestalt but as a set of psychological states required for people to feel a sense of control in their work. She conceptualized psychological empowerment as having four components: meaning, competence, self-determination, and impact. She found that psychologically empowered employees feel increased intrinsic work motivation and have a more proactive, rather than passive, orientation to their work roles (Spreitzer, 1996). Psychologically empowered individuals are more likely to feel that they make a difference in the work place (Locke, Schweiger, & Latham, 1986) and are able to participate in shaping the organizational system in which they are embedded (Kirkman & Rosen, 1999).

This study conceptualizes empowerment broadly. A complete conceptualization of empowerment must contain both dimensions because the structural dimension is organization-centric and the psychological dimension is individual-centric. Spreitzer (2007) argued that a complete understanding of empowerment at work requires the integration of both dimensions and that Kanter's core elements of structural empowerment are highly associated with psychological empowerment (Morgeson & Campion, 2003; Siu, Laschinger, & Vingilis, 2005). Spreitzer (2007) presented a comprehensive review of more than 20 years of research on empowerment at work. She maintained in this review that although a wide variety of methods are used to operationalize the macro-level structural empowerment dimension, psychological empowerment has consistently been found to be a mediator for commitment to the organization (Spreitzer, 2007). Spreitzer's (1995a) tool is used in this study to measure empowerment. For the first time, Research Questions 5 through 7 explore empowerment-mediated organizational commitment in an all LPN population.

The association of empowerment with organizational commitment has been studied in many occupational and professional groups but not in the LPN population

(Cohen, 1993; Mathieu & Zajac, 1990; Stearns & D'Arcy, 2008). Transformational leadership promotes empowerment and is known to increase organizational commitment and lower intent to leave among RNs and staff nurse samples; however, this has yet to be studied within a strictly LPN population (Leach, 2001). Further, workplace organizational variables such as moderate levels of conflict (Rahim, 1985), high degrees of input (Painter & Akroyd, 1998), respect (Mobley, 1977), access to training (Nelson, 2002), and trust (Moye, 2003) in the organization are also highly associated with both empowerment and organizational commitment across occupational groups, but again these relationships have not been studied with LPNs.

Trust is highly correlated with organizational commitment (Axelrod, 1984; Barber, 1983; Doney, Cannon, & Mullen, 1998; Good, 1988; Luhmann, 1979; Moye, 2003; Mishra, 1992; Zand, 1972) and is an antecedent of empowerment (Gomez & Rosen, 2001). Trust is critical for organizations and can take two forms: interpersonal and organizational. Interpersonal-level trust is the extent to which an employee expresses confidence in and is willing to act on the basis of the words, actions, and decisions of his or her administrator and/or co-workers (McAllister, 1995; Price & D'Aunno, 1988). Organizational trust may be defined as an employee's perception of the reliability of the systems in the organization (Moye, 2003; Sztompka, 1998; Tan & Tan, 2000).

Trust is essential in organizations because it enhances the open exchange of ideas, increases group cooperation, and moderates conflict (Cook & Wall, 1980). In high trust environments, the quality of information exchange leads to more effective organizational decisions (McAllister, 1995). Innovation is enhanced by trust, and environments with low levels of trust limit employee interactions and avert conflict (Hargreaves, 2002; Janssen, 2004). Organizational trust is linked to organizational commitment and lower levels of intent to leave (Cook & Wall, 1980). Trust is associated with empowerment, and these two variables together are linked to increased organizational commitment (Janssen, 2004; Spreitzer, 2007). This study focuses only on organizational trust because

the purpose for this research is to assess LPN commitment to the workplace. Research Question 3 explores for the first time whether organizational trust is associated with LPN organizational commitment, and Research Question 7 explores whether this relationship is mediated by empowerment.

For the purposes of this study, organizational trust is conceptualized as employees' perceptions of the reliability of the systems in the organization. Systems in the organization refer to the organization's policies, rules, regulations, and procedures. Organizational trust is used as an independent variable in this study because previous researchers have found it to be associated with organizational commitment (Moye, 2003). A seven-item sub-scale organizational trust tool, adapted from Butler (1991) by Moye (2003), is used to measure LPNs' organizational trust. This sub-scale and the measurement of organizational trust are further explored in Chapter 2.

All organizations experience conflict, and conflict is also highly associated with organizational commitment (Cox, 1998; Tschannen-Moran & Hoy, 2000). Thus, perceived conflict is also included as an independent variable in this study because organizational conflict is inevitable and is correlated with organizational commitment (Cox, 1998; Perrow, 1991; Wall & Callister, 1995).

Conflict has both positive and negative effects on organizations, but conflict-ridden work environments hinder empowerment (Coser, 1956; Singleton & Henkin, 1989). Although different levels of conflict exist, how the conflict is managed is key if leaders are to harness the productive functions of conflict (Coser, 1956; March & Simon, 1958). Conflict is positive when it allows for divergent thinking and is used to improve the quality of organizational decisions, but excessive conflict can decrease organizational commitment (Dee, 1999; Mintzberg, 1997). Suppressed conflict can be dysfunctional for organizations and is known to lower trust (Tschannen-Moran & Hoy, 2000). Janssen (2004) found that higher levels of conflict had a moderating effect on empowerment and a direct effect on employees' commitment to the organization. High levels of conflict are

impediments to organizational trust, empowerment, and organizational commitment (Rahim, 2002; Roy & Ghose, 1997).

Conflict in healthcare organizations often arises over the allocation of scarce resources. Undoubtedly, all LPNs encounter some levels of conflict in their organizations. Conflict is used as an independent variable in this study. The extent to which LPNs perceive the recurrence of conflict in their organizations is measured by a scale measuring Pondy's (1983) three general categories of organizational conflict: bargaining, bureaucratic, and lateral conflict. The preponderance of research indicates that high levels of conflict are associated with lower levels of organizational commitment (Cosser, 1956; Tschannen-Moran & Hoy, 2000). Research Question 2 explores whether high levels of organizational conflict are associated with lower organizational commitment in an LPN population. Research Question 6 explores if the relationship between conflict levels and organizational commitment is mediated by empowerment.

The seven independent demographic variables in this study are age, gender, marital status, caregiving responsibilities for dependent children, years as LPN, years as LPN at current organization, and work setting. These independent demographic variables were selected because meta-analytic studies have consistently found them to be highly associated with organizational commitment, especially among women (Mathieu et al., 2008; Mathieu & Zajac, 1990; Spreitzer & Mishra, 2002). Although males comprise a small yet growing proportion of the LPN workforce, the majority of LPNs are female. The variable identifying workplace setting is employed to provide information about the degree to which the respondent is employed by an organization characterized by hierarchical as opposed to flattened structures. Research Question 1 explores for the first time the association between the seven independent demographic variables (age, gender, marital status, caregiving responsibilities for dependent children, years as LPN, years as LPN at current organization, and work setting) and organizational commitment.

Research Question 5 further explores whether this relationship is mediated by empowerment.

Statement of the Problem

Organizational commitment has a strong association with intent to leave, employee retention, and job performance in many health professions (Hinshaw et al., 1983; Parasuraman, 1989; Porter et al, 1994; Price & Mueller, 1981); moreover, high levels of empowerment are known to increase organizational commitment (Larrabee et al., 2003). There is a lack of research specifically related to factors that predict or limit LPNs' commitment to the organization. Such evidence might offer managers insight into strategies for practices to improve LPN staff retention, job satisfaction, and performance. This study addresses this gap in the research by examining the relationships of empowerment, organizational conflict, and trust specifically to organizational commitment among LPN staff.

Significance of the Study

A CINAHL, MEDLINE, ERIC, PROQUEST, Journals@OVID, PubMed, PsychINFO, Health and Psychosocial Instruments (HAPI) and COCHRANE search from 1988 to 2010 indicated there were no research articles related specifically to the path relationship of organizational trust, organizational conflict, empowerment, and organizational commitment among LPNs. There were studies that demonstrated the association of empowerment and selective intrinsic and extrinsic work rewards with organizational commitment in RNs and mixed staff nurse groups working in hospital-based, long-term care, and assisted living settings, but these relationships have not been studied specifically among LPNs (Jalonen et al., 2006; Lou et al. 2007; Parasuraman & Nachman, 1987; Wakefield et al., 1988). In light of the national LPN staffing shortage and the gap in this body of research, more empirical research is needed to better understand factors associated with LPN organizational commitment.

Data obtained from mailed surveys to LPNs in one state using instruments with known psychometrics were used to study the relationship of empowerment, conflict, and trust to organizational commitment among LPNs. This information was used to test the conceptual model in a large sample of contemporary LPNs who are employed full time. The conceptual framework in Appendix A illustrates the components of the study.

Research Questions

The following research questions were addressed in an LPN population:

Research Question 1: Will organizational commitment be affected by age, gender, marital status, caregiving responsibilities for dependent children, years as LPN, years as LPN at current organization and work setting in an LPN population?

Research Question 2: Will higher levels of organizational conflict be associated with lower levels of organizational commitment at the current organization and work setting in an LPN population?

Research Question 3: Will higher levels of organizational trust be associated with higher levels of organizational commitment at the current organization and work setting in an LPN population?

Research Question 4: Will higher levels of empowerment be associated with higher levels of organizational commitment at the current organization and work setting in an LPN population?

Research Question 5: Will the relationship between empowerment and organizational commitment be influenced by employee demographic variables (age, gender, marital status, caregiving responsibilities for dependent children, years as LPN, years as LPN at current organization and work setting) at current work setting and organization in an LPN population?

Research Question 6: Will the relationship between empowerment and organizational commitment be influenced by organizational conflict at current work setting and organization in an LPN population?

Research Question 7: Will the relationship between empowerment and organizational commitment be influenced by organizational trust at current work setting and organization in an LPN population?

Definition of Terms

For the purpose of this study, the following definitions are employed:

Organizational commitment is defined as “the relative strength of an individual’s identification with and involvement in a particular organization” (Mowday, 1998, p. 387). It is further conceptualized by the following three factors: “a) a strong belief in and acceptance of the organization’s goals and values; b) a willingness to exert considerable effort on behalf of the organization; c) a definite desire to maintain organizational membership” (Porter et al., 1974, p. 604).

Empowerment is a broad construct and measure with both structural and psychological dimensions. Empowerment is defined as “a process of enhancing feelings of self-efficacy among organizational members through the identification of conditions that foster powerlessness and through their removal by both formal organizational practices and informal techniques of providing efficacy information” (Conger & Kanungo, 1988, p. 474). The four components of the psychological empowerment dimension in this study are conceptualized as meaning, competence, self-determination, and impact (Spreitzer, 1997). The four components of the structural empowerment dimension in this study are conceptualized as access to opportunity, information, support, and resources (Kanter, 1987).

Organizational trust is “an employee’s perception about the reliability of the systems in the organization” (Moye, 2003, p. 7). It is defined as an employee’s

perception that the rules, regulations, policies, and procedures of the organization are reliable, consistent, and fair (McKnight, Cummings, & Chervany, 1998).

Conflict in the organization is defined as the perceived extent that a mental struggle resulting from incompatible or opposing needs between supervisors and/or subordinates is recurring (Pondy, 1983). Organizational conflict is defined as “an expressed struggle between at least two interdependent parties who perceive incompatible goals, scarce resources and interference from others in achieving their goals” (Wilmot & Hocker, 2001, p. 23).

Licensed Practical Nurse (LPN) is a nurse who has completed an LPN educational program and passed the national licensure exam NCLEX-PN.

Limitations of the Study

This study has several limitations. The first is associated with the methodology. Survey research instruments delimit response options in contrast with open-ended interview techniques. Although the surveys employed in this study have sound psychometric characteristics, the number of surveys returned by respondents may limit analysis due to factors associated with non-response bias (Dillman, 2009).

Second, this study uses multiple regressions and path analysis to discover whether empowerment mediates organizational commitment. The statistics to test the hypotheses are limited to descriptions of correlational rather than causal relationships among variables involved. Multiple regression and path analysis are widely used approaches to determine the direct and indirect effects of independent variables on a dependent variable.

Another limitation of this study is that organizational commitment, empowerment, organizational trust, and conflict are considered large multidimensional constructs dependent on multiple factors that make them difficult to define precisely or to measure. The organizational commitment tool developed by Mowday et al. (1979) is widely used and well regarded by researchers interested in organizational commitment.

There is no broadly accepted measure of the macro-level structural dimension of empowerment. Therefore, the empowerment tool developed by Spreitzer (1995a, 1995b), which is widely used and regarded by researchers interested in empowerment, was chosen for this study. The validity of Spreitzer's tool is explored in this study by confirmatory factor analysis among an LPN population for the first time.

Finally, there are limitations of a regression model in terms of the data generated for this research. This will be discussed in Chapter 3. Some discussion will address issues of generalizability of the model to other samples. Other limiting factors may include residuals and errors as well as multicollinearity between the variables in the regression model and homoscedasticity.

Despite these limitations, more descriptive empirical research is needed to better understand factors directly and indirectly associated with LPN organizational commitment. This is the first study to provide a regional profile of a large population of contemporary full-time LPNs describing the relationships of empowerment, organizational conflict, and trust to organizational commitment among those LPNs. This study is important given the nationwide shortages of LPNs, a critical component of the current U.S. healthcare workforce, and may contribute to approaches that address staffing shortages of LPNs.

CHAPTER 2

REVIEW OF THE LITERATURE AND CONCEPTUAL FRAMEWORK FOR THE STUDY

Introduction

The purpose of this chapter is to review the literature on the two major concepts in this study, organizational commitment and empowerment. For each concept, this review will begin with a brief discussion of the conceptual origins, definitions, and measures. This is followed by an overview of research, previous definitions, and major researchers who frame current understanding. This chapter ends with a review of these concepts as applied in the literature and research on nursing, allied healthcare workers, certified nursing assistants, and licensed practical nurses (LPNs). This chapter concludes with a review of the literature on the two independent variables of organizational trust and conflict as well as the independent demographic variables.

Organizational Commitment: Conceptual Origins, Definitions, and Measures (Outcome Variable)

The focus of this study is on organizational commitment. Organizational research dates back to the 1950s. Organizational theorists including Becker (1960), Etzioni (1965), Kanter (1968), and Saunders (1956) produced seminal research on the concept of organizational commitment. These studies all suggested that organizational commitment is a large multivariate construct. Although it may elude precise definition, organizational commitment has been shown to be important to improving organizational effectiveness and retention.

More recently, organizational commitment has been studied with respect to other concepts such as careers, organizations, norms, identification, morals, work, job involvement, security “side-bets,” affect, psychological ownership, and so forth (Pierce & Geyer, 1991; Porter et al., 1974; Powell & Meyer, 2004; Liou & Cheng, 2008; Wagner, 2007). The majority of research in this area has been derived from the perspectives of

organizational psychology and sociology and has focused on retention and turnover (Mathieu & Zajac, 1990; Mowday et al., 1979; Price & Mueller, 1981).

Two distinct perspectives on the concept of organizational commitment have emerged: behavioral (Alutto, Hrbiniak, & Alonso, 1973; Blau, Surges, & Ward-Cook, 2003) and attitudinal (Etzioni, 1965; Kanter, 1968). Mowday et al. (1979) defined organizational commitment primarily in terms of an attitudinal approach. From their perspective, organizational commitment is “the relative strength of an individual’s identification with and involvement in a particular organization that is characterized by three factors: 1) a strong belief in and acceptance of the organization’s goals and values, 2) a willingness to exert considerable effort on behalf of the organization, and 3) a strong desire to maintain membership in the organization” (p. 226). These authors contended that their definition does not exclude the possibility that a person is committed to other aspects of the environment, such as family and friends, nor does it mean that an individual will display all three of these attributes (Zangaro, 2001). Weiner and Vardi (1980) viewed the concept more from a behavioral perspective and referred to organizational commitment as one’s persistence in making sacrifices for the good of the organization. Organizational commitment from a behavioral perspective describes a person’s preoccupation with the organization as evidenced by personal time devoted to organizational activities. More generally an employee displaying less of these attitudinal or behavioral attributes in terms of his or her employing organization may be more likely to leave and be at greater risk of turnover (Price, 2009).

Etzioni (1965) suggested that there are three types of organizational commitment: moral, calculative, and alienative. These three coincide with an employee’s response to organizational power and describe an individual’s attachment to an organization. Moral commitment is seen as a positive orientation in which an employee exhibits value-based affirmation. Calculative commitment is often viewed in negative terms based on the employee’s assessment that the costs of leaving outweigh those of staying. Alienative

commitment takes the form of employee commitment based on perceived force and lack of control or options, as for example a prison experience (Etzioni, 1965). Penley and Gould (1988) extended the concept by describing organizational commitment as either instrumental or affective. Instrumental commitment incorporates the idea of the rewards that an individual perceives he or she may derive from attachment to the organization. Affective commitment incorporates the employee's emotional attachment and a sense of obligation to the organization; the latter includes moral obligations. Employees often exhibit some combination of these commitment types. Some studies measure only affective commitment because it is believed to be the type of organizational commitment most closely linked to turnover. Coyle-Shapiro and Morrow (2006) argued that affective commitment is best explained by social exchange theory, which provides a basis for understanding commitment in its different forms.

Allen and Meyer (1996) presented organizational commitment as multidimensional and containing affective, continuance, and normative components. Their conceptualization suggested that employees either “want to,” “need to,” or “feel they should” remain in an organization (Meyer & Allen, 1997). They conceptualized organizational commitment as a three-dimensional model, with each dimension describing a core aspect of organizational commitment. Affective commitment involves the emotional (Kanter, 1968) or attitudinal (Sheldon, Turban, Brown, Barrick, & Judge, 2003) attachment of people to the organization. Continuance commitment is related to a balancing of the costs of leaving an organization and the benefits of staying. This component matches Becker's side-bet theory (Becker, 1960; Kanter, 1968). Normative commitment is related to internalized pressures to act in ways that comport with organizational goals and interests. This component suggests that employees feel a moral need to stay in the organization. Meyer and Allen (1997) argued that these dimensions capture different aspects of the multifaceted construct of organizational commitment and that the gestalt of commitment emerges.

Loyalty is related to commitment although it is usually considered to be one sided. Loyalty does involve the feeling of attachment but does not assume that both sides are loyal (Zangaro, 2001). Motivation is related to commitment but it also involves self-gratification. When goals are met, the motivation can stop. Motivation is similar to the more calculative forms of commitment; motivation to commit is based on a calculation that no better options exist.

Some theorists suggest that bi-directional communication is an essential component in developing organizational commitment among staff (Price & Mueller, 1981; Wagner, 2007). Satisfaction with communication with one's supervisor is also related to moral forms of commitment (Jernigan & Beggs, 2005). Here the organization is seen as understanding the needs, goals, and values of the employee while the employee views himself as understanding the needs, goals, and values of the organization. According to Moye (2003), organizations characterized by open communication tend to be innovative and demonstrate high levels of collaboration and trust. Open communication is seen as an integrative mechanism that strengthens commitment to the organization. Work is viewed as a trade between effort and loyalty in exchange for material and social rewards (March & Simon, 1958; Mowday, 1998).

Employees' perceptions of an organization's commitment and support for them are viewed as an antecedent to their commitment to the organization (Eisenberger, Huntington, Hutchison, & Sowa, 1986). Hutchison and Garstka (1996) suggested that employees' commitment to the organization is based, in part, on their perception of the organization. Several studies have shown a positive relationship between perceived organizational support and organizational commitment (Hutchinson, 1996) and affective commitment (Eisenberger, Fasolo, & Davis-LaMastro, 1990; Shore & Wayne, 1993). When behaviors are rewarded with treatment that indicates to the employee that she or he is valued by the organization, commitment is strengthened. Perceived organizational support is distinguishable from organizational support (Mowday et al., 1979). According

to Hutchinson (1996), organizational commitment can be viewed in the context of social exchange theory with communication and perceived organizational support as key components in the commitment process. He found that although individual attachment to the organization is a common theme in organizational research, an employee's perception of reciprocity (i.e., the organizations commitment to him or her) is a core component in the formation of organizational commitment. Hutchinson (1996) argued that administrators must communicate commitment to their employees as an antecedent to employee perceptions of administrator support and commitment.

According to the literature, antecedents of organizational commitment include personal characteristics, work experiences, and job characteristics. Communication is a theme among many of these antecedents. According to Zangaro (2001), "when an organization communicates honestly and openly, builds a trusting relationship, and offers a sense of belonging to an employee, the organization will increase the likelihood of retaining a morally committed employee" (p. 14). Consequences of organizational commitment include lower levels of intent to leave, increased retention, better attendance, and higher job productivity (McNeese-Smith, 1995; Price, 2009).

There are numerous studies on factors associated with organizational commitment. For example, distributive and procedural justice as well as conflict and trust are linked to organizational commitment (Lambert et al., 2007; Moye, 2003). Organizational commitment is also influenced by culture, gender, group diversity, commitment profiles, and organizational information (Cohen, 1992). Management communication, opportunity for learning, and work schedule flexibility are also associated with organizational commitment (Wilson & Laschinger, 1994). According to Zangaro (2001), organizational culture, leadership styles, and personality type preferences by an organization all impact organizational commitment as evidenced by the organization's philosophy and criteria for hiring.

Mathieu and Hamel (1989) stated that organizational commitment is a large multivariate construct containing many components and types of commitment. They reported that commitment can be usefully dismantled to reflect multiple commitments and that understanding of organizational commitment globally may be enhanced by attention to its multiple commitment components. They also noted that the organization is made up of various groups and that each employee will have a different conceptualization of the organization based on their group affiliation. This also impacts the degree of psychological attachment felt by employees. This is important because aspects of psychological attachment are believed to be linked to affective commitment (Meyer & Allen, 1997).

Mathieu and Zajac (1990) suggested that more research should be done to identify moderator variables linking commitment and its antecedents. The current study adds to the body of knowledge on moderator variables, specifically empowerment, as a link between antecedents and organizational commitment among LPNs. This is the initial study to explore empowerment as a moderator variable to workplace commitment in an LPN population. Research Questions 5, 6, and 7 explore empowerment as a moderator variable in the relationship linking commitment and its antecedents.

According to Hutchison and Garstka (1996), perceived organizational support moderates organizational commitment. They reported that actions taken by the organization modify actions taken by the employee. For example, policies such as allowing employees to participate in the decision-making process signal acceptance of the employees and appreciation of their contributions to the organization. They suggested that employees' perceptions of these actions by the organization mediates their commitment to the organization.

The literature contains several meta-analyses on organizational commitment that review the evidenced-based antecedents, correlates, and consequences of organizational commitment. These meta-analyses were used in this study to select independent,

conditioning, and demographic variables (Cohen, 1992, 1993; Mathieu & Hamel, 1989; Mathieu & Zajac, 1990).

According to the meta-analysis by Mathieu and Zajac (1990), the antecedent with the strongest weighted correlation to organizational commitment is perceived personal competence. The current study explores competence as a moderator variable. More specifically, competence is measured by using a subscale component of Spreitzer's (1995) empowerment scale. Mathieu and Zajac (1990) described other highly correlated antecedents including overall motivation, internal motivation, job involvement, overall job satisfaction, and the work itself. Wagner (2007) focused on consequences and found intent to search and intent to leave as most strongly associated with organizational commitment. Authors in both studies indicated that more empirically generated causal models are needed to explore endogenous and mediating variables on commitment to the organization and that such studies would help describe moderating relationships involving organizational commitment among various groups. They stated that such research would advance understanding of how organizational commitment actually influences employees' work behaviors. The meta-analysis by Mathieu and Zajac (1990) did not include age and tenure, which have been shown in other meta-analyses to increase organizational commitment. Further, they failed to address educational attainment, which has also been shown in other meta-analyses to decrease organizational commitment (Cohen, 1992).

The meta-analysis by Mathieu and Zajac (1990) is regarded as a high-quality meta-analysis among contemporary organizational commitment theorists (Price, 2009). In this meta-analysis, age, gender, marital status, number of children, and organizational tenure accounted for a large amount of variance in organizational commitment. Thus, these variables were selected as demographic independent variables for the current study. Respondent caregiving responsibility

for dependent children is also an independent demographic variable in this study because dependent children are highly associated with organizational commitment among women. This is important given that most LPNs are female (Mathieu & Zajac, 1990). Research Question 1 explores the direct association of these demographic variables with organizational commitment. Prior to path analysis, the relationship of the demographic variables to the mediator variable, empowerment, was explored. Question 5 explores empowerment as a mediator variable. This will be the first study to explore these relationships in an LPN population.

Cohen (1992) also conducted an organizational commitment meta-analysis for professional and non-professional groups. For professional groups, defined as employees with white collar jobs, he found the strongest weighted correlation coefficients among total motivation, role ambiguity, autonomy, centralization, communication, professional commitment, job involvement, and income. For blue collar and nonprofessional groups, defined as lower status occupations, Cohen found the strongest weighted correlation coefficients among age, total motivation, job involvement, marital status, role ambiguity, and leader consideration. LPNs are considered technical para-professional staff.

The two independent exogenous variables of conflict and trust were selected for this study because there is growing understanding that organizational conflict and trust account for a large amount of variance in organizational commitment (Bess & Dee, 2007; Callister & Wall, 2001; Moye & Henkin, 2006). This is the first study to explore these variables specifically among LPNs. Research Questions 2 and 3 explore the direct relationship between organizational conflict and trust to organizational commitment. Further, the influence of organizational conflict and trust on empowerment was determined prior to employing path analysis to answer Research Questions 6 and 7, which explore empowerment as a mediator variable in the proposed conceptual framework in an LPN population for the first time (see Figure A-1, Appendix A).

Definition of Organizational Commitment

Mowday et al.'s (1979) definition of organizational commitment is used for this study. They defined organizational commitment as “the relative strength of an individual’s identification with and involvement in a particular organization that is characterized by three factors: (a) a strong belief in and acceptance of the organization’s goals and values, (b) a willingness to exert considerable effort on behalf of the organization, and (c) a strong desire to maintain membership in the organization” (p. 226).

Measures of Organizational Commitment

Historically, most organizational commitment tools sought to measure organizational commitment from an attitudinal perspective as opposed to a behavioral perspective. Most early measures consisted of two- to four-item scales, created on an a priori basis, for which little or no validity and reliability data were presented. For example Grusky's (1966) scale used four items: company seniority, identification with the company, attitudes toward company administrators, and general attitudes toward the company. The median intercorrelation between the items was $r = .15$. Hrebiniak and Alutto (1972) developed a four-item scale to describe what it would take for the employee to leave the organization. Spearman-Brown reliability was reported as .79 but no further validity or reliability data were presented. Similar procedures were used by Brown (1996), Buchanan (1965), Gouldner (1958), Hall, Schneider, and Nygren (1970), Lee (1988), and Sheldon et al. (2003). Kanter (1968) used a 36-item scale but did not report validity or reliability. Gechman and Weiner (1975) asked employees to keep diaries of voluntary work-related activities on personal time and used decoding procedure to estimate organizational commitment.

Mowday et al. (1979) completed extensive empirical work on developing tools to measure organizational commitment, specifically the Organizational Commitment Questionnaire (OCQ). The OCQ consists of 15 items that assess the three components of

the authors' definition of commitment. Their tool employs a 7-point Likert scale for each item. Responses to each are summed and divided by 15 to arrive at a summary indicator of employee commitment. Several items are negatively phrased and reverse scored in an effort to reduce response bias. The authors contended that the OCQ was appropriate for most working populations although it has not been studied among LPNs. To determine psychometrics for their tool, Mowday et al. (1979) employed a validation strategy that included the use of multiple and diverse samples. They argued that if a general measure of commitment were to be achieved, it was necessary to collect validity and reliability data for various types of employees in different work environments and that cross-validation should be as complete as possible (p. 226).

A detailed review of the psychometric properties of the OCQ is presented in Mowday et al. (1979). In summary, their tool was administered to 2563 employees working in a wide variety of jobs in nine different public and private work organizations. A broad range of both job classifications and work organizations was used to capture a representative sample of the working population. A variety of analyses were carried out using the OCQ across several samples. The research focused on providing information pertinent to the following psychometric properties of the OCQ instrument: (a) means and standard deviations, (b) internal consistency reliability, (c) test-retest reliability, (d) convergent validity, (e) discriminant validity, and (f) norms. The psychometrics of the OCQ will be fully discussed in Chapter 3.

Meyer and Allen (1997) developed a tool to measure affective, continuance, and normative commitment to the organization. Their continuance scale has been used in numerous organizational commitment studies, but there are growing concerns related to the psychometrics of the tool. In particular, the continuance scale has not been found to fit the data in many studies (Henkin & Marchiori, 2003; Meyer & Allen, 1997; Swailes, 2004). Two other studies also found no relationship between continuance commitment

and performance (Cohen, 1996; Meyer & Allen, 1997). Meyer and Allen's tool was not selected for this study because of psychometric concerns (Swales, 2004).

The organizational commitment questionnaire (OCQ) developed by Mowday et al. (1979) used 15 items to assess organizational commitment and was employed in this study. This tool is most widely used in the organizational commitment literature and has the strongest psychometric evidence of validity and reliability across occupations and settings.

Organizational Commitment in Health Care Workers

Nursing Organizational Commitment

Studies: RNs and "Staff Nurse"

Samples of Combined LPNs and RNs

Interest in issues related to organizational commitment in nursing began to appear in the nursing literature over three decades ago (Zangaro, 2001). Early empirical studies consisted primarily of descriptive correlational studies, whereas later studies used more sophisticated tools and designs to explore the role of mediating variables in the link between antecedents and outcomes of organizational commitment among staff nurses. Although some nursing organizational commitment studies specifically explored commitment among RNs only, many studies used "staff nurse" samples that combined RNs and LPNs. Few studies exist regarding factors associated only with LPN organizational commitment, and no studies to date have specifically explored the proposed path relationship of organizational trust, conflict, and empowerment to organizational commitment among only LPNs.

Most early nursing organizational commitment studies of the 1970s focused on correlations between organizational commitment and related concepts such as staff nurse turnover and job satisfaction. The other primary foci of the early studies consisted of describing antecedents and consequences of organizational commitment among staff nurses. For example Steers (1977) found in a descriptive correlation study that tenure and

age were key antecedents and job satisfaction a key outcome of organizational commitment among a mixed staff nurse sample of RNs and LPNs. Organizational commitment tool development also marked this early period of research. Mowday et al. (1979) explored the construct validity of their organizational commitment measure. They tested their tool in a large sample of staff nurses and found key differences between sexes with regard to demographic data correlated with organizational commitment. For example, they found flexible schedules to be highly associated with organizational commitment among female staff nurses. Age, education, and autonomy were found to be key antecedents of commitment in other staff nurse commitment studies in this era (Slavitt, Stamps, Piedmont, & Haase, 1978). The association between RNs' relationship with their supervisors and organizational commitment was a focus of early commitment studies among new registered nurses (Cronin-Stubbs, 1977). The association of job satisfaction and organizational commitment among staff nurses was also explored in this decade (Annandale-Streiner, 1979, Cronin-Stubbs, 1977).

Organizational commitment studies in nursing during the 1980s continued to focus on the relationship of organizational commitment and related concepts such as turnover and job satisfaction, but professionalism was often added and explored as a predictor of commitment and intent to leave among staff nurses. In addition to the focus on educational preparation, professionalism as a predictor of organizational commitment appeared in several studies in this decade using RN-only samples. For example, a registered nurse's educational degree was often used as a proxy for professionalism, and many RN studies looked at whether RNs with associate, baccalaureate, or diploma degrees displayed more professionalism and whether educational level and professionalism predicted RN commitment to the organization (Burton & Burton, 1982; McCloskey & McCain, 1987; Price & Mueller, 1981).

The 1980s continued to focus on describing key antecedents and consequences of organizational commitment among staff nurses, but conceptual clarity issues continued

and many studies referred to job satisfaction and organizational commitment as conceptually synonymous. Key studies in this decade focused on staff nurse job and demographic characteristics and their relationships to job satisfaction and organizational commitment. For example, the association of job (e.g., participative leadership) and personal characteristics (e.g., age and job tenure) to commitment in nursing was increasingly explored. Unique variables such as staff nurse role conflict (Geiger & Davit, 1988), autonomy specifically among RNs (Munro, 1983), role ambiguity among staff nurses (Bacharach, Bamberger, & Conley, 1990), and staff nurse burnout (Leiter & Maslach, 1988) were identified as job and personal characteristics highly associated with organizational commitment among staff nurse samples. Empirical studies exploring workplace aspects associated with commitment among nurses grew in this decade. For example, work climates high in responsibility, warmth, and support were identified as associated with organizational commitment among staff nurses (Burton & Burton, 1982; Huey & Hartley, 1988).

Organizational commitment research among staff nurses grew in sophistication from 1990 to the present. Because of the difficulty of exploring organizational commitment through experimental designs, multivariate designs were increasingly employed in this era to explore structural causal models and mediating variables in the link between organizational commitment among staff nurses (Daly, 2005). In addition, more nursing organizational commitment studies used exclusively RN samples rather than mixed LPN and RN “staff nurse” samples. RNs in specific role categories, such as intensive care nurses and nursing management nurses, were explored for factors linked with organizational commitment among specific RN roles categories. For example, autonomy and professionalism were found to be highly linked to organizational commitment specifically among intensive care RNs (Boyle, Bott, Hansen, Woods, & Taunton, 1999). Nurse manager style, high nurse autonomy, participative management processes, and empowerment were a focus of many organizational commitment studies of

this era using both mixed staff nurse samples and among specific RN samples (Finegan & Laschinger, 2001; Larrabee et al., 2003; Lucas, Atwood, & Hagaman, 1993; Wagner, 2007; Wakefield et al., 1988; Zangaro, 2001). Guerney, Mueller, and Price (1997) explored organizational commitment for the first time specifically among RNs holding doctoral degrees and found RNs with doctoral degrees in nursing associated with higher organizational commitment than nurses with doctoral degrees in other fields. Sophisticated tools and advanced concept analysis techniques were also used to more clearly differentiate organizational commitment from related topics such as job satisfaction and intent to leave or stay (Allen & Meyer, 1996; Brierley, 1996; Kacmar & Carlson 1999; Swailes, 2004; Tang, 2003; Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2005).

Several key empirical nursing studies in the contemporary era present sophisticated structural models for organizational commitment among staff nurses that included mixed RN and LPN samples. For example, Price (2009) used a structural model and found career choice and generational issues to be a critical component of organizational commitment and retention, with significant implications in regard to person-environment fit and organizational commitment. Price argued that early nursing organizational theorists did not capture the unique characteristics of the contemporary and upcoming generational staff nurse cohorts and that multivariate influences impacted nursing career and staff nurse organizational commitment.

Numerous contemporary studies have continued to focus on and confirm the strong association of participative and transformational leadership style to organizational commitment in both mixed staff nurse and RN samples (Lucas et al., 1993; Tang, 2003). The following variables continue to show strong correlations to organizational commitment among RN and mixed staff nurse samples: participative leadership style, empowerment, home and family needs, learning opportunities, job satisfaction, retirement and monetary benefits, patient care delivery mode, unit cultural factors, and

relationship with supervisor and co-workers (Chen & Francesco, 2000; Fang, 2001; McNeese-Smith, 1995, 2001; Price & Mueller, 1981; Steinhaus, 1993; Wagner, 2007).

Contemporary studies have continued to focus on and confirm both structural and psychological empowerment dimensions as highly associated with organizational commitment among both RNs and staff nurse samples. Along with the growing use of international nurses to staff U.S. hospitals, several contemporary organizational studies focus on factors associated with organizational commitment among international nurses in the contemporary era (Fang, 2001; Laschinger et al., 2003; Laschinger, Wong, & Greco, 2006; Pearson & Chong, 1997). However, no nursing studies in the contemporary era have specifically used only LPN samples to explore the proposed path relationship of empowerment, organizational trust, and conflict to organizational commitment among LPNs. Although Laschinger et al. (2003) have published the bulk of the research on the relationship of empowerment dimensions and organizational commitment among staff nurses, they have generally used mixed staff nurse or RN samples and have not explored empowerment specifically among LPN-only samples in their studies.

In 2007, Wagner published an extensive literature review on nursing organizational commitment and identified it as an important predictor of turnover and its antecedents, including intent to leave. Wagner argued that organizational commitment is now considered a known predictor variable in decisions to leave a job and actual turnover among nurses. According to Wagner (2007), organizational commitment should be employed routinely in nursing turnover research studies despite inconsistent findings in prior research on nursing turnover. Wagner's (2007) in-depth literature review offers the most current study on organizational commitment and turnover in nursing, but again, no studies in the contemporary era have specifically explored LPNs organizational commitment; therefore, little is known about factors linked with organizational commitment among nurses with narrower job scopes than RNs (Parry, 2008).

Wagner (2007) pointed out that early research on staff nurses suggested that organizational commitment indirectly influences turnover through its direct effect on antecedents of turnover, such as intent to leave (Curry et al., 1986; Parasuraman, 1989; Price & Mueller, 1981). Price and Mueller initially ignored but later confirmed the relationship between organizational commitment and turnover (Curry et al., 1986; Hinshaw et al., 1983). Contemporary studies have continued to report a statistically significant relationship between organizational commitment and turnover behavior in staff nurse populations (Currivan, 1999; Holtom & O'Neill, 2004). These studies confirm the multidimensional nature of the concept of organizational commitment (McCloskey & McCain, 1987; Porter, Crampon, & Smith, 1976).

Wagner (2007), however, reported that there continues to be a gap in contemporary professional nursing organizational commitment literature regarding key mediating variables but argued that length of employment has consistently been noted as a key moderating variable in organizational commitment among staff nurses. Positive organizational culture and clinical manager organizational commitment have also consistently been found as key mediating variables in staff nursing organizational commitment (Way et al., 2007). Studies show that staff nurses tend to have variable career needs at different career stages and that a gap between career needs and career development programs mediates a decline in nurses' organizational commitment (Chan, 2004).

Current staff nurse studies continue to focus on whether various forms of commitment have differing antecedents and consequences. For example, McNeese-Smith (1995; 2001) looked specifically at RN organizational commitment in forms tied to job satisfaction, productivity, and management behavior. Wilson and Laschinger (1994) suggested that many nurse researchers have looked at factors related to commitment, but few studies have tried to evaluate forms of commitment among different levels of nurses or the factors that contribute to the various commitment forms.

Organizational commitment is a broad construct and difficult to define precisely. Few experimental designs have been employed to study organizational commitment among nurses (Wagner, 2007). Numerous contemporary causal models and multivariate designs have produced consistent evidence-based information regarding key antecedents and outcomes associated with organizational commitment among RN and mixed staff nurse samples. Age, tenure, role conflict, relationships with coworkers and supervisors, and structural components that lead to greater autonomy and empowerment have the most evidence as being highly associated with organizational commitment among RNs and mixed RN and LPN staff nurse samples (Fang, 2001; Laschinger, Finegan, & Shamian, 2001; McNeese-Smith, 2001; Price & Mueller, 1981; Steinhaus, 1992; Wagner, 2007),

Contemporary studies also have clearly shown a strong mediating link between structural and psychological empowerment dimensions and organizational commitment among RNs (Laschinger, Finegan, & Shamian, 2001; Manion, 2004; Porter-O'Grady, 2004; Spreitzer, 1995; Wagner, 2007). McClure and Hinshaw (2007) argued that RN organizational commitment research is now sophisticated enough that all "magnet hospitals" should clearly employ multiple structural and psychological empowerment measures to bolster organizational commitment and quality among RNs. These authors stated that in "magnet hospitals," RNs must utilize advanced leadership skills and only RNs with bachelor degrees and higher have had the appropriate educational preparation for the contemporary and more complex entry-level nursing practice roles. McClure and Hinshaw (2007), however, failed to recognize the impact of the current and large LPN workforce.

Conclusion to Historical Nursing Organizational

Commitment Studies: RN Samples

and Mixed "Staff Nurse" Samples Combining LPNs and RNs

Although many nursing organizational commitment studies since the 1970s have explored staff nurse organizational commitment, most studies excluded LPNs or

combined them with RNs in “staff nurse” samples despite the differences in job scope. Further, although empowerment is consistently linked with staff nurse organizational commitment, no studies have looked specifically at empowerment links to organizational commitment exclusively in a large sample of contemporary LPNs. Although LPNs are still highly used in all sectors of health care across the nation, they are somewhat less utilized in certain areas, such as in complex acute care hospitals. It is also recognized that higher education of all levels for nurses, are generally associated with improved patient care quality. Due to increasingly complex acute care health care settings, especially in hospitals, the job scope and responsibilities of nurses have drastically increased in the last decade, and LPNs are now less sought after as hospital staff nurses, especially in major tertiary acute-care hospitals. In fact, many hospitals now strongly prefer that RNs have a 4-year BSN degree. For example, “magnet hospitals” now highly encourage their RN staff to have a BSN or obtain a BSN within a certain date of hire. Magnet hospitals are encouraged to provide financial support for their RN staff to achieve a BSN via tuition reimbursement programs (McClure & Hinshaw, 2007). Magnet hospital literature argues that RNs alone should be used as hospital staff nurses. Magnet hospitals are strongly encouraged to employ nursing shared governance models, empowerment, and extended new RN internships to boost organizational commitment, retention, and job satisfaction (Hinshaw, 2008; McClure, 2005; Tang, 2003).

Although LPNs are less sought after today as nursing staff in high-acuity patient care settings, they are still generally utilized across the nation to deliver predictable nursing cares at lower costs, especially in long-term, rural, and routine care settings. Thus, uncovering factors specifically associated with contemporary LPN organizational commitment is paramount, particularly as the nation experiences growing numbers of aging baby-boomers in need of routine nursing care associated with aging and chronic illnesses.

Kenney (2001) suggested that reliance on LPNs is somewhat stigmatized and controversial today which may lead to a decreased emphasis on empowerment in many organizations. Kenney argued that current chillier workplace climates for LPNs might lead to LPN social isolation and potentially poor LPN resource utilization by RNs and dampen their organizational commitment (Eriksen et al., 1992). Current RN textbooks and the national RN board exam (NCLEX) focus mainly on specific tasks safe to delegate to LPNs. They do not emphasize research-based evidence regarding how to empower and promote organizational commitment among LPN staff (Huber, 2000).

One of the most frequently cited contemporary nursing organizational studies is by McNeese-Smith (2001). McNeese-Smith used an all RN sample so it is not known whether the identified factors are also highly associated with organizational commitment among LPNs. McNeese-Smith confirmed earlier findings and found the following as remaining highly associated with contemporary RN organizational commitment: educational opportunities, salary, relationships with co-workers, home/family needs, desire to serve diverse patients, shared governance, and empowerment (see also McDermott & Laschinger, 1996; Wagner, 2007). There continues to be a gap in the literature regarding whether these variables also impact contemporary LPN organizational commitment. Although Laschinger et al. (2000) found empowerment, trust, and certain structures to be highly associated with organizational commitment among staff nurses, they did not examine whether these variables are also predictive of organizational commitment specifically among LPNs. Finally, conflict and trust also appear to be highly linked to organizational commitment in staff nurse samples; however, no contemporary studies have specifically sorted out LPNs to explore the relationship of these concepts among an all-LPN sample (Laschinger & Finegan, 2005; Laschinger et al., 2006; Mintzberg, 1997).

Organizational Commitment in Allied
Health Care Delivery Groups

The term “allied health care” is a general term used to describe health care personnel who deliver health care but are not considered as nursing staff. For example, radiographers, physical therapists, occupational therapists, respiratory therapists, social workers, and certified nursing assistants are all considered allied health care providers. With few exceptions, researchers on organizational commitment among allied health professionals and para-professionals have not utilized multivariate designs. Early studies in these groups utilized descriptive correlational designs and explored antecedents and outcomes linked to organizational commitment, but later studies utilized more multivariate designs. Organizational commitment has been studied among numerous allied healthcare professional groups such as social workers and radiographers and also in para-professional technical groups such as occupational therapists and psychiatric technicians.

Akroyd et al. (2009) looked at the effects of organizational support, role ambiguity, role conflict, organizational type, managerial leadership, and demographic variables on organizational commitment using a cross-sectional predictive research design in a random sample of 3000 radiographers. They found that radiographers had only moderate levels of commitment to their employers, and that education level, perceived level of organizational support, role clarity, and organizational leadership predicted organizational commitment. Findler, Wind, and Mor Barak (2007) used a structural modeling technique and found fairness, inclusion, and social support to employees were positive outcomes of organizational commitment in a sample of social workers.

Organizational commitment was also studied in chiropractic faculty (Henkin & Marchiori, 2003). This study found tenure in higher education, gender, and age to be the most important predictors of organizational commitment. These authors used Allen and

Meyer's (1996) organizational commitment scale and found that benefits of higher levels of organizational commitment appear axiomatic and that women had higher levels of normative commitment.

Another study looked at organizational commitment in nursing home staff and found that job and organizational factors predicted organizational commitment and turnover intentions (Karsh et al., 2005). This study found organizational commitment to be more associated with actual turnover. The findings of this study may be challenged, however, because the authors combined nursing home staff across many varied educational levels. These findings match Mowday et al.'s (1979) findings among psychiatric technicians. They also found organizational commitment to be a better predictor of actual turnover than any facet of job satisfaction among psychiatric techs.

Predictors of organizational commitment were studied among certified occupational therapy assistants (COTAs; Painter et al., 2000). This study found that task involvement, general working conditions, salary, promotional opportunities, and supervision were associated with organizational commitment in COTAs. The authors pointed out that autonomy was not significant in their study. They argued that this seems logical because COTAs are non-professional technical staff who function in non-autonomous ways under the direct supervision of physical therapists. The authors noted that technicians may not expect to act autonomously in their roles. Licensed practical nurses are also technicians who also function, for the most part, in a limited and subordinate nature under the direct supervision of RNs. Thus autonomy was not selected as a variable in the current study involving LPNs. The study by Painter et al. (2000) used a random sample of COTAs from a three state population of 1030 COTAs and found that COTAs who described their work as meaningful had higher levels of organizational commitment. Meaning in work will also be explored in the current study because meaning is a component of the empowerment tool employed. Painter et al. (2000) argued that more empirical work is needed regarding the relationship between empowering

technicians with increased task involvement as a strategy to increase organizational commitment. The current study will explore empowerment effects on LPN commitment to the organization.

A few studies have looked at organizational commitment among certified nursing assistants (CNAs). For example, a qualitative study among CNAs found low wages along with the nature of the physically and emotionally difficult work as themes connected to low organizational commitment (Bowers, Esmond, Lutz, & Jacobson, 2003; Wiener, Squillace, Anderson, & Khatutsky, 2009). These authors found that CNAs left their jobs because they did not feel respected or involved in resident care planning or that they were part of the patient care team. According to Forbes-Thompson, Leiker and Bleich (2007), high-performing nursing homes are now using career ladders and increased empowering of CNAs as a culture change movement to strengthen organizational commitment and retention among CNAs. Another survey study suggested that grief experiences and burnout impacted organizational commitment and turnover among CNAs (Anderson, 2007). Anderson's study suggested that support and education can reduce negative consequences of dealing with grief for CNAs. CNAs reporting growth from their grief experiences reported higher levels of personal accomplishments in their work which may lead to higher organizational commitment. According to Woo et al. (2009), the national CNA licensure exam is constructed at a sixth-grade reading level. Reading level was not considered in these CNA studies, which may impact data reliability.

The federal government recognizes the need to explore factors associated with organizational commitment and retention among CNAs (Squillace et al., 2006). The recent and costly 2006 National Nursing Assistant Survey (NNAS) sponsored by the Center for Disease Control (CDC) gathered national survey data to test, among many other things, the relationship of aspects of empowerment, socio-demographic, and workplace variables to organizational commitment in over 3000 CNAs. These authors

contended that few seminal research studies have had large enough samples to sufficiently examine organizational commitment, recruitment, retention, and turnover of CNAs in greater detail. This dataset with a sample of 3,017 respondents provided the first estimates of the nursing assistant population based on a national probability sample of a cross section of CNAs. Although the major focus of the NNAS was to provide descriptive data, the public use dataset also has exploratory, confirmatory, and developmental aspects. In particular, it supports analysis of what contributes to the organizational commitment, job satisfaction, and retention of CNAs. The NNAS was designed by members of the technical advisory panel, as well as representatives from the National Institute for Occupational Safety and Health, the Occupational Safety and Health Administrations. The NNAS was designed to measure job satisfaction and organizational culture as well as to provide basic information on organizational commitment, job history, family life, and intention to continue to work as a nursing assistant.

Although the survey measured aspects of organizational commitment, it combined the measures of organizational commitment with related concepts such as job satisfaction and intent to leave. The survey also contained questions that attempted to measure the four dimensions of psychological empowerment: meaning, competence, self-determination, and impact. However, it did not use an instrument with known psychometrics to measure psychological empowerment. The new national data set contains a large sample size and uses a sophisticated national sampling plan; however, the data are limited by psychometrics issues. Further studies looking at organizational commitment among CNAs using psychometrically sound tools should compare results to the NNAS data set to determine if it proximally suggests similar outcomes.

Stearns and D'Arcy (2008) published the only study to date that has used the 2006 NNAS data set. This study found that supervision qualities, training, safety, and benefits affected both CNA commitment to the organization and facility retention. This study

reported that supervisor actions seen as empowering by CNAs, such as seeking their input in their training needs and safety protections, can be beneficial in reducing intent to leave. These authors argued that good facility management could improve the retention of CNAs. However, they pointed out that for CNA retention, there must be a balance between educational services provided and the potential that such education would lead the CNA to seek nursing-level jobs. Reading level of the CNAs was not considered in the NNAS; thus, the data reliability of this study may be questionable.

A severe national CNA staffing shortage has been reported and turnover of CNAs ranges up to 70% annually in many long-term care organizations (Stearns & D'Arcy, 2008). LPNs frequently supervise CNAs. They also perform many of the basic duties CNAs perform. While organizational commitment has been minimally studied among CNAs, no studies have explored organizational commitment specifically among LPNs. Retention of LPNs in long-term care may be associated with organizational commitment and retention of CNAs. Thus efforts to retain committed LPNs may also result in better retention of committed CNAs (Squillace et al., 2009).

Organizational Commitment in Licensed Practical Nurses

No empirical studies to date have examined organizational commitment and the links of empowerment, conflict, and trust to organizational commitment among a large group of contemporary LPNs directly. One study in the nursing literature looked at all levels of staff in an assisted living setting and explored predictors of organizational commitment among RNs, LPNs, CNAs, administrative staff, and dietary aides (Sikorska-Simmons, 2005). This study focused on culture, job satisfaction, and education, all of which were associated with organizational commitment across the mixed staff population. The author concluded that organizational cultures that value and respect staff members are most effective in promoting higher levels of organizational commitment. The convenience sample setting and the differences in job scope across respondents limited the focus and generalizability of the study findings. Several anecdotal articles

that called for increased attention to the retention of LPNs especially in times of RN staffing shortages were found. For example, Kenney (2001) called for nurse executives to seek to retain LPNs to offset the effects of an aging RN workforce in short supply, but the author did acknowledge differences in job skills between LPNs and RNs.

There is a lack of empirical research on LPN practice, but greater involvement of LPNs in panels and committees may lead to increased professional and organizational commitment. Seago and Ash (2002) recommended mentoring of LPNs by RNs and encouraging LPNs to seek additional training. Such approaches may in turn lead to greater LPN empowerment and organizational commitment. Morrison, Jones, and Fuller (1997) grouped LPNs and RNs together for data analysis and found that leadership style impacted organizational commitment in this combined licensed nurse group but not in unlicensed personnel such as CNAs.

Variables selected for this initial study on LPN organizational commitment were based on evidence of strong associations to organizational commitment in related RN, mixed staff nurse, and allied healthcare populations. This is the first study to explore organizational conflict and trust as predictors and empowerment as a mediator of organizational commitment specifically in a contemporary LPN population.

Empowerment: Conceptual Origins and Definitions (Intervening Variable)

Two complementary perspectives on empowerment at work have emerged in the literature over the last two decades. One is a macro focus on the structural (contextual) conditions that enable empowerment. The other is a micro focus on the psychological experience of empowerment at work. Structural empowerment focuses on empowering structures, policies, and practices. Psychological empowerment focuses on employees' perceptions and reactions to the structures, policies, and practices in which they are embedded (Spreitzer, 2007).

Structural Empowerment

Social exchange and social power theories provide the framework for the structural perspective on empowerment. Kanter (1977) used an ethnographic approach and found that women lacked access to “power tools,” which he called opportunity, information, support, and resources. Democracy and power sharing permeate this perspective. Power is shared at all levels of a system with the goal of distributing relevant decision-making power to the lower levels of the organizational hierarchy, matched to their scope and domain of work (Prasad, 2001). This perspective focuses on decreasing powerlessness in the workplace and encourages high involvement and ownership through participative decision-making, skill/knowledge-based pay, open flow of information, flat organizational structures, and training (Spreitzer, 2007). MacDuffie (1995) argued that these high involvement practices increase access to the four power tools: opportunity, information, support and resources. MacDuffie also reported the importance of implementing all five high involvement structural practices and that marginal empowerment will ensue if only some of the structural empowerment practices are employed.

Kirkman and Rosen (1999) also conceptualized empowerment more from a structural perspective and contended that an empowering work environment yields higher levels of organizational commitment. They argued that administrators should create structurally empowering work environments. They suggested that by structuring empowering work environments, administrators provide conditions necessary to empower employees ultimately resulting in enhanced organizational commitment. Huber (2000) and Porter-O’Grady (1998) also conceptualized empowerment from an administrator-generated structural focus. Huber (2000) suggested that structural empowerment involves endowing employees with authority, responsibility, and freedom to act on what they know and instilling them with confidence to do so. This perspective is limited in that it is organizationally centric and macro focused and has no universally

accepted measure. This limitation helped spur the emergence of the psychological perspective on empowerment (Spreitzer, 1995a, 1995b).

Psychological Empowerment

Psychological empowerment differs from the structural dimension of empowerment in that it focuses on intrinsic motivation rather than on structural managerial practices that comprise many of the factors in structural approaches (Spreitzer, 1995a). Spreitzer (1995b) offered a conceptualization of psychological empowerment as a set of related cognitive states. She contended that psychological empowerment “is a cognitive state characterized by a sense of perceived control, competence and goal internalization” (p. 483).

Spreitzer (1995a) focused on intrinsic motivation for viewing psychological empowerment and conceptualized it as a four-component model that focuses on the psychological states that individuals must experience for managerial empowerment interventions to be effective. Spreitzer’s four components of psychological empowerment are meaning, competence, self-determination, and impact.

From an attitudinal approach, psychological empowerment is viewed as a set of cognitions created by the work environment or context that reflects employees’ perceptions about themselves in relation to their work (Bandura & Wood, 1989; Spreitzer, 1995a). According to Potterfield (1998), psychological empowerment is “a subjective state of mind where an employee perceives that he or she is exercising efficacious control over meaningful work” (p. 20).

Two studies suggested that staff who feel psychologically empowered by their leaders perceive increased decision making at lower levels in an organization that enriches employees work (Liden et al., 2000). Conger and Kanungo (1988) defined psychological empowerment as “a process of enhancing feelings of self-efficacy among organizational members through the identification of conditions that foster powerlessness

and through removal by both formal organizational practices and informal techniques of providing self-efficacy information” (p. 474).

Psychological empowerment is a multidimensional construct and falls within Bandura and Wood’s (1989) theory of human agency in social cognition, especially with regard to the components of self-efficacy inherent in this theory. Spreitzer (1995a) contended that Bandura’s concept of self-efficacy fit psychological empowerment because this dimension of empowerment is a process in which an employee’s belief in his or her work self-efficacy is enhanced. Psychological empowerment is a cognitive perception about oneself. Thomas and Velthouse (1990) agreed with Spreitzer but argued that the four cognitions of empowerment are meaning, competence, choice, and impact and that these cognitions are set by the work context. Spreitzer (1995b) indicated that the four components of psychological empowerment are meaning, competence, self-determination, and impact. Spreitzer viewed self-determination as more fitting than choice as a component of empowerment because self-determination involves an autonomous self-efficacy focus. She argued that feeling a certain level of autonomy and efficaciousness is needed to feel psychologically empowered and that choice does not capture these aspects of empowerment.

Empirical research has shown that psychological empowerment aspects are linked to organizational commitment. Spreitzer (1996) and Kraimer, Seibert, and Liden (1999) found that higher levels of psychological empowerment and work autonomy mediated and predicted higher levels of organizational commitment. Spreitzer (1995a) argued that empowered staff feel at the center of things and that they make a difference in organizational success. Empowerment obligates staff to focus not only on their individual work but also on the organization. One study found that increased work autonomy, psychological empowerment, and openness of communication resulted in decreasing role ambiguity and stress and produced a more committed staff (Conger & Kanungo, 1988; Greco, Laschinger, & Wong, 2006).

Two studies found that when staff are given the opportunity to apply their talents toward discovering solutions to complex problems, they became more committed to the organization (Kuokkanen, Leino-Kilpi, & Katajisto, 2003; Spreitzer, 1995a). Konczak, Stelly, and Trusty (2000) found empowerment to be an antecedent of organizational commitment and that psychological empowerment mediated the relationship between leader behaviors and organizational commitment. Spreitzer (1996) and Froymovich (2007) suggested that empowered employees often see themselves as integrated into the political channels of getting things done and affecting the organization's success. It is hypothesized in the current study that higher levels of empowerment will be associated with higher levels of organizational commitment and that empowerment will mediate this relationship among LPNs.

In light of the current burgeoning research suggesting transformational leadership methods are associated with increased organizational commitment, empowerment was selected as a conditioning variable for this study (Akroyd et al., 2009; Karsh et al., 2005; Nguni, Slegers, & Denessen, 2006; Spreitzer, 1995a). Empowerment is increased task motivation and has been shown to be a conditioning variable contributing to a workers' commitment to the organizational (Locke et al., 1986; Spreitzer, 1996; Thomas & Velthouse, 1990).

Structural Empowerment: Evaluations

There is no universal measurement for the macro-focused structural empowerment, although Kanter's (1987) conceptualization of structural empowerment is most prevalent in the literature (Spreitzer, 2007). Kanter's model of structural empowerment was used as a measure in an RN study that employed structural equation modeling to better understand structural empowerment links to psychological empowerment. This study found that RNs who perceived more access to Kanter's structural empowerment categories of opportunity, information, support, and resources in

their workplace were associated with higher levels of psychological empowerment (Laschinger, Shamian, & Thomson, 2001).

Psychological Empowerment: Evaluations

Spreitzer's (1997) conceptualization of psychological empowerment is the most prevalent in the literature. Moreover, her tool is the most widely used measure of empowerment and measures it as a multifaceted, motivational construct manifested in the four related cognitions of: meaning, competence, self-determination and impact. She argued that no unidimensional conceptualization of psychological empowerment by itself can capture the scope of the concept. Furthermore, the four cognitive components are not antecedents or outcomes but rather the four related dimensions that represent different facets of the empowerment construct. Spreitzer's Empowerment Scale (1995b) will be used to measure empowerment in this study.

Spreitzer's (1995b) measure has been used in RN populations and was found to have construct validity (Kraimer et al., 1999). Confirmatory factor analysis of data from a sample of 160 registered nurses showed substantial support for Spreitzer's four empowerment dimensions of meaning, competence, self-determination, and impact. The study also found the four empowerment dimensions to be highly associated with organizational commitment among RNs. Spreitzer's tool has not been tested among a strictly LPN sample.

Empowerment: Approach and Measurement

Used in This Study

The LPNs in this study worked full time in various work settings and experienced varying structural empowerment practices in these workplaces. Since no universally accepted measure of structural empowerment exists, this study will employ Spreitzer's (1995) approach to and measurement of empowerment. However, her tool has not been tested among LPNs. Therefore, confirmatory factor analysis will be employed in this study to determine if there is support for the items in her tool as measuring a single

construct among a sample of LPNs. This should add to the construct validity literature on Spreitzer's tool.

Research on Empowerment in Nursing and Allied

Healthcare Workers

The literature on the effects of empowerment on organizational commitment does not extend to all levels of nursing and allied health care practitioners. Most of the empirical work has been conducted among RN populations or with combined staff nurse samples of LPNs and RNs.

Empowerment Among RNs and "Staff Nurse" Samples

that Combine LPNs and RNs

Interest in issues related to empowerment in nursing began to appear in the nursing literature over three decades ago (Laschinger, Finegan, & Wilk, 2009). Early empirical studies consisted primarily of descriptive correlational studies, while later studies use sophisticated tools and designs to explore the role of mediating variables in the link between antecedents and outcomes of empowerment among staff nurses. Although some nursing empowerment studies specifically explore empowerment among all RN samples most studies use "staff nurse" samples of RNs and LPNs combined (Laschinger et al., 2006; Laschinger et al., 1997). Although a few studies exist regarding factors associated with LPN empowerment, no studies exist to date that have specifically explored the proposed path relationship of organizational trust, conflict, and empowerment to organizational commitment exclusively among contemporary LPNs.

According to Huber (2000), contemporary RN managers and researchers embrace efforts to retain and empower RNs. Huber maintained that transformational leadership utilizing empowerment interventions amplify organizational commitment among RNs in healthcare organizations. Leach (2001) argued that the transformational leadership movement is sweeping healthcare organizations and encouraging an emphasis on staff nursing empowerment (McClure, 2005). Suggestions include organizations characterized

by a flattened hierarchy, shared governance, committee work, and internal restructuring to encourage change including opportunities for nursing staff to freely voice recommendations or dissent (DeCicco, Laschinger, & Kerr, 2006; Leach, 2001; McClure, 2005; McClure & Hinshaw, 2007). Several studies on staff nurses reported that efforts focused on boosting empowerment and perceived administrative organizational support fostered the nurses' organizational commitment, trust, integrity, and competence, and also resulted in a vision of shared objectives or outcomes (Connelly, Gallagher, & Gilley, 2007; Currie & Dollery, 2006; Faulkner & Laschinger, 2008; Gruber & Trickett, 1987).

Curtin (1994) found that hospitals that decentralize the structure of nursing departments and focus on RN empowerment have stronger RN job satisfaction and organizational commitment levels (Mintzberg, 1993). Wolf et al. (1994) found RN empowerment interventions associated with higher levels of organizational commitment. Another study on empowerment reported that psychological empowerment and selected personality characteristics strengthened job satisfaction and organizational commitment in RNs (Manojlovich & Spence, 2002).

McDermott and Laschinger (1996) found empowerment for RNs to be linked to higher levels of both job and organizational commitment. Porter-O'Grady (2004) studied the effects of shared governance on empowerment among RNs. He reported that empowerment is boosted by shared governance and that empowerment is strongly associated with higher quality care as well as higher levels of RN retention and organizational commitment. Magnet hospitals across the nation now use empowerment interventions, such as new or extended RN internships, to boost retention and organizational commitment in RNs (Becker, 1994; McClure & Hinshaw, 2007). Although RN studies have shown empowerment to be strongly linked to organizational commitment, no studies have looked specifically at these relationships with LPNs as the single focus of inquiry (Brown, McWilliam, & Ward-Griffin, 2006).

Empowerment in Certified Nursing Assistants

One study looked at empowerment in certified nursing assistants (CNAs; Yeatts & Cready, 2007). Yeatts and Cready looked at consequences of using CNA work-teams on perceptions of empowerment among CNAs in a long-term care setting. A multi-method, pre-test, post-test design was used to examine effects of CNA work-teams and found work teams had a modest yet positive effect on perceived empowerment, performance, and turnover. The authors argued that more research on CNA empowerment is needed because despite CNAs being under the direct supervision of RNs and LPNs, CNAs are often frontline staff especially in long-term care settings and deliver most of the routine bedside care directly provided to patients. Because CNAs make decisions directly related to the daily cares of residents, Yeatts and Cready (2007) contended that greater attention should be paid to empowering CNAs. Their findings mirrored Spreitzer's (1993) suggestion that organizational commitment is built by actions in which one is responsible for large consequences within the scope of one's practice (Cready, Yeatts, Gosdin, & Potts, 2008). Spreitzer (2007) also argued that even lower-level workers can be empowered within their scope of practice.

The 2006 National Nursing Assistant Survey (NNAS) also looked at CNA empowerment but did not use a psychometrically sound tool to measure empowerment (Squillace et al., 2009). The NNAS gathered information related to aspects of the four components of empowerment: self-determination, competence, impact, and meaning. For example the survey asked if the CNA was encouraged by supervisors to discuss the care and well-being of residents with their families. It also asked if CNAs could decide on their own how to do their work and if they felt confident in their ability to do their jobs. It also inquired about the impact and importance of their work. Meaning in work was also assessed in this survey. For example, the survey inquired whether the CNAs continued to work in their current position because of feeling good about the work they do. Squillace et al. (2009) argued that empowered CNAs feel respected by their

supervisors and that empowerment practices encourage CNAs to feel as though they make a difference in the workplace, which in turn leads to increased work motivation and commitment. Reading level of the CNAs was not considered in this study which may impact data quality.

Empowerment in Licensed Practical Nurses

No studies could be identified that examined empowerment as a mediator variable of organizational commitment specifically among a large group of contemporary LPNs. A few studies explored certain factors associated with empowering work environment among LPNs. For example Sikorska-Simmons (2008) examined whether organizational structures and culture predicted organizational commitment in all assisted living staff including RNs, LPNs, dietary aides, and administrative staff. Specifically the authors used a stratified cross sectional design and examined the effects of an empowering organizational culture, job satisfaction, and socio-demographic characteristics on levels of organizational commitment. This study found an empowering work environment and organizational culture, job satisfaction, and lower levels of education to be the strongest predictors of commitment in the mixed staff population. They concluded that organizational cultures that value and respect staff members are most effective in promoting higher levels of organizational commitment. The convenience sample, lack of attention to differences in reading levels, and vast differences in job scope among their sample are likely to limit the quality and generalizability of the findings of this study.

Morrison et al. (1997) used discriminant analysis and found leadership style and empowerment highly linked to job satisfaction and organizational commitment among licensed health care personnel such as RNs and LPNs but not among unlicensed personnel such as CNAs. Again, most nursing empowerment studies have used staff nurse samples of combined RNs and LPNs to explore factors associated with empowerment, and no studies have looked at mediating effects of empowerment

specifically among a large group of contemporary LPNs (Laschinger & Wong, 1999; McDermott & Laschinger, 1996).

The current study will expand on previous empirical studies among RNs and staff nurses and explore the mediating relationship of empowerment to organizational commitment specifically among LPNs. The conceptual framework for this study suggests that empowerment will have both direct and indirect effects and modify higher levels of organizational commitment among LPNs. Research Question 4 explores the direct effects of empowerment on organizational commitment. Research Questions 5 through 7 explore empowerment as a mediator variable in the proposed conceptual framework using selected demographic, conflict and trust as independent variables in the proposed path to organizational commitment among an LPN population (see Appendix A).

Organizational Trust: Conceptual Origins, Definitions, and Measures (Independent Variable)

Introduction

Trust is critical to organizations and highly associated with empowerment and organizational commitment (Axelrod, 1984, Barber, 1983, McKnight et al., 1998; Moyer, Henkin, & Floyd, 2006; Zand, 1972). Trust can be conceptualized at two levels: interpersonal and organizational. Interpersonal trust focuses on an individual's trust in co-workers and supervisors. McAllister (1995) conceptualized interpersonal trust as the extent to which an employee expresses confidence in and is willing to act on the basis of the words, actions, and decisions of his or her coworkers and administrators. Organizational trust focuses on the organization as a whole. Organizational trust is conceptualized as an employee's perception about the reliability of the systems that comprise the organization (Moyer, Henkin, & Egley, 2005; Sztompka, 1998). This study focuses only on the association of organizational trust to empowerment and organizational commitment.

Trust is essential in organizations because it enhances the open exchange of ideas, facilitates group cooperation, and decreases conflict (Axelrod, 1984). Trust improves the quality of information exchange, leads to more effective organizational decisions, and enhances innovation (Hargreaves, 2002; Henkin, Dee, & Singleton, 2000; McAllister, 1995;). Trust lowers intent to leave and serves as an antecedent to empowerment (Bryk, Schneider & Russell, 2002; Cook & Wall, 1980; Gomez & Rosen, 2001; Schoorman, Mayer, & Davis, 2007). Organizational trust will be used as an independent variable in this study because of its established association with empowerment and organizational commitment. A seven item sub-scale tool from Butler (1991) and adapted by Moye (2003), will be used to measure the LPNs perception of organizational system-level trust.

Definitions of Trust

Trust is a complex construct that has been studied in many fields, including psychology, sociology and management (Good, 1988). No universally accepted definition of the multi-dimensional construct of trust exists because it incorporates many dimensions (Doney, Cannon, & Mullen, 1998). The organizational trust dimension in this study is defined as an employee's perception that the rules, regulations, policies and procedures of the organization are reliable, consistent and fair (Butler, 1991; McKnight et al., 1998; Moye, 2003; Sztompka, 1998).

Overview of Trust

Trust based on the knowledge of the other (interpersonal-level trust) and situational trust based on knowledge of the system and situation are different (Axelrod, 1984; Bachmann, 2001; Zand, 1972). Trust has both situational and attitudinal dimensions. Attitudinal trust is dispositional, that is, an individual exhibits a propensity towards trusting others. Situational trust is contextual and relies on the characteristics of setting and experiences related to the present situation (Barber, 1983; Rotter, 1971). An individual's trust in his/her supervisor is different than trust in the organization (Tan &

Tan, 2000). The literature on trust and organizational commitment focuses more on situational trust (Bryk et al., 2002; Doney et al., 1998).

According to Luhmann (1979, 2006) and Moyer (2003), organizational trust can be best understood from a sociological perspective and is best described by the perception that the organization is running in proper order. Organizational trust is based on capacity, benevolence, and integrity at the organizational level (Bhatnagar, 2007; Bijlsma & van de Bunt, 2003; Hoy & Kupersmith, 1985). Participative leadership and empowerment are linked to employee perceptions of organizational trust. In addition, perceived justice, fairness, openness, competence, consistency, integrity and benevolence are also key dimensions of organizational trust (Korthuis-Smith, 2002).

Organizational trust in the systems around us is a necessary part of everyday life. Procedural trust is a specific variant of organizational trust and involves a perception that the system will treat you fairly (Sztompka, 1998). Culbert and McDonough (1988) suggested that managers seeking to enhance employee commitment are basically asking employees to internalize the operating assumptions and values of the system. They contended that long-term success of the institution requires that the employees internalize and acquire organizational trust. If such internalization does not occur, then employee guardedness may decrease both competence and performance. Employees lacking organizational trust will typically focus only on performance subject to evaluation. Such employees become “partisan” and limit their responsibilities to areas that give them the appearance of being effective.

According to Culbert and McDonough (1988), empowerment is the key to understanding trust in an organization. These and other authors contended that workers will not internalize a system if they do not feel personally and professionally empowered (Dickey, McKnight, & George, 2007; McKnight et al., 1998).

There are two types of organizational trust: situational normality and structural assurances. Situational normality entails a perception of organizational success under

standard operating conditions. Structural assurance entails perceptions of organizational success when contextual conditions such as promises and policies are in place, or for example, when licenses or certifications provide assurance of competence (Creed & Miles, 1996; McKnight et al., 1998). Mayer, Davis, and Schoorman (1995) suggested that organizational trust is determined by the perceived fairness of the systems in place (Henkin & Dee, 2001).

For the purposes of this study, organizational trust described employee's perceptions of the trustworthiness of the systems in the organization. This study examined only organizational trust because it was found to be most related to organizational commitment and empowerment (McKnight et al., 1998; Moyer, 2003).

Measures of Organizational Trust

Few valid or reliable measures of organizational trust are currently available in the empirical literature. Butler (1991) and Moorman, Zaltman, and Deshpande (1992) developed instruments that measure trust as distinct from its antecedents. Butler identified key conditions of trust through content analysis and confirmed by factor analyses. He constructed a trust scale, the Conditions of Trust Inventory (CTI), including an eleventh scale measuring overall trust as a way to discriminate it from conditions of trust as opposed to overall trust (Butler, 1991). He used convergent and discriminant validity with two subsamples. The reliability estimate for the overall trust scale was .97 (Butler, 1991). Moyer (2003) used the CTI's eleventh four-item scale to measure overall trust in a Fortune 500 firm.

This study included organizational trust as an independent variable because it was found to be highly associated with organizational commitment (Barber, 1983; Mishra, 1992). A seven-item scale measuring organizational system-level trust adapted from Butler (1991) by Moyer (2003) was used to measure organizational system-level trust. This seven-item scale inquires whether respondents believe organizational programs meet employee's needs. It also identifies whether they trust that the systems of the

organization will get the job done right and whether they have confidence in relying on the systems in the organization. This is the initial study to explore organizational trust among LPNs. Research Question 3 explores direct effects of organizational trust on organizational commitment. Research Question 7 explores empowerment as a mediator variable in the relationship between trust and organizational commitment. This is the first study to explore this proposed path relationship in a large sample of LPNs employed full-time (see Appendix A).

Conflict (Independent Variable)

Introduction

All organizations experience conflict (Henkin & Holliman, 2009; Robbins, 1974; Zey-Ferrell, 1981). Conflict is associated with organizational commitment and intent to stay (Cox, 1998; Cox, Jones, & Collinson, 2006). Perceived levels of organizational conflict were included as an independent variable in this study because of its association with organizational commitment (Wall & Callister, 1995). Conflict has both positive and negative outcomes on organizations and on organizational commitment (Coser, 1956; Deutsch, 1973; Katz & Kahn, 1966; Singleton & Henkin, 1989). Different levels of conflict exist with management of conflict key to whether leaders can harness the productive functions of conflict (Coser, 1956; March & Simon, 1958). Conflict can be positive in that it allows for divergent thinking and improves the quality of organizational decisions. Excessive conflict, however, can dampen organizational commitment (Bess & Dee, 2007; Mintzberg & McHugh, 1985). Suppressed conflict can be dysfunctional for organizations and is known to lower trust (Tschannen-Moran & Hoy, 1999). Janssen (2004) found higher levels of conflict to have moderating effects on empowerment and direct effects on employee commitment. High levels of conflict are impediments to trust, empowerment, and organizational commitment. Conflict in healthcare organizations often arises over the allocation of scarce resources, and undoubtedly all LPNs encounter some levels of conflict in their organizations.

Definitions of Conflict

Conflict is a complex construct that has been studied in many fields, including psychology, sociology, and management. No universally accepted definition of the multi-dimensional construct of conflict exists because it incorporates many dimensions. Organizational conflict, a variable in this study, is defined as “an expressed struggle between at least two interdependent parties who perceive incompatible goals, scarce resources, and interference from others in achieving their goals” (Wilmot & Hocker, 2001, p. 23).

Overview of Conflict

Perrow (1972) concluded that organizational conflict is an inevitable part of organizations and “stems more from organizational characteristics than from characteristics of individuals” (p. 132). For example, staff and administration experience conflict because of the nature of their relationship. Sales and marketing are also structured for inherent conflict because of the relationship between their functions. Cox (1998) suggested that critical theory contributes to understanding organizational conflict. Critical theory views organizations as systems of domination in which one class of actors exploits others. Differences are resolved by the more powerful suppressing the weaker. Both Cox and Perrow viewed organizational conflict as power-driven, situational, episodic, and inevitable. Generally low and high levels of conflict are negative. Moderate levels of conflict can actually be beneficial to an organization (Brown, 1983).

According to Mintzberg and McHugh (1985), conflict in institutions may be present but not dominant or may be the dominant system of influence. Mintzberg and McHugh divided degrees of conflict in institutions into four categories: the complete political arena, the confrontation, the shaky alliance, and the political organization. The degree of conflict in the complete political arena is intense and pervasive. The degree of conflict in the confrontation category is intense but confined and brief. The shaky alliance category of conflict is relatively stable, moderate, confined, and enduring.

Conflict in the political organization is relatively stable, and conflict is moderate but also pervasive and enduring. Mintzberg warned that when conflict becomes intense, it tends to pervade the entire organization and that few organizations can sustain a state of prolonged intense conflict. To be sustained, conflict must be moderate in intensity. An organization can sustain a state of pervasive moderate conflict only with some support (Mintzberg 1997). Administrators must manage this inevitable conflict and attempt to maintain organizational conflict in the moderate category so that conflict can work for the institution and not against it.

Conflict can also correct deficiencies and dysfunctions and functions to ensure that the strongest members of the organization are brought to leadership positions. It can ensure that all sides of an issue are debated. Finally, conflict is often required to promote needed organizational change blocked by legitimate powers (Mintzberg & McHugh, 1985). Coser (1956) even suggested that conflict could serve to help bind a group together. Mintzberg (1997) pointed to the more functional aspects of conflict in that conflict is a natural process important in the recycling and redistribution of necessary resources. Conflict may increase energy and spur creativity.

Conflict is functional when it improves the quality of decisions, stimulates creativity and innovation, encourages interest and curiosity, and provides a medium through which problems can be aired and tensions released. It is also functional when conflict fosters an environment of self-evaluation and change. If communication is restricted or group cohesion is weakened, then conflict can hinder performance (Cox, 1998).

Bess and Dee (2007) argued that power is important in assessing organizational conflict and that agency theory can be used to better understand organizational conflict. This approach suggests looking at the agency through which power is transmitted as helpful in understanding organizational power sources. The turbulent environment of

healthcare organizations creates conditions that breed conflict. With change comes conflict and power clashes (Huber, 2000).

Organizational trust is associated with conflict and organizational commitment (Axelrod, 1984; Barber, 1983; Moye, 2003; Mathieu & Zajac, 1990). Low levels of organizational trust may increase conflict (Cox, 1998; Cox et al., 2006). Conflict is inevitable and part of the fabric of healthcare organizations. Although conflict can be irritating, it can also offer rich opportunities, if well managed. The key to effective conflict management is accurate assessment of the roots and types of conflict that are occurring and recognizing that conflict is an episodic and dynamic process underlying all organizational behaviors.

Measurement of Conflict

Pondy (1983) and others provided a framework for conceptualizing conflict experienced in organizations (Mintzberg, 2007). Three major types of organizational conflict can be measured: bargaining, bureaucratic, and lateral. Bargaining conflict in organizations describes conflict among groups in competition for scarce resources and usually involves strategic bargaining between administrative levels. With this type of conflict, there is usually a need to secure consensus, compromise, and be flexible. Bureaucratic conflict in organizations deals with superior-subordinate conflicts along vertical dimensions and usually arises because superiors attempt to control the behavior of subordinates, and subordinates resist that control. Lateral conflict in organizations usually arises from complexities of coordination usually between subordinates. All three types of organizational conflict described by Pondy (1983) occur in healthcare organizations.

As noted earlier, conflict was included as an independent variable in this study because of its association with organizational commitment. A simple three-item scale, based on Pondy's (1983) work, was employed. The scale asks respondents about the extent to which conflict is a recurring and pervasive state among administrators

(bargaining conflict), between administrators and LPN staff (bureaucratic conflict), and finally among LPNs (vertical conflict). This is the initial study to explore the association of organizational conflict with organizational commitment among LPNs. The preponderance of research indicates that high levels of organizational conflict are associated with lower organizational commitment (Coser, 1956, Janssen, 2004; Rahim, 1985; Wall & Callister, 1995). This is the initial study to explore the relationship of organizational conflict to organizational commitment. Research Question 2 explores whether high levels of organizational conflict are associated with lower organizational commitment in an LPN population. Research Question 6 explores if this relationship is mediated by empowerment, using organizational conflict as an independent variable in the proposed conceptual framework (see Figure A-1, Appendix A).

Demographic Variables

Given meta-analytic research studies indicating strong associations of the variables of age, gender, marital status, workplace, and occupational tenure with organizational commitment, these items were included in the study (Cohen, 1992; Mathieu & Hamel, 1989; Mathieu & Zajac, 1990). Most LPNs are female. Thus caregiving responsibilities for dependent children was also included as an independent demographic variable because of established associations with organizational commitment, particularly among females. The aforementioned meta-analyses were reviewed in this chapter in the section regarding conceptual origins of the concept of organizational commitment.

Organizations vary in the degree of bureaucratization, with flat organizational structures generally employing more worker autonomy. It was recognized that the work settings of the LPNs in this study would vary in terms of degree of bureaucratization. Work setting was included as an independent demographic variable to explore whether a particular LPN work-setting category is highly associated with empowerment and organizational commitment. In acute hospitals, long-term care, and home-care settings,

LPNs generally have limited functions and work under the close direct supervision of RNs. In less acute work settings, such as in an office setting, LPNs often have less direct RN supervision. Office LPNs may potentially perceive more empowerment and organizational commitment.

The demographic variables relationships to organizational commitment are explored in Research Questions 1 and 5. Research Question 1 explores the direct relationships of age, gender, marital status, caregiving responsibilities for dependent children, years as LPN, years as LPN at current organization, and work setting to organizational commitment. Research Question 5 explores whether the relationship is mediated by empowerment using demographic variables as independent variables in the conceptual framework (see Figure A-1, Appendix A).

Conclusion

This chapter reviewed the literature on the two major concepts in this study, organizational commitment and empowerment. It reviewed the development of each concept, conceptual origins, definitions, and evaluations. It also included an overview of research, previous definitions, and major researchers who frame current understanding. This chapter concluded with a review of the concepts as applied in literature and research on nursing, allied healthcare, certified nursing assistants, and licensed practical nurses. Finally, it reviewed the literature on the two independent variables of trust and conflict and their association with seven independent demographic variables. Throughout this review, the lack of empirical research specifically related to factors that predict or limit LPN commitment to the organization was highlighted. This is the initial study to address this gap in the research by examining the relationships of empowerment, organizational conflict, and trust to organizational commitment among a large group of contemporary LPN staff.

CHAPTER 3

METHODOLOGY

Introduction

This chapter discusses the specific methodological procedures used to test the conceptual model. The conceptual model was tested using data obtained from surveys mailed to a large sample of licensed practical nurses (LPNs) who were working full-time in one Midwestern state. Appendix A contains the conceptual framework for the study.

Methodology

The conceptual model was used to test organizational commitment as the dependent variable; empowerment as the intervening variable; organizational conflict and trust as independent variables; and age, gender, marital status, caregiving responsibilities of dependent children, years as LPN, years as LPN at current organization, and work setting as independent demographic variables.

Organizational commitment was defined as “the relative strength of an individual’s identification with and involvement in a particular organization” (Mowday et al., 1982, p. 226). Organizational commitment was determined using Mowday et al.’s (1979) 15-item organizational commitment questionnaire, an instrument with reliable psychometrics.

Empowerment as a broad construct was defined as “a process of enhancing feelings of self-efficacy among organizational members through the identification of conditions that foster powerlessness and through their removal by both formal organizational practices and informal techniques of providing efficacy information” (Conger & Kanungo, 1988, p. 474). Empowerment was considered as a broad construct in this study and conceptualized from both a structural (macro contextual) focus and a psychological (micro) focus. The construct of empowerment incorporates these two related dimensions. No universally accepted tool exists to measure the macro-focused structural empowerment dimension. In this study, empowerment was measured by

Spreitzer's (1995) 12-item empowerment questionnaire, derived from the work of Thomas and Velthouse (1982). Spreitzer's tool focused primarily on measuring psychological empowerment and has not been tested among an LPN population for content validity. Factor analysis was employed to determine if all factors in Spreitzer's tool loaded on the psychological empowerment dimension in the LPN population. Those not loading on this dimension were deleted and discussed as possibly measuring aspects of structural empowerment in the LPN population.

For purposes of this study, organizational trust was defined as an employee's perception about the reliability of all the systems in place in the respondent's workplace (Butler, 1991; Moye, 2003). McKnight et al. (1998) conceptualized organizational trust as a broad measure of the employee's perception that the rules, regulations, policies, and procedures of the organization are reliable, consistent, and fair. Respondents' perceptions of organizational trust were measured using Moye's (2003) adapted scale for system-level employee trust based on the work of Butler (1991).

Conflict in the organization was defined as "an expressed struggle between at least two interdependent parties who perceive incompatible goals, scarce resources, and interference from others in achieving their goals" (Wilmot & Hocker, 2001, p. 23). For the purposes of this study, organizational conflict was conceptualized as the extent to which a state of disagreement recurred in the workplace from the perspective of respondents. Organizational conflict intensity was measured using a three-item scale adapted from Pondy's (1983) conceptualization of organizational conflict. These categories included bargaining (administrative level conflict), bureaucratic (administrative and LPN conflict), and lateral conflict (conflict among LPNs).

The 45-item survey was mailed to all registered and active LPNs employed full time in one Midwestern state (see Appendix B). Postal addresses were available from the state's Board of Nursing Registry List of active and registered LPNs who indicated they were working full time.

This chapter reviews the study methodology and is divided into five sections: (a) population and study participants, (b) variables, (c) data collection procedures, (d) measures, and (e) data analysis and statistical methodology.

This study was designed as a descriptive survey using self-administered questionnaires. The survey elicited data to test the study hypotheses that sought to describe organizational commitment in LPNs related to one intervening variable (empowerment), two independent variables (organizational conflict and trust), and seven independent demographic variables. Thus the exogenous variables in this study were the seven demographic and the independent variables of organizational conflict and trust. The intervening conditioning variable was empowerment, and the endogenous variable was organizational commitment. It was recognized that the potential for reciprocal causal effects existed. However the preponderance of empirical research in organizational behavior suggests the use of exogenous work environment variables as predictors of the conditioning variable empowerment and the endogenous variable organizational commitment (Gomez & Rosen, 2001; Janssen, 2004; Koberg et al., 1999; Laschinger et al., 2003; Price, 2009; Spreitzer, 2007). A descriptive study was appropriate because limited empirical evidence was found to describe factors associated with organizational commitment among LPNs, a population critical to the delivery of health care.

National LPN licensure exams are administered only in English. LPNs graduate from educational programs offered primarily in community colleges, and they must pass the National Council of State Board of Nursing's Practical Nursing Exam (NCLEX-PN) to practice as an LPN. This exam is written at the 11th-grade reading level (Woo et al., 2009). A pilot of the survey was given to three selected LPNs at different ages and stages in their careers to identify problems related to the content, format, and/or directions on the instrument. No issues were encountered with the readability of the survey questions or directions among the sample of LPNs.

Population and Study Participants

According to the State Board of Nursing Registry in the target state, as of November 2009, there were 5486 LPNs listed as registered, active, and working full-time. LPNs must renew their licenses every 3 years. The State Registry generated a list of all registered and active LPNs who indicated they are working full time. Only full-time LPNs were surveyed, as there is some evidence that different variables impact organizational commitment among part-time employees (Heshizer, 1994; Jalone et al., 2006; Mellor, Mathieu, Barnes-Farrell & Rogelberg, 2001).

In an effort to maximize the number of returned surveys, a purposive sample included all currently registered and active full-time LPNs in one state. This is the initial study to describe organizational commitment among LPNs, a population that is infrequently studied or surveyed. In addition, path analysis was used to answer some of the research questions, and path analysis is generally not a robust analysis technique unless large samples are analyzed. Consequently the instrument was broadly inclusive.

The Board of Nursing in the state under investigation used a “real-time database” to maintain their LPN registry. This database automates known address changes as the registry becomes aware of them. However, a small number of surveys were expected to be returned to the author by the U.S. Postal Service because of unknown address changes. All LPN addresses received from the registry also were submitted to an electronic mail stream data service. This service tracks and automates national changes of address and makes necessary address changes to labels prior to mailing. The author did not attempt to locate surveys returned as undeliverable.

With a known small population of approximately 5000 total subjects, it is possible to calculate a sample size within an associated confidence interval. According to Holbrook, Farrar, and Popkin, (2006), for a small population of approximately 5000 total subjects, 880 returned surveys provides a 95% confidence interval. In an effort to obtain

at least a 95% confidence interval, the instrument was broadly inclusive and was mailed to the entire population of approximately 5486 eligible LPNs in the target state.

Data Collection and Procedures

Bulk mail processes have shown decreased response rates. Thus, the original survey and instructions were mailed to respondents via the U.S. Postal Service using presorted standard mail services (Dillman, 2009). Presorted standard mail processes were also used for the return envelopes and non-response cards. All respondents were assured in the IRB approved sealed cover letter that participation in the study was voluntary and confidential. The instructions explained that individual respondents would remain anonymous, and all reported data from the survey would be summarized.

Respondents were given a 3-week period to return the completed survey. One reminder postcard was sent to all non-respondents at the end of the third week of the study. The reminder postcard indicated that they should return the survey within the next 2 weeks or telephone the author at the number listed if they misplaced their survey to request a replacement. Completed surveys were no longer accepted postmarked after the sixth full week from the initial mailing. Each survey had a form number in the lower left hand corner ranging from form 1 through form 5486. These numbers corresponded to each LPN respondent. The researcher opened each envelope daily and marked off the number corresponding to the LPN's form. This allowed the mailing service to know which LPN needed to be mailed a 3-week reminder postcard. It also would allow for wave analysis to be computed at the time of analysis if needed to address non-response bias by indicating which returned surveys were from early and late responders. The assumption with wave analysis techniques is that late responders approximate non-responders (Creswell, 2009). If wave analysis determines that early responders do not differ from late responders, then non-response bias concerns are minimized (Tse-Hua, Shih, & Fan, 2008). However due to the very large return rates, wave analysis was not employed.

Although no empirical data exist regarding mailed survey return rates among LPNs, Dillman (2009) suggested that a reminder card could increase mailed survey return rates in certain populations. It is recognized that although mailed surveys elicit higher response rates than on-line surveys, response rates for mailed surveys are on the decline (Evans & Mathur, 2005). The reminder postcard also served as an effort to decrease non-response bias (Dillman, 2009).

Eight \$25 gift cards were awarded by lottery drawing to eight LPNs from a pool of all the LPNs who return a completed survey postmarked by the stated deadline. The survey contained a separate lottery ticket instructing the LPN to write in his or her name and phone number to be entered into the lottery for one of the eight gift cards. Respondents were instructed to mail the completed lottery ticket with the completed survey in the enclosed addressed and stamped envelope. The lottery drawing took place 6 weeks from the date the survey was first mailed. The mailing did not include the name of a department store for the gift card so that public mail rates could be used. If the word of a department store was mentioned on the gift card, the author would be considered as marketing for that store. However, when the author telephoned each lottery winner, each LPN was asked from which major department store they would like their \$25 gift card purchased. The investigator accommodated their request for a \$25 gift-card from the major department store of their choice. The investigator purchased and mailed the gift card to each of the eight LPN winners. The University of Iowa Institutional Review Board (IRB) protocol and policies were followed regarding cash handing of this small gift-card incentive that was used to boost survey return rates.

The study was submitted to the University of Iowa Institutional Review Board for review and approval prior to the mailing of the surveys (see Appendix G). All data were reported in aggregate form. Only persons directly involved in the analysis and approved by IRB had access to respondent data.

The surveys were mailed directly to the personal residences or addresses provided by the public-use state LPN Registry Roster List. No email addresses were available for the LPNs, as the board relied only on postal addresses through the state LPN Registry. The mailing consisted of a brief cover letter containing the elements of consent for the study and requesting the subject's participation. A stamped and addressed return envelope was included in each mailing. The cover letter, survey questionnaire, and lottery ticket are included in Appendices B through D. Appendix G includes the IRB approved cover letter which all eligible LPNs and respondents received.

When responses were received, completed paper surveys were scanned by SNAP 9.0 Survey Software, which automatically imported the data into an Excel spreadsheet. The data imported from SNAP to the Excel spreadsheet were checked for accuracy by using 2009 SNAP Software protocols for data accuracy checking. The data were then imported into PASW and AMOS statistical software packages. Responses were coded using the form number on each returned survey and were entered in order of date received to an Excel spreadsheet prior to analysis to allow for wave analysis if necessary (Polit & Beck, 2006).

Hypotheses

The following hypotheses were addressed in an LPN population:

Hypothesis 1: Organizational commitment will be affected by age, gender, marital status, caregiving responsibilities for dependent children, years as LPN, years as LPN at current organization and work setting in an LPN population.

Hypothesis 2: Higher levels of organizational conflict will be associated with lower levels of organizational commitment at current organization and work setting in an LPN population.

Hypothesis 3: Higher levels of organizational trust will be associated with higher levels of organizational commitment at current organization and work setting in an LPN population.

Hypothesis 4: Higher levels of empowerment will be associated with higher levels of organizational commitment at current organization and work setting in an LPN population.

Hypothesis 5: The relationship between empowerment and organizational commitment will be influenced by employee demographic variables (age, gender, marital status, care giving responsibilities for dependent children, years as LPN, years as LPN at current organization and work setting) at current work setting and organization in an LPN population.

Hypothesis 6: The relationship between empowerment and organizational commitment will be influenced by organizational conflict at current work setting and organization in an LPN population.

Hypothesis 7: The relationship between empowerment and organizational commitment will be influenced by organizational trust at current work setting and organization in an LPN population.

Measures used in the study are described below. The cover letter and survey are found in Appendices B and C.

Measures of Organizational Commitment

The dependent variable in this study is organizational commitment. Porter et al. (1974) conceptualized organizational commitment as the relative strength of an employee's identification with and involvement in a particular organization. These authors contended that organizational commitment is characterized by at least three factors: "a) a strong belief in and acceptance of the organization's goals and values; b) a willingness to exert considerable effort on behalf of the organization; and c) a definite desire to maintain organizational membership" (Porter et al., 1974, p. 604).

Organizational commitment was measured using the Organizational Commitment Questionnaire originally developed by Porter et al. (1974) and further refined by Mowday et al. (1979). The Cronbach coefficient alpha reported an average reliability of .88 in

over 90 research studies using this questionnaire (Mathieu & Zajac, 1990). A measure of overall commitment for each respondent was derived by taking the mean score across all items and was originally administered to 2,563 employees in nine different occupations (Mowday et al, 1979). The instrument appeared to measure a single construct with the internal consistency of the instrument ranging from .82 to .93 (Mowday et al., 1979).

Measures of Empowerment

The intervening variable in this study was empowerment. Spreitzer's (1995a) measure of empowerment was used to assess LPN empowerment in this study. Spreitzer developed her tool from the empowerment literature and interviews with the intent of measuring primarily the psychological empowerment dimension. She developed a generalizable conceptualization of empowerment with four dimensions: meaning, competence, self-determination, and impact. Spreitzer (1995a) found that the reliability estimates using Cronbach's alpha for the overall measure was .72 for the industrial sample and .62 for the insurance sample. She also estimated test-retest coefficients for each of the dimensions using the insurance sample and found that they were satisfactory. Confirmatory factor analysis (CFA) was conducted on each of the two samples to test the convergent and discriminate validity of the items and the contribution of the four dimensions to the overall construct of empowerment. Each item loaded strongly on the corresponding factor and all factors were significantly correlated with each other in both samples. Spreitzer's tool has not been tested among an LPN population.

The current study employed confirmatory factor analysis to add to the content validity literature regarding Spreitzer's (1995a) tool. Factor analysis was employed to uncover the underlying factor structure, and varimax rotation was used to determine the factor loading of each item. Items loading above .4 were considered reliable measures of psychological empowerment and those loading under .4 were deleted. If confirmatory factor analysis revealed that certain items did not load on the corresponding factor or that the factors were not significantly correlated, a discussion was included regarding future

research needs to explore whether these items might be measuring aspects of structural empowerment in an LPN populations.

Kanter (1987) developed the most widely used conceptualization of the macro-focused structural empowerment dimension. He reported that the core components of this dimension are access to resources, support, information, and opportunity in the workplace. No universally accepted tool exists to measure the macro-focused contextual dimension of structural empowerment, however.

Measures of Organizational Trust

One independent variable in this study was organizational trust. Moyer's (2003) seven-item organizational trust system-level trust scale was used to measure organizational trust. A minimal number of instruments exist for measuring organizational trust, and most instruments designed to measure trust measure interpersonal trust. Butler (1991) constructed the Ten Conditions of Trust Inventory (CTI) including eleven different scales to identify a set of conditions of trust in a specific person. Butler's eleventh scale measures overall trust with a five-point Likert scale with 5 corresponding to *strongly agree* and 1 corresponding to *strongly disagree*. Moyer (2003) adapted Butler's (1991) eleventh scale measuring overall trust consisting of four items that were adapted to test overall trust in organizations. Cronbach's alpha for the overall trust scale in Butler's study was .97 (Butler, 1991). The subscale taken from Butler (1991) was reduced at analysis to a categorical sorting variable of high medium and low trust because factor analysis indicated the subscale did not load well. The organizational trust subscale had a 1 to 5 response scale. Each respondent's organizational trust mean score was reclassified as low trust (mean score 1-1.667), medium trust (mean score >1.667 -3.334), or high trust (mean score >3.334 -5).

Measures of Conflict

A second independent variable in this study was conflict. LPNs' perceived conflict levels in their work environments were included as an independent variable.

Conflict has been found to be inevitable in all organizations and correlated with organizational commitment (Cox, 1998; Perrow, 1986; Wall & Callister, 1995). It was hypothesized that higher levels of perceived conflict would be associated with lower organizational commitment. Conflict was measured by respondents' reported intensity of conflict within their work environments. Pondy's (1983) conceptualization of the three categories of conflict in organizations were used in this study and included bargaining, bureaucratic, and lateral conflict (Katz & Kahn, 1966; Deutsch, 1973; Mintzberg, 1997). Bargaining conflict deals with conflict among groups in competition for scarce resources and usually involves administrative level strategic bargaining. Bureaucratic conflict deals with superior-subordinate conflicts along vertical dimensions. Lateral conflict usually arises from coordination complexities.

Three items were used to measure perceived conflict intensity in the LPNs work environment. LPNs' perceived extent of conflict were measured by respondents' reported intensity of conflict among supervisors, LPNs and supervisors, and among LPNs.

Independent Demographic Control Variables

Seven independent demographic variables were included in this study and were used as control variables. The seven demographic variables were age, gender, marital status, caregiving responsibilities for dependent children, years as LPN, years as LPN at current organization, and work setting. The seven demographic level variables were measured by a checklist of categories.

These demographic control variables were selected for the following reasons. Mathieu and Zajac (1990) reported that the following variables were highly correlated with organizational commitment: age, gender, marital status, and organizational tenure. Number of dependent children is highly correlated with organizational commitment among women. Further, because LPNs are predominately female, this variable was also used (Salazar, 2000).

The use of control demographic variables enabled these variables to be held constant to examine the actual relationship between empowerment and organizational commitment. Control variables allowed the examination of the relationships among the independent, intervening, and dependent variable.

Validity, Reliability, and Construction of the Survey Instrument

The validity of the survey used is supported by the fact that a majority of the survey was derived from two established instruments with known psychometrics. After assembling the survey, the researcher piloted the survey with 3 LPNs at different ages and stages of their careers to determine that the survey directions, format, and content were clear.

After collecting the survey data, an exploratory factor analysis using the Kaiser Criterion and wave analysis was conducted to establish the validity of the instrument and the sample respondents. Using exploratory factor analysis, the dimensions of the survey were analyzed to evaluate the construct validity of the empowerment tool. Dimensions extracted among the variables were determined by the eigenvalue-greater-than-one rule. Varimax rotation was used to choose significant factor loadings in this study. Factor loadings were used to establish factor analysis of the instrument. After collecting the survey data, the researcher established the reliability for this particular instrument and sample using Cronbach's alpha.

Principal component factor analysis (varimax rotation) was used to determine which variables formed a coherent subset and were relatively independent of one another. Variables that were correlated with each other but mainly independent of other subsets of variables were combined into factors. Factors reflected the underlying processes that created the correlations among the variables (Tabachnick & Fidell, 2007). Principal component analysis was the determining method for construction of a valid survey instrument. Items were omitted if factor analysis showed an item not to be a good fit, and

this will be discussed in the analysis section. Variables that loaded at .4 or above were considered reliable. Cronbach's alpha coefficients were computed in the determination of scale reliability.

The organizational trust sub-scale that was used did not load well so it was transformed, using mean scores, into a categorical sorting variable of high, medium, and low organizational trust.

Data Analysis and Statistical Methodology

To assure that assumptions of inferential statistical analyses were met, prior to analyzing the data, tests for multicollinearity, normality, linearity, homoscedasticity, and independence of residuals were assessed (Pedhazur & Kerlinger, 1982). After these assumptions were tested, data were analyzed using exploratory factor analysis, ordinary least square, ANOVA and path analysis.

Ordinary least squares and multiple regressions were used to assess the relationship between the independent variables and the dependent variable. This helped to explain the magnitude and direction of the independent variables while controlling for the demographic variables of age, gender, marital status, caregiving responsibilities of dependent children, years as LPN, years as LPN at the current organization, and work setting.

Path analysis procedures, also known as structural equation modeling (SEM) with maximum likelihood estimation, were used to test the fit of the research model and to explore the direct and indirect effects of variables hypothesized as causes of variables treated as effects (Pedhazur & Kerlinger, 1982). SEM allowed for testing all relationships simultaneously while providing a statistical test of the overall fit of the model. The researcher understands, however, that path analysis is intended merely to shed light on the tenability of the casual model (Pedhazur & Kerlinger, 1982). Data were analyzed using PASW software. Structural modeling was conducted using AMOS 17.0 software. After preliminary analyses were conducted, it was expected that some

variables might need to be reduced if it was discovered that after controlling for the large number of demographic variables, statistical significance was not found. Since it was unclear whether empowerment would have any effect as a conditioning variable on LPNs' organizational commitment, Path Analysis was used to test the tenability of the study model. This is the initial study of the relationship if any, of empowerment, conflict, and trust to organizational commitment among LPN staff. For these reasons, the analysis and interpretation of survey results depended on a large number of returned surveys because of the unknown and potentially small effect size of the research variables within an LPN population. Thus the survey was mailed to all 5486 LPNs employed full time in one Midwestern state (Algina, Keselman, & Penfield, 2007).

CHAPTER 4

ANALYSIS OF DATA AND FINDINGS

This chapter contains findings from the statistical analysis related to the hypotheses. It also examines validation regarding the reliability of the instruments as well as a discussion of the assumptions for the statistical analyses and demographic characteristics of the respondents. The nomenclature used for the variables is shown in Table 4-1.

Table 4-1. Nomenclature for Study Variables

Symbol	Name
Age	Age of Respondents
Gender	Gender of Respondents
Married	Marital Status of Respondents
Long-term relationship	Long-Term Relationship
Current years	Years as LPN at current workplace
Total years	Number of years as LPN
Dependent children	Caregiving responsibility for dependent children
Work setting	Current work setting category
Empowerment	Overall Empowerment
Empowerment M	Empowerment meaning subscale
Empowerment C	Empowerment competence subscale
Empowerment S	Empowerment self-determination subscale
Empowerment I	Empowerment impact subscale
Org Commitment	Organizational Commitment
Org Trust	Organizational Trust
Org Conflict	Organizational Conflict

Assumptions

To use ordinary regression and path analysis methods to analyze data, the following assumptions were tested: (a) multicollinearity, (b) normality, (c) linearity, (d) homoscedasticity, and (e) independence of residuals (Fields, 2005).

Multicollinearity was tested by examining correlation. If multicollinearity existed between variables, it would increase the standard errors of the parameter estimates and decrease the unique effects of the variables. If an extremely strong correlation existed

between variables, for example above .90 correlation coefficient, multicollinearity might be suspected (Fields, 2005). Table 4-2 shows the correlation coefficients among the variables in this study. The correlation coefficient between number of years as an LPN and age was the highest at .702. Therefore, it was assumed that no two variables were correlated significantly.

The normality assumption was successfully tested for observing all probability-probability plots. All variables satisfied the normality assumption. The linear assumption was also successfully tested by observing that all scatter plots were linear. Homoscedasticity was assessed by observing all residual and scatter plots. All plots contained points that were approximately the same width. In addition, all data were normally distributed; thus, the problem of homoscedasticity was minimized. The Durbin-Watson coefficient was used to test the independence of residuals. According to Fields (2005), to test for independence of residuals, the Durbin-Watson coefficient should be close to 2. All Durbin-Watson coefficients were calculated, and the lowest was 1.938, thus indicating that the independence of residuals assumption was also satisfied.

Table 4-2. Correlational Coefficients Matrix Among Variables in This Study

	Age	Current years	Total years	Empowerment	Org conflict
Current years	.397**				
Total years	.702**	.499**			
Empowerment	.057	.140**	.083**		
Org conflict	.120**	-.095**	.128**	-.211**	
Org trust	.065*	.096**	.100**	.400**	-.407**

* $p < .05$; ** $p < .01$

Response Rate and Representativeness

The paper survey was distributed to all eligible full-time LPNs in the target state (N = 5486). Data were collected in the beginning of the 2010 spring semester. All eligible LPNs received the IRB-approved survey and cover letter.

A large sample of Midwestern LPNs employed full time was obtained. According to Holbrook, Farrar, and Popkin, (2006), for a small known population of approximately 5000 total subjects, 880 returned surveys provide a 95% confidence interval that a representative population was obtained. Thus to obtain a representative sample and minimize sampling biases, the instrument was broadly inclusive, was mailed to the entire population of 5486 eligible LPNs in the target state, and 21% or 1164 LPNs responded.

Return rates were considered excellent for a mailed paper survey in that 21% or 1164 LPNs responded (Holbrook et al., 2006). All 1164 surveys used in the sample were obtained from LPNs who read the sealed IRB cover letter granting their consent to participate (see Appendix G). Surveys were scanned to a spreadsheet and checked for accuracy using SNAP 9.0 software. There were minimal missing data per use of SPSS listwise deletion techniques resulting in a valid N of 1064 for analysis. Although the IRB cover letter indicated respondents had the option of not answering a question, few respondents omitted questions. With the return rate of 21% and little missing data, wave analysis was not necessary to justify the number of returned surveys. Non-response bias was minimized by the large return rate. Further demographic characteristics of the survey respondents described below resemble closely the characteristics of the study population; thus, the survey respondents may be assumed to be similar to those in the population (Fields, 2005).

Demographic Characteristics of Survey Respondents

Table 4-3 summarizes LPN respondent demographics. No reference LPN demographics are available for LPNs who worked *exclusively* full time. Appendix H contains reference demographics, but data combine full- and part-time LPNs.

Table 4-3. Full-Time LPN Respondent Demographics

Variables	Frequencies (%)
Gender	
Female	1120 (96.2)
Male	31 (2.7)
Missing	13(1.1)
Age	
Less than 25	16(1.4)
25 – 34	148(12.7)
35 – 44	204(17.5)
45 – 54	413(35.5)
55 – over	382(32.8)
Missing	1(.1)
Married	
Yes	829(71.2)
No	328(28.2)
Missing	7(.6)
Long-term Relationship	
Yes	683(58.7)
No	236(20.3)
Missing	245(21.0)
Years as LPN at current workplace	
Less than 1 year	59(5.1)
1-2	144(12.4)
3-5	230(19.8)
6-10	192(16.5)
Over 10	534(45.9)
Missing	5(.4)
Caregiving responsibilities for dependent children	
Yes	378(32.5)
No	767(65.9)
Missing	19(1.6)
Current work setting	
Hospital	151(13.0)
Office	310 (25.9)
LTC/Skilled	468(40.2)
Home Care	57(4.9)
Other	137(11.8)
Missing	50(4.3)
Organizational Trust	
Low	74(6.4)
Medium	423(36.3)
High	653(56.1)
Missing	14(1.2)

Validation and Construction of the Instruments

To test the construct validity of each instrument, a principal component analysis with varimax rotation was used. Varimax rotation is a technique used in principal component analysis that maximizes the sum of the variance of the squared loadings. It is commonly used in survey research to see how groupings of items measure the same concept. Varimax rotation attempts to maximize the dispersion of factor loadings within factors and tries to load a smaller number of variables onto each factor resulting in more interpretable clusters of factors (Fields, 2005). The eigenvalue-greater-than-one rule was used in the analysis. This rule is commonly used as cut-off criteria to determine component selection criteria and the number of components extracted among variables. Table 4-4 shows the results of the factor analysis. Items with a factor loading less than .40 were deleted. According to Fields (2005), as a rule of thumb, only variables with loadings of .30 and above should be interpreted.

Component 1 consisted of 15 items (items 13 through 27) representing organizational commitment. Items with factor loadings ranging from .068 to .332 (items 13, 15 and 19) were deleted. Components 2 through 5 consisted of 12 items that measured the four empowerment subscales: meaning, competence, self-determination, and impact. No empowerment items were deleted because all empowerment items loaded well over .40.

In summary, five factors were determined through principal components analysis using the varimax rotation method: organizational commitment and the empowerment components of meaning, competence, self-determination, and impact as suggested by Spreitzer (1995). Only three items from the commitment questionnaire were omitted from the final analysis because they showed low factor loading values.

Table 4-4. Principal Component Analysis with Varimax Rotation

Item	Variable	Factor Loading					
		1	2	3	4	5	6
1	Empowerment M	.122	.835	.259	.015	.142	.076
2	Empowerment M	.158	.842	.231	.092	.165	.074
3	Empowerment M	.133	.863	.273	.020	.149	.074
4	Empowerment C	.025	.315	.869	.035	.095	.007
5	Empowerment C	.053	.263	.885	.050	.144	-.003
6	Empowerment C	.067	.162	.830	.041	.229	.000
7	Empowerment S	.139	.167	.408	.130	.674	-.037
8	Empowerment S	.110	.154	.173	.126	.848	-.016
9	Empowerment S	.201	.146	.088	.294	.776	.069
10	Empowerment I	.274	.189	.081	.762	.174	.043
11	Empowerment I	.284	.031	.056	.831	.217	.101
12	Empowerment I	.322	.047	.011	.852	.134	.052
13	Org Commitment (omitted)	.332	.506	.089	.267	.023	-.015
14	Org Commitment	.752	.247	.034	.181	.128	.110
15	Org Commitment (omitted)	.068	.143	-.042	.016	.018	.735
16	Org Commitment	.579	.072	.015	.164	.058	-.254
17	Org Commitment	.768	.038	.071	.198	.065	.060
18	Org Commitment	.837	.148	.062	.117	.098	.164
19	Org Commitment (omitted)	.277	-.062	.075	.131	-.120	.624
20	Org Commitment	.744	.133	.065	.293	.101	.133
21	Org Commitment	.408	.073	-.003	-.003	.145	.592
22	Org Commitment	.782	.062	.054	.090	.096	.141
23	Org Commitment	.554	.062	-.030	.153	.016	.465
24	Org Commitment	.563	.015	-.031	.229	.023	.354
25	Org Commitment	.708	.282	.033	.134	.020	.143
26	Org Commitment	.804	.044	.066	.163	.079	.220
27	Org Commitment	.709	.073	.027	-.004	.161	.346
Eigenvalue		9.36	3.84	1.96	1.28	1.21	1.05
Explained Variance (%)		34.7	14.2	7.24	4.75	4.47	3.88
Cumulative Variance (5)		34.7	48.9	56.2	60.9	65.4	69.3

Reliability of the Instruments

Cronbach's alpha coefficient was used to assess the internal consistency of the instrument scales. Alpha coefficients were computed for each of the scales (empowerment and organizational commitment) using the Statistical Package for Social

Sciences 17.0 program (see Table 4-5). A high level of alpha coefficients generally means that the various items in a scale can be attributable to one factor (Fields, 2005).

The reliability coefficient of psychological empowerment was .864. The reliability coefficient of the four psychological empowerment subscales ranged from .814 (self-determination) to .924 (meaning). The reliability coefficient of organizational commitment was .923. Generally, .70 is regarded as an acceptable level of reliability coefficient (Fields, 2005). Thus, the reliability coefficients of the scales were acceptable.

Table 4-5. Comparison of Reliabilities by Factors (Cronbach's Alpha)

Factor	Reliability
Empowerment	.864
Empowerment subscale on meaning	.924
Empowerment subscale on competence	.902
Empowerment subscale on self-determination	.814
Empowerment subscale on impact	.879
Organizational Commitment	.923

Descriptive Statistics of Attitudinal Variables

Table 4-6 shows the descriptive statistics related to attitudinal variables of the sample. Respondent LPNs showed moderate levels of perceived organizational conflict (M=1.57). They showed moderately high levels of organizational commitment (M=3.65) and a high level of empowerment (M=4.15). In addition, they showed high levels of empowerment on the meaning (M=4.63), confidence (4.58), and self-determination (4.14) subscales, but only moderate levels of empowerment on the impact subscale (M = 3.22). The impact subscale had the lowest mean score, indicating that the LPN respondents overall perceived a lesser ability to impact the organization. The impact scale also had a higher standard deviation, indicating a wider measure of variability, that is, the measure of average deviation of the scores from the mean. Thus, the data were spread out more from the mean and had more variance than the other subscales.

Table 4-6. Descriptive Statistics of Attitudinal Variables

Variables	N	Min	Max	Mean	SD
Org conflict	1135	1	3	1.5744	.52126
Org commitment	1126	1	5	3.6542	.77711
Empowerment	1132	1	5	4.1458	.55401
Meaning	1162	1	5	4.6265	.66573
Competence	1159	1	5	4.5833	.59321
Self-determination	1141	1	5	4.1373	.78723
Impact	1160	1	5	3.2190	1.0428
Valid N (listwise)	1064				

Regression and ANOVA Analysis

Ordinary least-squares (OLS) regression analysis was employed to test the effects of the continuous demographic variables and organizational conflict on the intervening variable (empowerment) and the dependent variable (organizational commitment). Table 4-7 shows the results.

Table 4-7. Statistically Significant Relationships Between the Continuous Demographics and Attitudinal Variables Using Ordinary Least Squares Techniques

Attitudinal Variable	Demographic Variable	Beta (β)	sig
Org commitment	Age	.112	.000***
Org commitment	Years at current workplace	.128	.000***
Org commitment	Total years as LPN	.121	.000***
Org commitment	Org conflict	-.452	.000***
Empowerment	Years at current workplace	.140	.000***
Empowerment	Total years as LPN	.830	.005**
Empowerment	Org conflict	-.211	.000***

* $p < .05$; ** $p < .01$; *** $p < .001$

To test for differences of the categorical demographic variables (i.e., the variables of gender, marital status, caregiving responsibilities for dependent children, work setting, and the three organizational trust categories) on organizational commitment, ANOVA methods were employed. To test for differences between the categorical variables (gender, marital status, caregiving responsibilities of dependent children, work setting,

and the three organizational trust categories) and the intervening variable (empowerment), ANOVA methods were also employed.

The Scheffé Post Hoc test was employed for the categorical variables of work setting and trust groups because these categorical variables had more than two categories. The Scheffé test was used to determine which of the multiple categories significantly varied from each other on the dependent variable. Tables 4-8 through 4-13 show the results of the regressions and the ANOVAs.

Age had positive significant effects on organizational commitment ($\beta = .112$, $p < .000$). Older LPNs showed a higher level of organizational commitment. Years at current workplace ($\beta = .128$, $p < .000$) had positive significant effects on organizational commitment. Total years as LPN ($\beta = .121$, $p < .000$) had positive effects on organizational commitment. Higher organizational conflict negatively affected organizational commitment ($\beta = -.452$, $p < .000$).

Years at current workplace ($\beta = .140$, $p < .000$) had positive significant effects on empowerment. Total years as LPN ($\beta = .830$, $p < .005$) had positive effects on empowerment. Higher organizational conflict negatively affected empowerment ($\beta = -.211$, $p < .000$).

Table 4-8. Significant Difference of Attitudinal Variables by Gender Using ANOVA Techniques

Attitudinal		Sum of Squares	df	F	Sig
Org commitment	B groups	2.416	1	3.999	.046*
	W groups	671.105	1111		
	Total	673.521	1112		
Empowerment	B groups	2.368	1	7.748	.005**
	W groups	341.427	1117		
	Total	343.796	1118		

* $p < .05$; ** $p < .01$; *** $p < .001$

There was a significant difference for gender on organizational commitment at the $p < .05$ level [$F(1, 1111) = 3.999, p = .046$]. Mean score for male ($M = 3.369, SD = .936$) was significantly different than for female ($M = 3.657, SD = .773$). Females had a higher mean score for organizational commitment.

There was a significant difference for gender on empowerment at the $p < .05$ level [$F(1, 1117) = 7.748, p = .005$]. Mean score for male ($M = 3.871, SD = .570$) was significantly different than for female ($M = 4.151, SD = .55239$). Females had a higher mean score for empowerment. Only 2% of LPN respondents were male, which is similar to national LPN male demographic data. Nationally only 5% of LPNs are male (Seago, Spetz, Chapman, Dyer, & Grumbach, 2004).

Table 4-9. Significant Difference of Attitudinal Variables by Married Using ANOVA Techniques

Attitudinal		Sum of Squares	df	F	Sig
Org commitment	B groups	7.937	1	7.937	.000***
	W groups	677.335	1117		
	Total	675.271	1118		
Empowerment	B groups	2.449	1	8.001	.005**
	W groups	343.688	1123		
	Total	346.136	1124		

* $p < .05$; ** $p < .01$; *** $p < .001$

There was a significant difference for married LPNs on organizational commitment at the $p < .05$ level [$F(1, 1117) = 7.937, p = .000$]. Mean score for married ($M = 3.704, SD = .764$) was significantly different than for not married ($M = 3.517, SD = .797$). Married LPNs had a higher mean for organizational commitment.

There was a significant difference for married LPNs on empowerment at the $p < .05$ level [$F(1, 1123) = 8.001, p = .005$]. Mean score for married ($M = 4.174, SD = .558$)

was significantly different than for not married ($M=4.071$, $SD=.541$). Married LPNs had a higher mean for empowerment.

Table 4-10. Significant Difference of Attitudinal Variables by Long-Term Relationship Using ANOVA Techniques

Attitudinal		Sum of Squares	df	F	Sig
Empowerment	B groups	2.341	1	7.918	.005**
	W groups	263.991	893		
	Total	266.332	894		

* $p < .05$; ** $p < .01$; *** $p < .001$

There was a significant difference for long-term relationship on empowerment at the $p < .05$ level [$F(1, 893)=7.918$, $p=.005$]. Mean empowerment scores for long-term relationship ($M=4.169$, $SD=.548$) were significantly different than for no long-term relationship ($M=4.051$, $SD=.530$). LPNs in a long-term relationship had higher empowerment means.

Table 4-11. Significant Difference of Attitudinal Variables by Work Setting Category Using ANOVA Techniques

Attitudinal		Sum of Squares	df	F	Sig
Org commitment	B groups	14.577	4	6.169	.000***
	W groups	633.227	1072		
	Total	647.804	1076		

* $p < .05$; ** $p < .01$; *** $p < .001$

There was a significant difference of work setting on organizational commitment at the $p < .000$ level [$F(4, 1072)=6.169$, $p=.000$]. Because there were significant effects of the work setting categories on organizational commitment, the Scheffé technique was

employed to explore which categories differed. Scheffé results indicated that the mean organizational commitment score for long-term care/skilled ($M=3.524$, $SD=.80704$) was significantly different than for both office ($M = 3.7205$, $SD=.72670$) and other ($M=3.6558$, $SD=.77592$). Office and other had higher mean scores for organizational commitment than LTC/skilled.

Table 4-12. Significant Difference of Organizational Commitment by Organizational Trust Categories Using ANOVA Techniques

Attitudinal		Sum of Squares	df	F	Sig
Org commitment	B groups	372.170	2	681.545	.000***
	W groups	303.614	1112		
	Total	675.784	1114		

* $p<.05$; ** $p<.01$; *** $p<.001$

There was a significant difference of organizational trust levels on organizational commitment at the $p<.000$ level [$F(2, 1112)=681.545$, $p=.000$]. Because there were significant differences of organizational trust categories on organizational commitment, the Scheffé technique was employed to explore which trust categories differed. Scheffé results indicated that all three organizational trust categories significantly differed on organizational commitment. Mean score for low organizational trust ($M=2.172$, $SD=.674$) was significantly different than for medium organizational trust ($M=3.206$, $SD=.550$) and high organizational trust ($M=4.107$, $SD=.484$). Further, the organizational commitment mean score for the medium organizational trust group ($M=3.206$, $SD=.550$) was significantly different than for the high organizational trust group ($M=4.107$, $SD=.484$). The high organizational trust group had the highest organizational commitment mean, and the low organizational trust group had the lowest organizational commitment mean.

Table 4-13. Significant Difference of Empowerment by Organizational Trust Categories Using ANOVA Techniques

Attitudinal		Sum of Squares	df	F	Sig
Empowerment	B groups	55.384	2	107.033	.000*
	W groups	288.735	1116		
	Total	344.119	1118		

*p<.05; ** p< .01; *** p< .001

There was a significant effect of organizational trust levels on empowerment [F(2, 1116)=107.033, p=.000]. Because there were significant effects of the three organizational trust categories on empowerment, the Scheffé technique was employed to explore which trust categories differed on empowerment. Scheffé results indicated that all three organizational trust categories significantly differed on empowerment. The mean score for low organizational trust (M=3.6526, SD=.621) was significantly different than for medium organizational trust (M = 3.946, SD=.528) and high organizational trust (M=4.331, SD=.482). Further, the empowerment mean for the medium organizational trust group (M=3.946, SD=.528) also differed from that of the high organizational trust group (M=4.331, SD=.482). The high organizational trust group had the highest empowerment mean followed by the medium organizational trust group.

Summary Regression and ANOVA Analysis

Age, total years as LPN, years as LPN at current work setting, and organizational conflict had significant effects on organizational commitment. Gender, marital status, and the work setting categories of LTC/Skilled, office, and “other” showed significant differences for organizational commitment. All organizational trust categories showed significant differences for organizational commitment.

Current years as LPN, total years as LPN, and organizational conflict had significant effects on empowerment. All organizational trust categories showed

significant differences for empowerment. Long-term relationship showed significant differences for empowerment.

Hypothesis Testing

Hypothesis 1

Hypothesis 1: Organizational commitment will be affected by age, gender, marital status, caregiving responsibilities for dependent children, years as LPN, years as LPN at current organization and work setting in an LPN population.

This hypothesis was partially supported. Ordinary least square regression equations were first estimated to determine the relationship between the three continuous demographic variables (age, years as LPN, and years as LPN at current organization) and organizational commitment. Given that commitment was hypothesized to be associated with the selected demographic variables, the continuous demographic variables were regressed on organizational commitment.

Table 4-7 shows results of the regressions. Table 4-14 shows the regression equation model for this hypothesis. The model indicates age, years at current organization, and total years as an LPN predict organizational commitment.

Table 4-14. Regression Model for Hypothesis 1

Org commitment = β_1 (age)
Org commitment = β_2 (current years)
Org commitment = β_3 (total years)

The regression model suggested that higher levels of age, years at current workplace, and total number of years as LPN were positively associated with organizational commitment. Organizational commitment was positively related to age ($\beta = .112, p < .001$), years at current position was positively related to organizational

commitment ($\beta = .128$, $p < .001$), and total years was positively related to organizational commitment ($\beta = .121$, $p < .001$). Table 4-15 contains the results.

Table 4-15. Contribution of Continuous Demographic Variables to Organizational Commitment

Dependent Variables	Independent Variables	β	sig
Org Commitment $R^2 = .013$ Adj $R^2 = .012$	Age	.112	.000***
Org commitment $R^2 = .016$ Adj $R^2 = .015$	Current years	.128	.000***
Org commitment $R^2 = .015$ Adj $R^2 = .014$	Total years	.121	.000***

* $p < .05$; ** $p < .01$; *** $p < .001$

These regression results supported Hypothesis 1. LPNs with higher age, current years, and total years as LPN positively affected organizational commitment. It was a positive relationship; thus, higher age, current years, and total years were positively associated with higher levels of organizational commitment. The summed R square results indicated that 4.4% of the variance in organizational commitment was explained by age, current years, and total years as LPN. Thus, although age, current years, and total years as LPN supported this hypothesis, only a small amount of variance in LPN organizational commitment was explained by these three demographic variables

Given that organizational commitment was hypothesized to be associated with the selected categorical variables, ANOVA and Scheffé techniques were employed to test for categorical mean group differences on organizational commitment. ANOVA techniques were used to test for significant differences in organizational commitment between the

categories of gender, marital status, long-term relationship, caregiving responsibilities, and work setting. Only gender, married, and three workplace settings were significant. Table 4-8 shows gender differences on organizational commitment. Table 4-9 shows married differences on organizational commitment. Table 4-11 shows workplace settings on organizational commitment. Scheffé results revealed significant differences on organizational commitment between long-term care/skilled and office and long-term care/skilled and other. Mean scores for organizational commitment between long-term care/skilled ($M=3.52$, $SD=.807$) were significantly different than office ($M=3.72$, $SD=.726$). Mean score for organizational commitment between long-term care/skilled ($M=3.52$, $SD=.807$) were significantly different than the workplace category of other ($M=3.83$, $SD=.787$).

ANOVA results partially supported Hypothesis 1. There were significant differences in organizational commitment between the groups of gender and married and among LPNs employed in LTC/skilled and office and LTC/skilled and other.

Hypothesis 2

Hypothesis 2. Higher levels of organizational conflict will be associated with lower levels of organizational commitment at current organization and work setting in an LPN population.

This hypothesis was supported. Given that organizational conflict was hypothesized to be negatively associated with organizational commitment, conflict was regressed on commitment. A single regression equation (Table 4-16) was estimated to determine the relationship between organizational conflict and organizational commitment. Table 4-17 shows results of the regressions.

Table 4-16. Regression Model for Hypothesis 2

$$\text{Org commitment} = \beta_1 (\text{conflict})$$

Table 4-17. Contribution of Organizational Conflict to Organizational Commitment

Dependent Variables	Independent Variables	β	sig
Org Commitment	Org conflict	-.452	.000***
R ² = .205			
Adj R ² = .204			

*p<.05; **p<.01; ***p<.001

The regression results supported Hypothesis 2. Higher organizational conflict negatively affected organizational commitment in the LPN sample. It was a negative relationship; therefore, higher conflict levels were negatively associated with organizational commitment. Results indicated that R squared = .205; thus, 21% of the variance in organizational commitment was explained by organizational conflict. This supported Hypothesis 2 in that LPNs with lower levels of conflict also possessed higher levels of organizational commitment.

Hypothesis 3

Hypothesis 3: Higher levels of organizational trust will be associated with higher levels of organizational commitment at current organization and work setting in an LPN population.

As previously noted in the analysis, when principal component varimax rotation techniques were applied, the organizational trust scale failed to indicate satisfactory factor loadings. Thus, the originally continuous organizational trust measures were reduced to a ranked categorical sorting variable of high, medium, and low organizational trust by evenly dividing organizational trust mean scores into three ordered trust category groups.

ANOVA and Scheffé techniques were applied to the three organizational trust groups to test for mean trust group differences on organizational commitment. Table 4-

12 shows ANOVA results of organizational trust differences on organizational commitment. Scheffé results revealed significant differences on organizational commitment between all three organizational trust groups. There were significant differences on organizational commitment between low trust ($M=2.17$, $SD=.674$) and medium trust groups ($M=3.21$, $SD=.549$). There were significant mean differences on organizational commitment between low trust ($M=2.17$, $SD=.674$) and high trust groups ($M=4.11$, $SD=.484$). There were also significant mean differences on organizational commitment between medium trust groups ($M=3.21$, $SD=.549$) and high trust groups ($M=4.11$, $SD=.484$).

ANOVA results indicated that there were significant differences in organizational commitment between all three groups as to organizational trust. LPN respondents generally had medium to high organizational trust. Only 74 respondents were categorized into the low organizational trust group, whereas 423 had medium organizational trust and 653 respondents had high organizational trust.

Hypothesis 4

Hypothesis 4: Higher levels of empowerment will be associated with higher levels of organizational commitment at current organization and work setting in an LPN population.

This hypothesis was supported. Two OLS regression equations were estimated in Table 4-18. The first single regression equation was estimated to examine the relationships between total empowerment and organizational commitment. The first equation regressed total empowerment on organizational commitment. The second equation was estimated to examine the relationship between the four empowerment subscales and organizational commitment. The empowerment subscales (Meaning, Competence, Self-Determination, and Impact) were utilized in SEM techniques to test the proposed conceptual framework (see Appendix A). Thus, the empowerment subscales were also regressed on organizational commitment. Table 4-19 shows the regression

results of the first single regression equation. Table 4-20 shows the regression results of the second equation.

Table 4-18. Regression Models for Hypothesis 4

Org commitment = β_1 (empowerment)
Org commitment = β_1 (emp m) + β_2 (emp c) + β_3 (emp s) + β_4 (emp i)

The first single regression model suggests that higher levels of total empowerment were positively associated with organizational commitment. Results supported this hypothesis and indicated that 25% of the variance in organizational commitment was explained by total empowerment.

Table 4-19. Significant Contribution of Empowerment to Organizational Commitment

Dependent Variables	Independent Variables	β	sig
Org Commitment	Empowerment	.503	.000***
R ² = .253			
Adj R ² = .253			

*p<.05; **p<.01; ***p<.001

The second regression model suggests that higher levels of the sub-scales of empowerment were also positively associated with organizational commitment. Results supported this hypothesis. All the relationships between the empowerment sub-categories and organizational commitment were statistically significant. Table 4-20 shows the empowerment subscale regression results.

Table 4-20. Significant Contribution of Empowerment Subcategories to Organizational Commitment

Dependent Variables	Independent Variables	β	sig
Org Commitment $R^2 = .119$ Adj $R^2 = .118$	empowerment_m	.345	.000***
Org Commitment $R^2 = .025$ Adj $R^2 = .024$	empowerment_c	.157	.000***
Org Commitment $R^2 = .123$ Adj $R^2 = .122$	empowerment_s	.350	.000***
Org Commitment $R^2 = .276$ Adj $R^2 = .276$	empowerment_i	.526	.000***

* $p < .05$; ** $p < .01$; *** $p < .001$

The second single regression model suggests that higher levels of the empowerment subscales were positively associated with organizational commitment. Results supported this hypothesis and indicated that 12% of the variance in organizational commitment was explained by empowerment_m. Results indicated that 3% of the variance in organizational commitment was explained by empowerment_c. Results indicated that 20% of the variance in organizational commitment was explained by empowerment_s. Results indicated that 28% of the variance in organizational commitment was explained by empowerment_i.

Results implied that empowerment was highly associated with organizational commitment. This suggests that empowerment impact explained the most variance in organizational commitment followed by self-determination and meaning. The empowerment competence subscale was significant for explaining variance in organizational commitment, but it explained only 3% of the variance.

Structural Equation Modeling Results:

Hypotheses 5, 6, and 7

Structural equation modeling (SEM) tests the tenability of proposed causal models that are formulated on theory (Pedhazur, 1997). SEM was used to confirm the proposed conceptual framework regarding organizational commitment among LPNs and to answer Hypotheses 5, 6 and 7. These hypotheses tested empowerment as a mediator of organizational commitment. Mediation models are causal models, thus SEM was used to estimate the paths of the causal model (see Appendix A).

To use SEM techniques to establish mediation, the independent variables must be correlated with both the outcome and the mediator variables, and the mediator variable must affect the outcome variable. SEM mediation results establish whether the mediator completely or partially mediates the outcome variable. Indirect effects are the reduction of the effect of the independent variables on the outcome variable once the mediator variable has been employed (Pedhazur, 1997).

Structural modeling explores direct effects of the independent variables on a dependent variable, but indirect and total effects are also considered. Indirect effects are obtained by multiplying the path coefficients between the dependent variable and each independent variable. Total effects are the sum of the direct and indirect effects. Thus SEM was applied to test the effects of the independent variables (the demographic variables, organizational trust, and organizational conflict) through the mediating variable (empowerment) on the dependent variable (organizational commitment).

Independent variables that influence both the mediating variable and the outcome variables are age, married, years as LPN at current organization, total years as LPN, caregiving responsibilities for dependent children, organizational conflict, and organizational trust. Thus these variables were used in the SEM techniques. Dummy coding was used for categorical variables so that SEM regressions could be employed

(Pedhazur, 1997). Categorical variables that were dummy coded are indicated by the letter “D” preceding the variable name.

Figure 4-1 makes it easier to visualize the complex SEM relationships among the many variables intuitively. For clarity, only significant estimated regression coefficients for organizational commitment are included in the figure. The figure illustrates the independent variables covariance and also that all independent variables are tested for effects through the mediating variable, empowerment on the outcome variable, organizational commitment. Table 4-24 shows the results of the path analysis. Table 4-25 lists estimated regression coefficients as well as indirect effects, total effects, and significance. Structural equation modeling (SEM) using the AMOS 18 program was used in the analysis. All figures and tables are presented later in the analysis to follow.

Hypothesis 5

Hypothesis 5: The relationship between empowerment and organizational commitment will be influenced by employee demographic variables (age, marital status, caregiving responsibilities for dependent children, current years as LPN, and total years as LPN) at current organization in an LPN population.

To examine the path relationship between empowerment and organizational commitment with the influence of the independent demographic variables, one OLS regression equation was estimated. AMOS 18 software was applied to conduct the SEM techniques. Because empowerment was hypothesized to be associated with organizational commitment, empowerment along with the demographic independent variables were regressed on organizational commitment to test the proposed conceptual framework (see Appendix A).

To test for effects on organizational commitment by demographic variables through empowerment, a regression equation was developed. Independent variables included empowerment, demographic variables, and a variable representing the interaction between empowerment and demographic variables. Table 4-15 shows the

SEM regression model for Hypothesis 5. Table 4-24 shows the estimated regression coefficients (β) from the structural modeling techniques with bold indicating the significant paths. Table 4-25 includes estimated regression coefficients, including indirect, direct and total effects as well as significance.

Table 4-21. Regression Model for SEM for Hypothesis 5

$$\begin{aligned} \text{Organizational commitment} = & \beta 1 (\text{empowerment_m}) + \beta 2 (\text{Empowerment_c}) + \beta 3 (\text{Empowerment_s}) + \beta 4 \\ & (\text{Empowerment_i}) + \beta 5(\text{age}) + \beta 6(\text{married}) + \beta 7(\text{current years}) + \beta 8(\text{total years}) + \beta 9(\text{care-giving children}) \\ & + \beta 10 (\text{empowerment_m*age}) + \beta 11 (\text{empowerment_m*married}) + \beta 12(\text{empowerment_m*current years}) + \\ & \beta 13 (\text{empowerment_m*total years}) + \beta 14(\text{empowerment_m*care-giving children}) + \beta 15 \\ & (\text{empowerment_c*age}) + \beta 16 (\text{empowerment_c*married}) + \beta 17(\text{empowerment_c*current years}) + \beta 18 \\ & (\text{empowerment_c*total years}) + \beta 19(\text{empowerment_c*care-giving children}) + \beta 20 (\text{empowerment_s*age}) \\ & + \beta 21 (\text{empowerment_s*married}) + \beta 22(\text{empowerment_s*current years}) + \beta 23 (\text{empowerment_s*total \\ & years}) + \beta 24(\text{empowerment_s*care-giving children}) + \\ & \beta 25 (\text{empowerment_i*age}) + \beta 26 (\text{empowerment_i*married}) + \beta 27(\text{empowerment_i*current years}) + \beta 28 \\ & (\text{empowerment_i*total years}) + \beta 29(\text{empowerment_i*care-giving children}) \end{aligned}$$

SEM techniques revealed several significant direct effects between demographic variables and the mediating variable, empowerment subscales. Caregiving responsibilities for dependent children had a significant negative direct effect on empowerment_m ($\beta = -.084$, $p < .01$) and empowerment_c ($\beta = -.094$, $p < .01$). Thus in this path model, LPNs with caregiving responsibilities for dependent children had significantly lower scores on the empowerment meaning and competence subscales than did LPNs free of dependent child care. Higher current years at present LPN position had a direct positive effect on three empowerment subscales: empowerment_c subscale ($\beta = .067$, $p < .05$), empowerment_s subscale ($\beta = .077$, $p < .05$), and the empowerment_i subscale ($\beta = .105$, $p < .001$). Thus in this path model, LPNs with more years at current job had significantly higher perceived empowerment with regard to competence, self-determination, and impact. Higher total years as LPN had a significant positive direct effect on empowerment_c ($\beta = .172$, $p < .001$) but a significant negative direct effect on empowerment_i ($\beta = -.086$, $p < .05$). Thus, in this path model, LPNs with higher total

years as LPN had significantly higher scores on the empowerment competence subscale but significantly lower scores on the empowerment impact sub-scale. Table 4-25 shows SEM regression coefficients as well as indirect effects, total effects and significance.

This hypothesis was not supported because SEM results indicated the relationship between empowerment and organizational commitment was not significantly influenced by the demographic variables. Employing SEM techniques to test empowerment as a mediating variable revealed that empowerment fully mediated the relationship between the demographic variables and organizational commitment. That is, empowerment used as a mediating variable eliminated the direct effects of employee demographic variables (age, marital status, care giving responsibilities for dependent children, current years as LPN, and total years as LPN) on organizational commitment. See estimated regression coefficients (β) from the structural model in Table 4-24. Table 4-25 lists SEM estimated regression coefficients for organizational commitment as well as indirect effects, total effects, and significance.

Hypothesis 6

Hypothesis 6: The relationship between empowerment and organizational commitment at current organization will be influenced by organizational conflict at current work setting and organization in an LPN population.

To test for effects on organizational commitment by organizational conflict with empowerment employed as the mediating variable, a regression equation was developed in which independent variables included empowerment, organizational conflict, and a variable representing the interaction between empowerment and organizational conflict. The regression equation is shown in Table 4-22.

In order to examine the relationship between empowerment and organizational commitment with the influence of organizational conflict as an independent variable, one OLS regression equation was estimated and AMOS 18 software employed to conduct the SEM techniques. Because empowerment was hypothesized to be associated with

organizational commitment, empowerment along with the organizational conflict variable was regressed on organizational commitment. Table 4-22 contains the SEM regression model for Hypothesis 6. Table 4-24 shows the estimated regression coefficients (β) from the structural modeling techniques. Table 4-25 lists estimated regression coefficients for organizational commitment as well as indirect effects, total effects and significance.

Table 4-22. Regression Model for Hypothesis 6

$$\text{Organizational commitment} = \beta_1 (\text{empowerment}_m) + \beta_2 (\text{empowerment}_c) + \beta_3 (\text{empowerment}_s) + \beta_4 (\text{empowerment}_i) + \beta_5 (\text{org conflict}) + \beta_6 (\text{empowerment}_m * \text{org conflict}) + \beta_7 (\text{empowerment}_c * \text{org conflict}) + \beta_8 (\text{empowerment}_s * \text{org conflict}) + \beta_9 (\text{empowerment}_i * \text{org conflict})$$

This hypothesis was partially supported but with complex results. SEM results indicated in this path model that empowerment only partially mediated the relationship between organizational conflict and organizational commitment. There were still significant direct effects of organizational conflict on organizational commitment when empowerment was employed as the mediating variable using SEM techniques. Thus empowerment did not completely mediate the relationship of organizational conflict on organizational commitment. SEM results indicated that conflict had a significant negative direct effect on organizational commitment ($\beta = -.156, p < .001$) with empowerment employed as the mediating variable.

There were several direct effects of organizational conflict on the empowerment subscales in the path model. Conflict had a negative direct effect on both the empowerment self-determination subscale, empowerment_s ($\beta = -0.08, p < .05$) and the empowerment impact subscale, empowerment_i ($\beta = -0.128, p < .001$). Thus, in this path model, organizational conflict negatively affected perceived self determination and impact aspects of empowerment. SEM results indicated that conflict had a positive direct effect on the empowerment meaning subscale, empowerment_m ($\beta = 0.072, p < .05$). This

path result indicated that organizational conflict had positive effects on aspects of empowerment that measure meaning.

SEM results indicated a significant negative standardized total effect of organizational conflict through empowerment on organizational commitment ($\beta = -0.176$, $p < .001$). In SEM, total effects are sometimes used to rank the importance of a variable in terms of explaining the variance in a dependent variable (Pedhazur, 1997). Thus the significant total effect indicates that empowerment significantly mediated the relationship between organizational conflict and organizational commitment but empowerment did not completely mediate the relationship. Thus Hypothesis 6 was partially supported. Results support the tenability of the proposed conceptual framework in that organizational conflict through empowerment did influence organizational commitment.

Hypothesis 7

Hypothesis 7: The relationship between empowerment and organizational commitment will be influenced by organizational trust at current work setting and organization in an LPN population.

To test for effects on organizational commitment by organizational trust levels through empowerment, an OLS regression equation was developed in which independent variables included empowerment, organizational trust, and a variable representing the interaction between empowerment and organizational trust. The regression equation is shown in Table 4-23. AMOS 18 software was employed to conduct the SEM techniques. Dummy coded organizational trust variables were used so that SEM techniques could be employed utilizing the low trust group as the reference group. Table 4-23 contains the SEM regression model for Hypothesis 7. Table 4-24 shows the estimated regression coefficients (β) from the structural modeling techniques. Table 4-25 lists estimated regression coefficients for organizational commitment as well as indirect effects, total effects and significance.

Table 4-23. Regression SEM Model for Hypothesis 7

$$\begin{aligned} \text{Organizational commitment} = & \beta 1 (\text{empowerment_m}) + \beta 2 (\text{empowerment_c}) + \beta 3 (\text{empowerment_s}) + \beta 4 \\ & (\text{empowerment_i}) + \beta 5 (\text{medium org trust}) + \beta 6 (\text{high org trust}) + \beta 7 (\text{empowerment_m} * \text{medium org trust}) + \\ & \beta 8 (\text{empowerment_m} * \text{high org trust}) + \beta 9 (\text{empowerment_c} * \text{medium org trust}) + \beta 10 \\ & (\text{empowerment_c} * \text{high org trust}) + \beta 11 (\text{empowerment_s} * \text{medium org trust}) + \beta 12 \\ & (\text{empowerment_s} * \text{medium org trust}) + \beta 13 (\text{empowerment_i} * \text{medium org trust}) + \beta 14 \\ & (\text{empowerment_i} * \text{medium org trust}) \end{aligned}$$

This hypothesis was partially supported. SEM results indicated that empowerment partially mediated the relationship between organizational trust levels and organizational commitment. Although empowerment mediated the relationship, there were still direct effects of organizational trust on organizational commitment after empowerment was employed as a mediating variable in the structural model.

SEM results indicated that medium organizational trust had significant standardized direct effects on organizational commitment ($\beta = .499, p < .001$) with empowerment employed as a mediating variable. High organizational trust also had significant standardized direct effects on organizational commitment ($\beta = .923, p < .001$) with empowerment employed as a mediating variable.

SEM techniques revealed several significant direct effects between organizational trust levels and the mediating variable empowerment subscales. Medium organizational trust had significant direct effects on empowerment-meaning ($\beta = 0.133, p < .05$), empowerment-self determination ($\beta = 0.217, p < .001$) and empowerment-impact ($\beta = 0.292, p < .001$). High organizational trust also had significant direct effects on empowerment-meaning ($\beta = 0.41, p < .001$), empowerment-self determination ($\beta = 0.384, p < .001$), and empowerment-impact ($\beta = 0.605, p < .001$). Table 4-25 lists estimated regression coefficients for organizational commitment as well as indirect effects, total effects, and significance. Results indicated that medium and high organizational trust positively affects LPN empowerment in the structural model.

This hypothesis was partially supported. SEM results indicated significant positive standardized total effects of both medium ($\beta = 0.589$, $p < .001$) and high ($\beta = 1.116$, $p < .001$) organizational trust through empowerment on organizational commitment. In SEM, total effects are sometimes used to rank the importance of a variable in terms of explaining the variance in a dependent variable (Pedhazur, 1997). The significant total effects indicated that empowerment significantly mediated the relationship between organizational trust levels and organizational commitment; however, empowerment did not mediate the relationship completely. Thus Hypothesis 7 was partially supported. Results supported the tenability of the proposed conceptual framework in that organizational trust through empowerment did significantly influence organizational commitment.

Finally, it should be noted that SEM results indicated that neither organizational trust nor organizational conflict had any path effects through the empowerment competence subscale in the path model. Thus empowerment competence did not mediate the relationship between organizational trust levels or organizational conflict to organizational commitment. Results suggested that aspects of empowerment that focused on competence did not affect the path model.

Summary of Structural Equation Modeling Results for Hypotheses 5, 6, and 7

SEM results for Hypothesis 5 indicated that while several demographic variables had direct effects on empowerment, none of them had significant direct effects on organizational commitment after empowerment was employed as a mediating variable. In this study, empowerment completely mediated the relationship between the LPNs' demographic variables (age, marital status, current years as LPN in present job, total years as LPN, and caregiving responsibilities for dependent children) and organizational commitment. Although these demographic variables alone predicted organizational commitment, in this path model they were completely mediated by empowerment. Thus

empowerment appeared to be an excellent mediator of these variables with regard to the organizational commitment relationship in LPNs employed full time.

SEM results for Hypotheses 6 indicated that organizational conflict had direct effects on empowerment and a significant negative direct effect on organizational commitment with empowerment employed as a mediating variable. Thus SEM results indicated that empowerment only partially mediated this relationship. Although organizational conflict negatively predicted organizational commitment, in this path model empowerment only partially mediated this relationship in a large LPN population employed full time.

Finally, SEM results for Hypotheses 7 indicated that both medium and high organizational trust had direct effects on empowerment and significant positive effects on organizational commitment. Thus SEM results indicated that empowerment only partially mediated this relationship. Although higher organizational trust predicted organizational commitment, empowerment only partially mediated the relationship in full-time LPNs.

Table 4-24. Estimated Regression Coefficients (β) from the Structural Model

	Dependent variables				
	Emp m	Emp c	Emp s	Emp i	Commitment
Age	0.077	-0.045	-0.016	0.013	0.032
D_Married	-0.019	-0.019	-0.012	-0.044	-0.034
Current yrs	0.043	0.067*	0.077*	0.105***	0.002
Total yrs	-0.04	0.172***	0.001	-0.086*	0.005
D_Children	-0.084**	-0.094**	-0.043	0.002	0.023
Org_Conflict	0.072*	0.02	-0.08*	-0.128***	-0.156***
D_Org Trust Medium	0.133*	-0.058	0.217***	0.292***	0.499***
High	0.41***	0.072	0.384***	0.605***	0.923***
Empowerment_m	-	-	-	-	0.139***
Empowerment_c	-	-	-	-	-0.043*
Empowerment_s	-	-	-	-	0.06**
Empowerment_i	-	-	-	-	0.192***

Note: bold indicates significant estimated regression coefficients

* $p < .05$; ** $p < .01$; *** $p < .001$

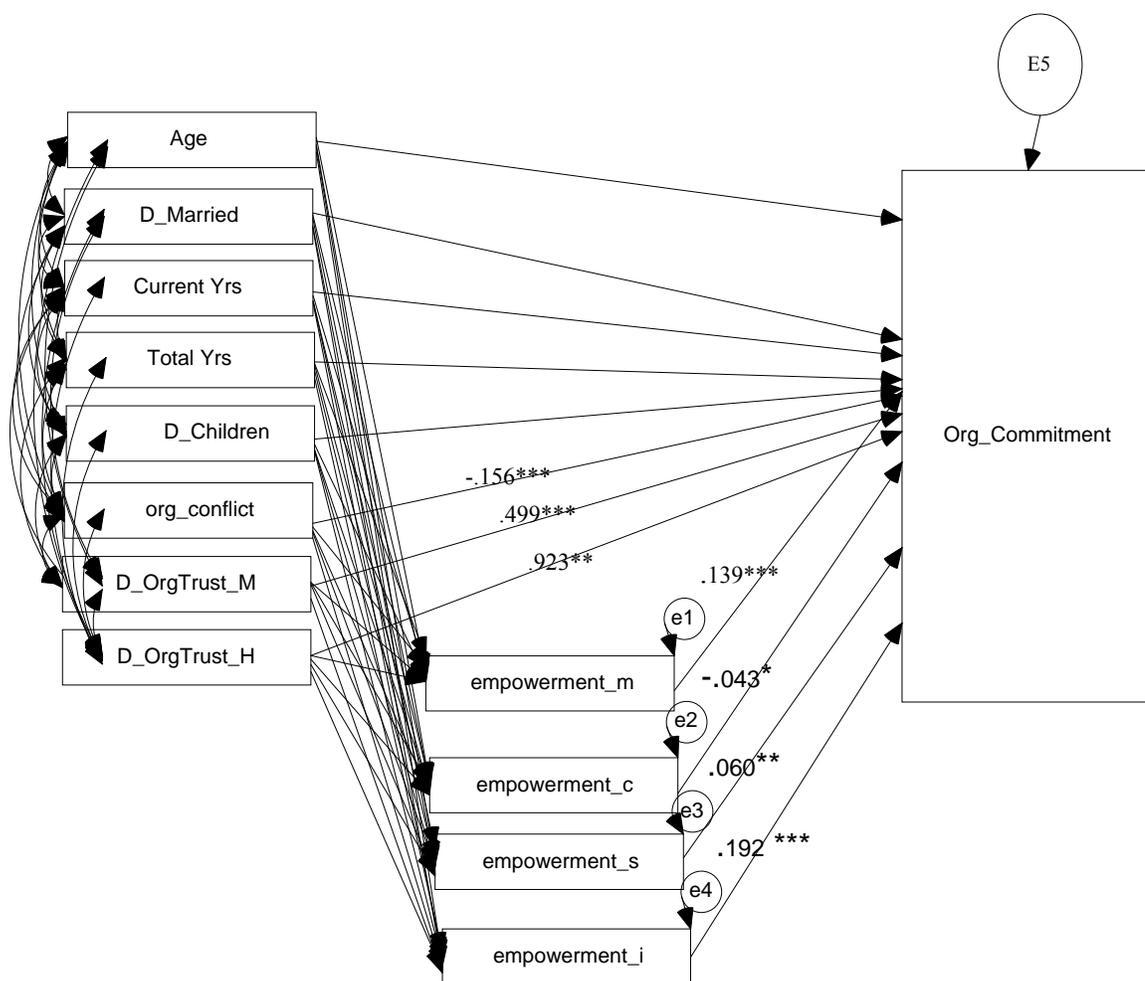


Figure 4-1. Path Model of Organizational Commitment

Note: Only significant estimated regression coefficients for organizational commitment are included on the figure, and circles indicate error.

Table 4-25. Path Analysis Results: Estimated Regression Coefficients and Significance

Variables	Emp_M	Emp_C	Emp_S	Emp_I	Org Commitment	Org Commitment	
	Direct Effect	Direct Effect	Direct Effect	Direct Effect	Standardized Direct Effects	Standardized Indirect Effect	Standardized Total Effects
Age	.077	-.045	-.016	.013	.032	.014	0.047
Married	-.019	-.019	-.012	-.044	-.034	-.011	-0.044
Current Years	.043	.067*	.077*	.105***	.002	.028	0.030
Total Years	-.040	.172***	.001	-.086*	.005	-.029	-.024
Dependent Children	-.084**	-.094**	-.043	.002	.023	-.010	0.013
Org Conflict	.072*	0.02	-0.08*	-0.128***	-.156***	-.020	-0.176***
Org Trust_M	0.133*	-0.058	0.217***	0.292***	.499***	.090***	0.589***
Org Trust_H	0.41***	0.072	0.384***	0.605***	.923***	.193	1.116***

* $p < .05$; ** $p < .01$; *** $p < .001$

CHAPTER 5

DISCUSSION AND ANALYSIS

This chapter recapitulates major study findings, places them in the context of existing literature, and discusses implications for nursing. Recommendations for future nursing research are also discussed.

The central focus of this study was to explore the proposed relationships of factors hypothesized to be associated with LPNs' commitment to their organizations. In addition, the role of empowerment as a mediator of LPN organizational commitment was explored. Scant empirical research exists regarding LPN organizational commitment. This study addresses this gap with a proposed model to explore the relationships between organizational conflict, trust, demographic variables and an intervening variable, empowerment, with organizational commitment. This study surveyed a large sample of full-time LPNs.

Model

The study posited the following model to examine these concepts in a population of full-time LPNs.

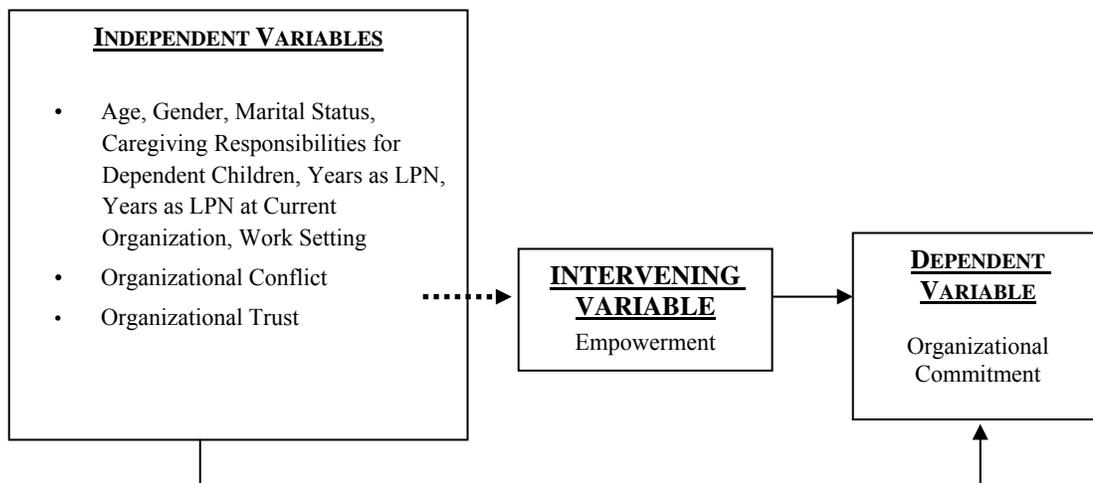


Figure 5-1. Conceptual Framework

Table 5-1. Summary of Hypothesis Test Results

H1	Organizational commitment will be affected by age, gender, marital status, long-term relationship, caregiving responsibilities for dependent children, years as LPN, years as LPN at current organization and work setting in an LPN population.	Partially supported
H2	Higher levels of organizational conflict will be associated with lower levels of organizational commitment at current organization and work setting in an LPN population.	Fully supported
H3	Higher levels of organizational trust will be associated with higher levels of organizational commitment at current organization and work setting in an LPN population.	Partially supported
H4	Higher levels of empowerment will be associated with higher levels of organizational commitment at current organization and work setting in an LPN population.	Fully supported
H5	The relationship between empowerment and organizational commitment will be influenced by demographic variables at current work-setting and organization.	Not supported
H6	The relationship between empowerment and organizational commitment will be influenced by organizational conflict at current work-setting and organization.	Partially supported
H7	The relationship between empowerment and organizational commitment will be influenced by organizational trust at current work-setting and organization.	Partially supported

Seven hypotheses framed this study. Table 5-1 summarizes study findings in terms of these hypotheses. Hypotheses 2 and 4 were fully supported. Hypothesis 1 was only partially supported because not all the demographic variables were found to be associated with organizational commitment. Hypothesis 3 was only partially supported because organizational trust was reduced at analysis to a three-tier categorical variable when it failed to load effectively. Although there were significant differences between all three categories of trust with regard to organizational commitment, only group differences could be derived from the data. Hypothesis 5 tested mediating effects of empowerment, and empowerment fully mediated the relationships and eliminated the direct effect of demographic variables

on organizational commitment. Thus, this hypothesis was not supported, although current and total years as LPN as well as dependent children had significant indirect effects. Hypotheses 6 and 7 were partially supported because results indicated that empowerment partially mediated these relationships and the total effects were significant, but the direct effects of organizational conflict and trust on commitment remained after empowerment was employed as a mediating variable.

Empowerment and Organizational Commitment

Empowerment was a significant predictor of LPN organizational commitment. Higher cumulative levels of empowerment, as well as higher levels on all empowerment subscales, affected organizational commitment among the population of LPNs. Data confirmed the general organizational literature and suggested that empowerment matters in generating added commitment to the organization among LPNs (Bowen & Lawler, 2006; Conger & Kanungo, 1988; Gomez & Rosen, 2001; Henkin & Marchiori, 2003).

Empowerment is defined broadly as “a process of enhancing feelings of self-efficacy among organizational members through the identification of conditions that foster powerlessness and through their removal by both formal organizational practices and informal techniques of providing efficacy information” (Conger & Kanungo, 1988, p. 474). This broad definition captures both the structural and psychological aspects of empowerment. Empowerment is a motivational construct manifested in four related psychological cognitions: meaning, competence, self-determination, and impact (Spreitzer, 1995a). Meaning refers to the degree to which persons value their work in relation to their own ideals and standards. That is, there is a fit between work requirements and employees’ beliefs, values, and behaviors. Competence is self-efficacy in employees’ ability to perform tasks with skill. Self-determination refers to employees’ sense of having a choice in initiating and regulating actions. That is, the employees perceive latitude in how a job is done. Impact is the degree to which individuals feel they can influence administrative or strategic outcomes at work and possess significant control

over what happens in their department (Potterfield, 1998; Spreitzer, 2007). For psychological empowerment to occur, managers must first provide workers with structural empowerment aspects such as opportunity, information, support, and resources (Kanter, 1977; Spreitzer, 1995b).

LPNs who reported higher psychological empowerment also reported higher levels of commitment to the organization. One possible rationale for the positive association between psychological empowerment and organizational commitment may be that psychological empowerment is rooted in the self-efficacy theory of human agency in social cognition (Bandura & Wood, 1989; Spreitzer 1995a, 2007). This theory posits that individuals who have higher self-efficacy with regard to the cognitive components of empowerment feel a greater sense of power, which in turn would be expected to yield greater commitment to the organization (Bowen & Lawler, 2006; Conger & Kanungo, 1988; Manion, 2004; Potterfield, 1998; Spreitzer, 1995b).

Structural empowerment mechanisms bring about some degree of power sharing and are considered to decrease perceived powerlessness among workers and to garner psychological empowerment (Kanter, 1977; Potterfield, 1998; Spreitzer, 1995a; Thomas & Velthouse, 1990). Spreitzer (2007) contended that the four components of her psychological empowerment model each contribute to workers' self-efficacy and that they make a difference in organizational success. She argued that empowered workers see themselves as well integrated into the political channels that contribute to getting things done, and in turn workers feel a greater commitment to the organization (Avolio et al., 2004; Spreitzer, 2006). The data from the current study supports Spreitzer's hypothesis that empowered workers exhibit higher levels of organizational commitment.

Relationship between Empowerment and Organizational Commitment with Indirect Effects of Demographic Variables

The influence of the demographic variables related to empowerment and organizational commitment (age, marital status, dependent children, and tenure as LPN

and at organization) on the relationship between empowerment and organizational commitment was not significant. Thus Hypothesis 5 was not supported by the findings of this study.

Although these demographics are well-documented antecedents of organizational commitment across many occupational groups (see meta-analysis by Mathieu & Zajac, 1990), when empowerment was employed as an intervening variable, there were no remaining direct effects of the demographic antecedents on organizational commitment among LPNs. One possible rationale is that empowerment is a significant mediator of organizational commitment among LPNs, and when present, the main effects of the demographic antecedents on organizational commitment are eliminated (Cohen, 1992; Kacmar & Carlson, 1999; Lawler, 1996; Mathieu & Hamel, 1989; Spreitzer, 2007). If true, this is promising given that empowerment provides a range of strategic options available to managers while demographic antecedents of organizational commitment do not (Cohen, 1993; Meyer & Allen, 1997; Spreitzer, 1995a).

Relationship between Empowerment and Organizational
Commitment with Indirect Effects of the Independent
Variable Organizational Conflict

These results partially supported Hypothesis 6 in that organizational conflict was significant and the effect of empowerment was influenced by conflict. Results indicated a main effect of organizational conflict on commitment to the organization in that employees with perceptions of greater organizational conflict had lower levels of organizational commitment. One theory for this negative relationship could be that high organizational conflict would not likely facilitate empowerment (Janssen, 2004; Rahim, 2002, Spreitzer, 1995a). Since empowerment boosts organizational commitment, it makes some sense that lowering conflict would boost the effectiveness of empowerment on organizational commitment (Rahim, 1985; Spreitzer, 2007). Structural and psychological empowerment mechanisms augment power sharing and collaboration and

may lower organizational conflict as well (Axelrod, 1984; Bess & Dee, 2007; Coser, 1956, March & Simon, 1958). Conflict-ridden environments may be more likely to derail effective communication, which in turn would likely lessen the effectiveness of empowerment on organizational commitment (Mintzberg & McHugh, 1985; Perrow, 2000; Spreitzer, 2006). Although structural empowerment mechanisms supply workers with psychological empowerment in terms of self-efficacy, organizational conflict may dampen the acquisition of self-efficacy regarding empowerment (Perrow, 1991; Pondy, 1983; Spreitzer, 2007). Individuals with a lower self-efficacy with regard to the cognitive components of empowerment would likely feel a lower sense of power, which in turn would be expected to yield lower commitment to the organization (Bowen & Lawler, 2006; Conger & Kanungo, 1988; Manion, 2004; Potterfield, 1998; Spreitzer, 1995b). The data in the current study support the hypothesis that organizational conflict negatively affects the relationship between empowerment and commitment to the organization (Janssen, 2004).

In general, Hypotheses 6 was partially supported, but it should be noted that results indicated that only three of the empowerment subcategories acted as a “go-between” in the chain, linking organizational conflict to empowerment and organizational commitment. The empowerment competence subscale was never significant in these partially mediated relationships. That is, the direct effect of conflict was partially reduced on the outcome variable organizational commitment but only through the empowerment meaning, impact, and self-determination subscales. One reason for this might be that LPNs’ perception of organizational conflict does not particularly influence their perception of how competent they feel (Goodstein, 1983; Pondy, 1983; Rahim, 2002; Schism et al., 2000; Wall & McAllister, 1995; Wilmot & Hocker, 2001). LPN competence is rooted in education, experience, feedback, and licensure. Competence with regard to empowerment is explained by Spreitzer (1995a) as self-efficacy in a worker’s ability to perform tasks with skill. Because full-time LPNs likely have more

work experience and, thus, higher self-efficacy regarding their skill competence, their perceptions of competence may not be readily impacted by conflict (Molzahn, 1992). Further, LPN skill sets are considered predictable, low risk, and practical; thus, it may not be difficult for LPNs to maintain a perception of competence, even in high conflict environments (Bacharach et al., 1990; Kenney, 2001; Paquay et al., 2007).

Results support the argument that organizational conflict negatively influences the relationships of empowerment to organizational commitment (Goodstein, 1983; Rahim, 2002). The data support the literature by confirming that in high conflict settings, the acquisition of empowerment by LPNs is dampened, especially with regard to the aspects of psychological empowerment pertaining to meaning, self-determination, and impact (Kanter, 1987; Spreitzer, 2006).

Self-determination refers to employees' sense of having choices in regulating actions as to how a job is done (Spreitzer, 1995b). Perhaps in high conflict environments, LPNs may feel less latitude or self-determination in deciding how a job is done, perhaps fearing increased conflict if self-determination is utilized (Cox, 1998; Janssen, 2004). Spreitzer (1993) contended that the aspects of impact related to psychological empowerment refer to the degree of perception a worker feels with regards to having an influence on strategic work outcomes (Spreitzer, 2007). LPNs may feel less impact or control in the organization in high conflict environments because effective communication is muted by excessive conflict (Bowen & Lawler, 2006; Coser, 1956). According to Spreitzer (1996), aspects of empowerment that pertain to meaning refer to the degree to which workers value their work in relation to their own ideals and standards or the fit between work requirements and the workers' beliefs, values, and behaviors. Perhaps in conflict-ridden work settings, LPNs may question whether they can operationalize their values and beliefs. In high conflict milieus, LPNs may not reap satisfying personal meanings due to conflicts over work processes. High conflict adds

complexity to organizational dynamics (Axelrod, 1984; Foster, 2001; Wall & Callister, 1995; Weber, 2009).

It is important to note that the total effect of this partially mediated relationship was significant. The data supported the notion that organizational conflict is significant and that the effect of empowerment on organizational commitment is influenced by conflict (Bess & Dee, 2007). Given that organizational commitment plays an important role in organizational effectiveness, it seems managers would do well to facilitate workers' feelings of empowerment and manage organizational conflict appropriately so that empowerment mechanisms can work to full potential (Brown, 1996; March & Simon, 1958; Spreitzer, 1996; Wilmot & Hocker, 2001). Data support that empowerment may move conflict theoretically to a more effective moderate range. There are practice implications based on this finding.

Relationship between Empowerment and Organizational
Commitment with Indirect Effects of the Independent
Variable Organizational Trust

These results partially supported Hypothesis 7 in that organizational trust was significant and the effect of empowerment was influenced by trust. Results indicated a main effect of trust on commitment to the organization in that employees with higher perceptions of organizational trust had higher organizational commitment. One theory on how trust influences empowerment is that trust is thought to augment empowerment strategies (Bryk et al., 2002; Gomez & Rosen, 2001; Spreitzer, 1995a). Workers with higher organizational trust would be expected to more easily accept structural empowerment mechanisms, which in turn would boost the workers' self-efficacy and commitment to the organization (Butler, 1991; Schoorman et al., 2007). An assumption is that empowered workers perceive more organizational trust and have higher commitment to the organization because they feel a sense of organizational control and

ownership (Cook & Wall, 1980; Hargreaves, 2002; Henkin & Dee, 2001; Kanter, 1977; Mayer et al., 1995; McAllister, 1995; Spreitzer, 2007).

Although in general Hypothesis 7 was partially supported, it should be noted that results indicated that when empowerment was added as a mediating variable, only three empowerment subscales linked organizational trust to empowerment on organizational commitment. The empowerment competence subscale was not significant in these partially mediated relationships. One possible reason for this may be that LPN skill sets are more routinized and practical and may not be as difficult to maintain even in low trust environments (Bandura & Wood, 1989; Cox et al., 2006; Dickey et al., 2007; Fukuyama, 1995; Tan & Tan, 2000; Weber, 2009).

The direct effect of organizational trust on organizational commitment was influenced through the empowerment subscales relating to meaning, impact, and self-determination. One explanation for this could be that in low trust organizational milieus, perceptions of self-determination may be dampened because workers are not confident that self-determination on their part would be met with administrative acceptance (Gomez & Rosen, 2001). Mistrustful subordinates would also not be expected to feel a genuine sense of organizational impact, and low organizational trust would likely not enhance feelings of self-efficacy (Good, 1988). Low trust may cause LPNs to question if they will be able to employ their skill sets in ways that match their ideals and standards (Bandura & Wood, 1989). Empowerment mechanisms that supply workers with self-efficacy and high organizational trust would likely facilitate acquisition of empowerment mechanisms. The data supported the assumption that empowered workers with organizational trust have higher commitment to the organization because they perceive a greater sense of possessing some authentic organizational control and ownership (Cook & Wall, 1980; Laschinger, Shamian, & Thompson, 2001; Mishra, 1992; Spreitzer, 2007).

It is important to note that the total effect of these partially mediated relationships was significant. Thus, empowerment overall functioned as a significant intervening

variable in the paths between organizational trust on commitment, but empowerment did not completely mediate the relationships of these variables on organizational commitment. The data support the notion that organizational trust is significant and the effect of empowerment on commitment to the organization is influenced by organizational trust (Findler et al., 2007; Foster, 2001; Fukuyama, 1995). Given that organizational commitment plays an important role in organizational effectiveness, it seems that managers would do well to facilitate workers' feelings of empowerment and promote organizational trust so that empowerment mechanisms can work to full potential (Forbes-Thompson et al., 2007; Koberg et al., 1999). This finding has implications for practice.

Organizational and Policy Implications

This study has several organizational and policy implications for managers as well as providing additional evidence with regard to the positive and mediating relationship of empowerment on organizational commitment (Bowen & Lawler, 2006; Conger & Kanungo, 1988; Henkin & Marchiori, 2003; Huber, 2000; Liu et al, 2006; McDermott & Laschinger, 1996; Spreitzer, 2007). Following are general organizational and policy implications from the study results.

The central focus of this study was on organizational commitment. Organizational commitment is recognized as a fundamental element in highly effective and stable organizations (Cohen, 1992; Mathieu & Zajac, 1990; Meyer & Allen, 1997; Mintzberg, 1997; Mowday, 1998, Wagner, 2007; Zangaro, 2001). Although turnover is a multi-stage process, low organizational commitment has been shown to have a strong and direct impact on intent to leave and actual turnover in many occupational groups (Allen, 2003; Cohen, 1993; Porter & Steers, 1979). Organizational commitment is a large multivariate construct. Although it may elude precise definition, organizational commitment has been shown to be important in improving organizational effectiveness and retention (Liou & Cheng, 2008; Mathieu & Zajac, 1990; Mowday, 1998; Pierce & Geyer, 1991; Porter et

al., 1974; Powell & Meyer, 2004). Consequences of organizational commitment include lower levels of intent to leave, increased retention, better attendance, and higher job productivity (Avolio et al., 2004; Bess & Dee, 2007; McNeese-Smith, 1995). Managers in general would do well to utilize evidence on organizational commitment to decrease turnover and lower costs, especially among targeted occupational groups with high turnover (Becker, 1994; Bowen & Lawler, 2006; Castle, 2006).

There are two perspectives on the concept of organizational commitment: behavioral (Alutto, Hrbiniak, & Alonso, 1973; Blau, Surges, & Ward-Cook, 2003) and attitudinal (Etzioni, 1965; Kanter, 1968). Mowday et al. (1979) defined organizational commitment primarily in terms of an attitudinal approach. From their perspective, organizational commitment is “the relative strength of an individual’s identification with and involvement in a particular organization that is characterized by three factors: (1) a strong belief in and acceptance of the organization’s goals and values, 2) a willingness to exert considerable effort on behalf of the organization, and 3) a strong desire to maintain membership in the organization” (p. 226). More generally, an employee displaying neither of these attitudinal or behavioral attributes in terms of his or her employing organization may be more likely to leave and be at greater risk of turnover (Cohen, 1993; Pierce & Geyer, 1991). Work is viewed as a trade-off between effort and loyalty in exchange for material and social rewards (March & Simon, 1958; Mowday, 1998; Spreitzer, 2007). Managers would do well to note the congruence of this study to the general organizational literature with regard to the importance of empowerment and a positive workplace climate to organizational commitment (Mathieu & Zajac, 1990; Mowday et al., 1979; Price & Mueller, 1981; Spreitzer, 2007; Wagner, 2007).

Managers should recognize that employees’ perceptions of an organization’s empowering characteristics and support for them are antecedent to employees’ commitment to the organization (Eisenberger et al., 1986). When workers’ behaviors are rewarded with empowering treatment indicating that they are valued by the organization,

commitment is strengthened. According to Hutchinson (1996), organizational commitment can be viewed in the context of social exchange theory, with empowerment, communication, and perceived organizational support as key components in the commitment process. This study supported the theory that managers should provide structural empowerment mechanisms as appropriate to demonstrate their support of employees and that they should utilize positive communication patterns demonstrating that employees are valued (Spreitzer, 2007). Such processes will display participative decision making and an organizational tendency toward employee empowerment. This study supports the general organizational theory literature indicating that empowered employees track with higher organizational commitment (Bowen & Lawler, 2006; Conger & Kanungo, 1988; Henkin & Marchiori, 2003; Huber, 2000, Liu et al., 2006; McDermott & Laschinger, 1996; Spreitzer, 2007).

The meta-analysis on antecedents, correlates, and consequences of organizational commitment by Mathieu and Zajac (1990) is highly regarded among contemporary organizational theorists and policy makers (Price, 2009). In their meta-analysis, age, marital status, and organizational and professional tenure accounted for a large amount of variance in organizational commitment. These demographics were again confirmed in this study and add support to Mathieu and Zajac's work. Although managers can include demographic predictor antecedents of organizational commitment, such as age and professional tenure, in the hiring process, it is important to note that in general, demographic predictors are not employee characteristics that managers can modify. According to Spreitzer (2007), modifiable antecedents of organizational commitment and empowerment include aspects of organizational climate such as organizational conflict and trust, as well as job characteristics such as task autonomy. The current study is useful in that it confirms organizational trust and moderate conflict as positive work place antecedents of organizational commitment and empowerment (Cohen, 1992;

Mathieu & Hamel, 1989; Spreitzer, 2006). The study also supports the idea that managers can empower employees with opportunities, information, support, and resources, all aspects of structural empowerment, to garner the psychological empowerment and commitment of employees to the organization (Findler et al., 2007; Henkin & Holliman, 2009; Kanter, 1987; Spreitzer, 1995a).

This study is important in that it responds to Mathieu and Zajac's (1990) call for more research to identify intervening variables linking organizational commitment and its antecedents among various occupational groups. The current study adds to the body of knowledge on moderator variables, especially empowerment, as a link between antecedents and organizational commitment specifically among LPNs. According to Hutchison and Garstka (1996), perceived organizational support is viewed as empowering and moderates organizational commitment. They argued that empowering actions taken by the organization modify actions taken by the employee and boost worker commitment to the organization. For example, policies such as supporting and allowing employees to participate in decision-making processes signal acceptance of the employees and appreciation for their contributions to the organization. They suggest that employees' perceptions of these actions by the organization mediate their commitment to the organization. This study finds empowerment to be a moderator of the antecedents and correlates of organizational commitment in general and, for the first time, among lower skilled nurses. This study responds to Spreitzer's (1995a) and Wagner's (2007) call for more empirically generated causal models such as the current study to explore exogenous and mediating variables on commitment to the organization. These authors argued that such studies would help describe moderating relationships involving organizational commitment among various groups. These theorists posited that such research would advance understanding of how empowerment and organizational commitment actually influence employees' work behaviors. The data support the notion that managers are well served by utilizing empowering mechanisms in positive work

environments to influence and boost workers' commitment to the organization. This study supports participative management as a strategy as appropriate to settings employing LPNs.

Although the variables of organizational conflict and trust are not focal to this study, they were included because of growing understanding that organizational conflict and trust account for substantial variance in organizational commitment and that both impact empowerment as well (Axelrod, 1984; Bess & Dee, 2007; Callister & Wall, 2001; Good, 1988; Henkin & Dee, 2001; Moye & Henkin, 2006; Tschannen-Moran & Hoy, 2000). Results confirm the general literature and indicate that managers would do well to monitor conflict appropriately and in a manner that promotes organizational trust and moderates conflict (Bess & Dee, 2007; Cox, Jones, & Collinson, 2006; Pondy, 1983). Moderate organizational conflict is linked to higher organizational commitment (Cox, 1998; Lambert et al., 2007; Moye, 2003; Pondy, 1983; Zangaro, 2001). Further, managers gain trust with communication patterns that engage employees in straightforward and accurate communication. Studies also show that employees perceive higher trustworthiness in managers who utilize empowering participative management techniques (Doney, Cannon, & Mullen, 1998; McKnight & Chervany, 1996). Trust is again supported as an antecedent of empowerment (Gomez & Rosen, 2001). The current study channels that general research and confirms empowerment's moderating impact on the relationship between organizational conflict and trust on commitment to the organization (Coser, 1956; Janssen, 2004; Spreitzer, 2007). That is, if employees feel empowered, they will likely have more positive working relationships with managers, which would be expected to positively influence trust, decrease conflict and lead to higher employee commitment toward the organization.

Organizational and Policy Implications for Nursing

Introduction

This study has implications for the management of non-RN staff, specifically of full-time LPNs, and has nursing organizational and policy implications regarding the empowerment, utilization, and leadership of LPNs. Contemporary health care delivery requires a team effort, and the composition of those teams is based primarily on managerial considerations of quality, cost, and nursing skill mix. Although LPNs are hired at a much lower cost, the current national conversation suggests that LPNs are of a much lower quality and/or are not appropriate staff for contemporary, complex health care settings; yet comparison research using strictly LPN samples is lacking and when available, mainly hospital based (McClure & Hinshaw, 2007; McNeese-Smith, 2001; Porter-O'Grady, 2004; Wagner, 2007). Although LPNs are often devalued, even stigmatized as having lower quality skill sets and limited training, they continue to be an integral component of the current health care delivery team, especially in long-term and skilled-care settings where the direct care workforce crisis exists most acutely (Stone, 2007). Thus an organizational workplace environment that maximizes the potential of all licensed staff nurses may become paramount as health care dollars shrink. Devaluation may dampen organizational commitment of LPNs (Eriksen et al., 1992). This study brings to light the need to confirm the value of LPNs in various contemporary healthcare settings (Foster, 2001; Lafer & Moss, 2007; McClure, 2005; Porter-O'Grady, 2001; Seago et al., 2004; Stone, 2007). Once confirmed, managers would do well to note the congruence of this study with previous nursing literature which extends the knowledge base regarding associations of empowerment, conflict, and trust on organizational commitment to LPNs.

This study has organizational and policy implications because previous evidence on nursing organizational commitment neglects to include specific LPN data and is mainly hospital based (Liu et al., 2006). Since the 1970s, nursing studies have explored

the dynamics of organizational commitment in staff nurses, with later studies using more sophisticated causal modeling and predictive techniques (Castle, 2006; Cronin-Stubbs, 1977; Daly, 2005; Hinshaw et al., 1983; Huber, 2000; Huey & Hartley, 1988; Leach, 2001; Lou et al., 2007; McClure & Hinshaw, 2007; Price & Mueller, 1981; Wagner, 2007). Most nursing studies are hospital based and exclude LPNs or combine this population with RNs in “staff nurse” samples despite major differences in job scope. Issues of conceptual clarity remain with many nursing studies that view intent to stay, organizational commitment, and job satisfaction as synonymous (Fang, 2001; Huey & Hartley, 1988; McCloskey & McCain, 1987; Slavitt et al., 1978; Steers, 1977; Tang, 2003, Zangaro, 2001). Although empowerment is consistently linked with organizational commitment among RNs, no studies have looked at organizational conflict and trust links to the relationship of empowerment and organizational commitment exclusively among LPNs (Laschinger et al., 2003; Way et al., 2007).

Increased levels of nursing education, autonomy, and professionalism have been consistently linked to organizational commitment, but again the population studied has been primarily RNs employed in hospital settings or specialty areas such as critical care nurses or nursing administrators (Boyle et al., 1999; Castle, 2006; Huber, 2000). Participative management is highly linked to organizational commitment among RNs (Guerney et al., 1997; Larabee et al., 2003; Lucas et al., 1993, Wolf et al., 1994). McNeese-Smith (2001) confirmed earlier findings and found empowerment, educational opportunities, salary, relationships with co-workers, desire to serve diverse patients, and shared governance to be highly associated with contemporary RN organizational commitment (Hinshaw, 2008; McClure, 2005; McDermott & Laschinger, 1996; Wagner, 2007). Larrabee et al. (2003) found empowerment, trust, lower conflict, and flatter organizational structures were highly associated with commitment to the organization among RNs, but their study did not include LPNs. Although often not directly comparable, due to varied mediator variables or tool differences, empowerment strategies

are well supported as mediating antecedents to organizational commitment among RNs and staff nurses (Holtman & O'Neill, 2004; Price & Mueller, 1981; Wagner, 2007; Wilson & Laschinger, 1994).

Collaborative and trusting relationships with supervisors and co-workers and positive organizational culture have consistently been linked to organizational commitment specifically among RNs (Chen & Francesco, 2000; Fang, 2001; Laschinger et al., 2006; Pearson & Chong, 1997; Way et al., 2007). The current study supports that administrators would also do well to empower LPNs, limit conflict, and promote trust in healthcare environments employing LPNs (Laschinger & Finegan, 2005; Laschinger et al., 2006; Mintzberg, 1997). The current study extends this general nursing literature to LPNs and has potential policy implications for both RNs and LPNs.

Key Nursing Organizational and Policy Implications

First, organizational commitment has been confirmed as a core element in staffing stable health care organizations (Wagner, 2007). LPNs confront various challenges that threaten their future. As politically charged magnet hospital methodology and socialization gains momentum, health care organizations appear to be devaluing the contributions of LPNs to healthcare delivery, despite little evidence as to their role in contemporary practice and almost no research on outcomes specific to LPNs. Managers should explore evidence that compares outcomes for BSN versus ADN outcomes to LPNs (McClure & Hinshaw, 2007; McNeese-Smith, 2001; Porter-O'Grady, 2004; Seago & Ash, 2002; Tang, 2003; Wagner, 2007). This study is important and timely in providing evidence that full-time LPNs have relatively high levels of organizational commitment and empowerment despite an adverse political environment and arguments for phasing out LPNs in many institutions. Administrators should look for evidence in performance and outcomes for LPNs before acting on anecdotal calls to replace LPNs in BSN staffing models. Such a move to all-BSN staffing would drive up already skyrocketing healthcare costs and may, in fact, not be necessary. In addition, analysis of

the dynamics of LPN work by institutional type should be explored largely because, at present, most evidence of organizational commitment and empowerment of RNs has been obtained from hospital settings while most LPNs work in skilled or long-term care settings (McClure & Hinshaw, 2007; McNeese-Smith, 1995; Seago et al., 2004; Stone, 2007).

Second, there is little guidance in contemporary RN curricula and textbooks on how to manage or retain LPNs (Huber, 2000; Sohn, 1991). This study offers initial evidence that full-time LPNs should be empowered to the level that matches their skill sets so as to enhance LPN commitment to the organization and retain experienced employees. Many BSNs become nursing managers and supervisors, so BSN curriculums should reflect the changing dynamics of healthcare delivery. This study supports the idea of added curricular exposure to prospective management practices that enhance the empowerment of lower skilled nurses and recommends dissemination of study results to nursing educators and institutional-based staff development personnel.

Third, evidence of the importance of the personal meaning that full-time LPNs appear to derive from their frontline work in patient care is important. An unexpected result in this study was the very high score on the empowerment meaning subscale. According to Spreitzer (1995a), meaning refers to the degree to which persons value their work in relation to their own ideals and standards. That is, there is a fit between work requirements and employees' beliefs, values, and behaviors. Full-time LPNs may remain committed to their jobs simply because they find meaning in their work.

There is evidence that higher levels of nursing education are related to better patient and organizational outcomes, but these studies primarily focus on hospitals. Further such studies have not explored the personal meaning that more educated level nurses may find in the routine skills provided by LPNs or in the broader range of institutional settings that deliver healthcare (Huber, 2000; McClure, 2005; Parasuraman & Nachman; 1987; Porter-O'Grady, 1998; Seago & Ash, 2002; Sohn, 1991). The current

tone of nursing graduate education across the nation encourages nurses who want to practice to seek the new Doctorate of Nursing Practice degree or the DNP. However, no research exists on whether BSNs or nurses with graduate practice degrees derive higher levels of personal meaning from providing the routine, low-risk patient care that LPNs perform. Segmentation in the forms of care delivered by various classes of nurses would appear to be well underway without concomitant concern for the preparation of those groups' assigned tasks at the more "hand on" end of the care spectrum nor the meaning they derive from that basic level of care.

Fourth, data indicated that LPNs reported their lowest level of empowerment in terms of impact. This has policy implications in that LPNs should be regularly reminded of the impact they have on both patients and the organization and included in decision-making meetings regarding their work as appropriate (Weber, 2007). Spreitzer (2007) argued that lower skilled workers can and should be fully empowered to their full potential. She contended that psychological empowerment "is a cognitive state characterized by a sense of perceived control, competence, and goal internalization" (p. 483). She emphasized that it is key to empower employees at all levels of the work hierarchy to gain the highest degree of organizational effectiveness. Proper utilization, empowerment, and management of LPNs may be an important factor in improving healthcare cost effectiveness and reducing turnover.

According to Spreitzer (2007), impact is the degree to which individuals can influence administrative or strategic outcomes at work and possess significant control over what happens in their department. Perhaps yearly LPN awards rewarding excellence in LPN care would boost perceptions of LPNs' impact on organizations and patient outcomes. Administrators would do well to explore studies that research specific impacts and outcomes most directly impacted by the care sets provided by LPNs. Indeed, LPNs may have their greatest impact on patient satisfaction – a relationship not yet explored in research on nursing in varied care settings. Much research focuses on BSN-

sensitive outcomes, which has fueled the powerful magnet movement sweeping the nation, yet no comparison studies have looked at strictly LPN-sensitive outcome data (Hinshaw, 2008; Huber, 2000; McClure, 2005). Again magnet hospital literature calls for hospitals especially to hire mostly BSN nurses and avoid hiring LPN or ADN nurses as staff nurses. Magnet hospital methodology argues that BSNs have a broader scope of liberal arts education and thus can produce a higher impact on patient and organizational outcomes. Data on outcomes defined in terms of LPN care sets, however, is not available.

Results indicating that LPNs perceive their impact to be moderate is not surprising and may have policy implications for nurse managers. LPNs are currently not generally included on Nurse Practice Councils or hospital-wide committees, especially in magnet hospitals (McClure, 2005). Whether including LPNs in such policy bodies would boost overall LPN empowerment levels or even be desirable is a matter for discussion. If so, then managers may want to showcase ways in which LPNs impact organizational performance and publically express gratitude for their work. Weber (2009) suggested forming specific LPN Practice Councils to encourage LPNs to become fully integrated members of the health care team. Practice Councils typically utilize shared governance models resulting in more professional control over practice, but they have traditionally been used primarily for RN practice. Low mean results on the empowerment impact subscale suggest that full-time LPNs may benefit from a venue that helps them perceive a greater impact on the organization.

Fifth, study results offer initial policy evidence that managers may not want to dedicate large resources to added LPN competency skill training, given that competence was not significant in all paths linking empowerment to organizational commitment. This observation, however, must be tempered by the individual LPN's desire for advancement or quality of skill set. Many LPNs gain confidence in their nursing skills as

they gain experience and seek RN degrees especially when encouraged by a supportive administration.

Sixth, although community colleges are reducing or discontinuing LPN programs, LPNs remain essential to the current healthcare delivery system of the nation. Thus the development and maintenance of an educated and committed LPN workforce is a major national policy concern (Aiken & Patrician, 2000; Buccini & Ridings, 1994; Buerhaus, 1994; Eriksen et al., 1992; Kenney, 2001). This study provides evidence that may inform this debate. As LPN programs decrease the number of LPN graduates and new LPN graduates become scarce, retention of current LPNs will become paramount. Thus policy and managerial implications exist for managers to ensure the quality of healthcare environments for LPNs. This study calls for managers to develop workplace strategies that reinforce behaviors that emphasize LPN worthiness.

Seventh, study findings offer initial evidence of a significant positive relationship between empowerment and LPNs' organizational commitment. Again previous studies have shown that hospital-based RNs and mixed-staff nurses employed in empowering environments are associated with higher organizational commitment (Larrabee et al., 2003; McNeese-Smith, 2001; Porter-O'Grady, 1998; Price & Mueller, 1981; Spreitzer, 2007; Wolf et al., 1994; Wagner, 2007). This study adds to that general nursing literature. Administrators and policy makers would do well to utilize best practices for the empowerment of less well educated nursing staff such as LPNs, although scant research exists on this topic and more research is needed to build on this initial study. Empowerment may encourage LPNs to raise their overall quality and abilities, which may in turn reverse the questions and growing stigma over LPN quality of practice. Results support providing structural empowerment such as opportunity, information, support, and resources to garner psychological empowerment among LPNs (Kanter, 1977; Spreitzer, 2007).

Eighth, results support the notion that LPN empowerment and organizational commitment are augmented by higher organizational trust (Laschinger, Shamian & Thomson, 2001; Laschinger & Finegan, 2005; Moye, 2003; Tschannen-Moran & Hoy, 2000). In low-trust environments, empowerment is muted and the effect on organizational commitment decreased. Results point to policy and managerial implications that call for monitoring levels of organizational trust among LPNs. Trust may be enhanced by including LPNs in formulating unit and organizational policies regarding their skill mix and in rewarding their work with specific organizational mechanisms and awards. In the absence of trust, empowerment strategies are often derailed (Mishra, 1992). Contextual variables such as increasing access to resources and information needed for practice may, in turn, lead LPNs to have higher levels of trust in their organization (Wilson & Laschinger, 1994). Enhancing policies and processes that protect LPNs' scope of practice to its full potential may also augment trust. For example, policies may be revised to include safeguards for reporting workplace behaviors that target, harass, or devalue LPNs.

Finally, study results support the notion that organizational conflict is mediated by empowerment to commitment to the organization among LPNs. This supports previous evidence that high conflict decreases empowerment and the effect of empowerment on organizational commitment (Bess & Dee, 2007; Janssen, 2004; Larrabee et al., 2003; Mintzberg & McHugh, 1985; Parasuraman, 1989; Spreitzer, 2007). Nurse managers should track and then address issues that produce high levels of conflict among LPNs in various settings. Conflict should be monitored in efforts to harness the positive outcomes of conflict while limiting the negative outcomes (Bess & Dee, 2007; Coser, 1956; Cox, 1998; Janssen, 2004; Mintzberg, 1997; Wall & Callister, 1995). Policy implications assuring that all staff support and empower LPNs to their maximum skill mix should be pursued. The moderate to high conflict levels may reflect some degree of conflict related to growing devaluation of the LPN credential. Nursing administrators would do well to

monitor conflict levels of LPNs related to initial evidence that organizational conflicts affect the relationship between empowerment and commitment to the organization among LPNs (Kenney, 2001; McCloskey & McCain, 1987; McClure, 2005; Stone 2007).

Recommendations for Future Nursing Research

Results from this study confirm the utility of its conceptual framework for understanding the work environment of full-time LPNs. This study extends both the empirical and theoretical literature in nursing, despite observations that the main variables in the study, organizational commitment and empowerment, are large multi-focal organizational constructs that are difficult to precisely define or explore experimentally. The following suggest areas for further nursing research on empowerment and organizational commitment among LPNs. As the first evidence of importance of organizational commitment to LPNs, this study points to the need for more research on LPNs generally and for better evidence on LPN-sensitive outcomes for patients as well as their employing organizations before policy changes are made from this evidence.

First, this study adds initial data confirming many aspects of the proposed model as well as the mediating effects of empowerment on organizational commitment across various settings in which LPNs work. This research needs replication and refinement in terms of specific settings for health care delivery and different geographical locations. Variables such as intent to leave and job embeddedness could be added to the model, especially in rural settings where few alternatives for employment exist (Holtom & O'Neill, 2004).

Second, since the literature on LPNs is so limited, more descriptive as well as empirical research on this population is needed. Descriptive research should also distinguish between full- and part-time LPNs. The paucity of contemporary demographic and descriptive literature on LPNs is alarming especially given looming LPN personnel shortages. Published LPN turnover rates approach 30% yearly or higher in long-term

care settings (Seago & Ash, 2002; Stone, 2007); however, turnover rates combine LPNs who work both full- and part-time (Bureau of Labor Statistics, 2002; Seago et al., 2004). Results indicate that 46% of the full-time LPNs were employed at their present work setting for over 10 years and 67% were 45 years or older. These demographics match antecedents in Mathieu and Zajac's (1990) meta-analysis indicating that older workers with higher tenure have higher organizational commitment. No comparison data exist for part-time LPNs (Bureau of Labor Statistics, 2002; Seago et al., 2004). Given scant descriptive data on full-time LPNs and organizational commitment, dissemination of results may have hiring implications based on research showing organizational commitment as a proxy for turnover among RN and mixed-staff nurse studies (Wagner, 2007). Employing LPNs full time may defray costly turnover since full-time LPNs had surprisingly high organizational commitment levels in this study.

Third, the survey tool used in this study was descriptive in nature, based on self-reports by LPN of their perceptions of workplace attitudes. Voluntary self-reports provide subjective data. Future studies should also design more objective measures of the variables to improve data integrity, despite the fact that precise measurement of constructs, such as organizational commitment and empowerment, is elusive.

Fourth, although the survey cover letter guaranteed anonymity, LPNs with low trust may have been reluctant to complete the survey for fear of retaliation if they answered in a negative way. Thus the study sample may sort on LPNs with higher levels of trust; however, the normality assumption was met and the large sample size somewhat offsets this concern. Future studies should retest Butler's (1991) organizational trust subscale and other trust tools to gather psychometric evidence and enhance data integrity regarding organizational trust in LPNs.

Fifth, study data are from one Midwestern state. Thus, generalization of findings to other states is inappropriate as each state defines its scope of practice for LPNs differently. Despite this, LPN scope of practice statutes share important similarities

across state lines. Future research might also employ a stratified national sample that includes more diverse populations given that the target state is not considered racially or ethnically diverse. It may be that specific care delivery settings in different geographic locations have differential effects on LPNs due to the skill mix needed in those settings. For example, Southern states such as Texas typically hire more LPNs and work from expanded Scope of Practice statutes. Such research could be tailored to different State Practice Statutes so as to explore the effects of expanded scope of practice on empowerment and organizational commitment among LPNs.

Sixth, although currently no tools exist to measure structural empowerment, future research should include some distinct measures that try to tap key aspects of structural empowerment. Structural empowerment is a construct distinct from psychological empowerment and is believed to be the mechanism by which psychological empowerment is derived (Laschinger et al., 1997; Spreitzer, 2007). According to Kanter (1987), power is distributed by delegation of the four structural conditions of (a) opportunities for advancement, (b) access to information, (c) support for decision making, and (d) resource access. This is especially important for studying LPNs because Spreitzer (2007) argued that employees at the lowest levels of the organization can and should be empowered to full potential. She posited that all workers should be afforded the contextual conditions that seed psychological empowerment. Future studies could explore effects on empowerment from specific structural interventions aimed at sharing more information with LPNs (Faulkner & Laschinger, 2008). For example, LPNs could be included in higher level committees to develop shared visions and goals for the organization. These techniques may improve mechanisms for collaboration and support (Locke et al., 1986). Structurally empowering LPN teams and offering these teams relevant skill training may augment the empowerment of LPNs and provide professional development as well (Dee et al., 2006; Henkin & Dee, 2001; Kirkman & Rosen, 1999; Yeatts & Cready, 2007).

Seventh, research on LPNs employed part-time should be considered. Part-time LPNs may exhibit differing empowerment levels and lower levels of organizational commitment. Ladder curriculums are common in nursing education. Thus part-time LPNs may not intend to commit to the organization but rather are working part-time for various reasons. Many LPNs pursue an RN degree while working part-time as an LPN. This fact likely clouds true LPN turnover rates, which according to Stone (2007) approach 30% yearly or higher in long-term care settings. In a part-time population of LPNs, expectation for further educational degree should be included as a variable.

Eighth, due to the very high mean score on the empowerment meaning subscale, this study calls for qualitative research into what forms of personal meaning full-time LPNs reap from their unique skill sets. Perhaps aspects such as varied levels of social and cultural capital as well as religiosity impact types of meaning and enjoyment found from assisting patients with routine and basic self-care deficits. Further comparative work might help to understand whether more educated RNs, when required to do so, derive the same types and levels of meaning and enjoyment from delivering these same basic levels of physical care to patients as that performed by LPNs. Numerous LPN respondents enclosed thank you notes with their returned surveys expressing gratitude for being given the first opportunity to comment on their current work environment. These notes generally indicated that they find great meaning and importance in their LPN roles, both for patients and for the organization. Results suggest that qualitative work might further explore types of meaning that LPNs derive from their more limited skill sets and compare these findings with those for RNs for levels of meaning attributable to the same skill sets. Such evidence might differentiate the effects of education on meaning in terms of nursing skills and better differentiate the appropriate level of delegation of routine and/or lower risk care to LPNs.

Ninth, study results provide initial psychometric evidence of the validity and reliability of the organizational commitment and empowerment tools among LPNs.

Replication of psychometric testing, however, should be conducted (Larrabee et al., 2003; Mathieu & Zajac, 1990; Price & Mueller, 1981; Spreitzer, 2007; Wagner, 2007). In light of national LPN staffing shortages, especially in LTC/skilled settings, this is important new psychometric information regarding valid and reliable tools to measure organizational commitment and empowerment in full-time LPNs.

Finally, although it was not surprising to find moderate to high organizational conflict levels, these data should be interpreted with some degree of caution because they were measured by a simple three-item scale. Again, in light of scant tools to measure organizational conflict, LPNs were simply asked to assess their perceptions of levels of conflict between supervisors, between LPNs and supervisors, and between LPNs and other LPNs within their organizational setting. A summary score for conflict was then used as the measure of perceived organizational conflict. As better organizational conflict tools are developed, additional research regarding organizational conflict among LPNs is needed.

Conclusion

In summary, this study adds to the literature that demonstrates the mediating effects of empowerment on organizational commitment in a long understudied population of LPNs employed full time. This study begins to respond to the call for more research on mediators between the antecedents of organizational commitment, especially among lower educated and less skilled staff nurses. The conceptual framework for this study contributes to our knowledge about linkages to organizational commitment, despite the fact that the study model is not as simple as suggested initially (see Appendix A).

This study has important implications for managers in healthcare settings who employ full-time LPNs. Little attention has been paid to research on LPNs. In part, this reflects changing delivery modality preferences and some devaluation in the status of LPNs across the nation. However, healthcare delivery still depends heavily on LPNs, particularly in underserved locations and in rural settings. This study adds to knowledge

with regard to evidence relevant to leading and managing full-time LPNs and points to the value of augmenting their commitment to the organization. This study revealed that organizational climate and empowerment matter to full-time LPNs. Not unexpectedly, results imply that full-time LPNs want to feel appreciated, affirmed, and supported. Organizational commitment encourages extra role behaviors, paramount in times of decreasing resources such as that facing all sectors of national health care.

Healthcare organizational stability rests on organizational commitment. No one knows the future trajectory of national healthcare or the economy. LPNs may be more highly sought after in the near future if LPN-sensitive research shows their continued value and cost effectiveness for specific and important patient and organizational outcomes, especially in light of the growing geriatric population that will require increasingly chronic and routine basic care.

Healthcare institutions will increasingly struggle to meet these needs and ensure patient safety and quality of care while competing in the market for healthcare personnel. As bedside RNs become more highly educated, they may disdain employment that involves the repetitive, low-risk patient care that LPNs currently provide. Not all nursing care involves highly skilled nursing judgments. This study sheds renewed light on the question of what kind of educationally prepared nurses are needed and the appropriate mix of varied levels of preparation and delegation among those termed nurses.

Nursing educators proclaim that all nurses should be lifelong learners and strive for the highest level of education. Often this takes the form of credentialism with current calls that the doctorate of nursing practice degree (DNP) be a standard for practicing nursing. This may fly in the face of the current nursing economic and policy environment facing severe pressures to cut costs. Thus, there is a real need to better understand and work with those at the lower end of the spectrum of employees responsible for delivering healthcare. LPNs are key among these. The limited research on contemporary LPNs is disheartening and alarming. More empirical data on LPNs,

their roles, and performance is needed before the nation limits the supply, efficient utilization, and retention of full-time LPNs. Organizational commitment is a critical element of staff nurse retention and highly associated with intent to leave and actual turnover. This study adds to the evidence regarding the organizational commitment of LPNs.

APPENDIX A
CONCEPTUAL FRAMEWORK: EMPOWERMENT,
TRUST, CONFLICT, AND ORGANIZATIONAL
COMMITMENT AMONG LICENSED PRACTICAL NURSES

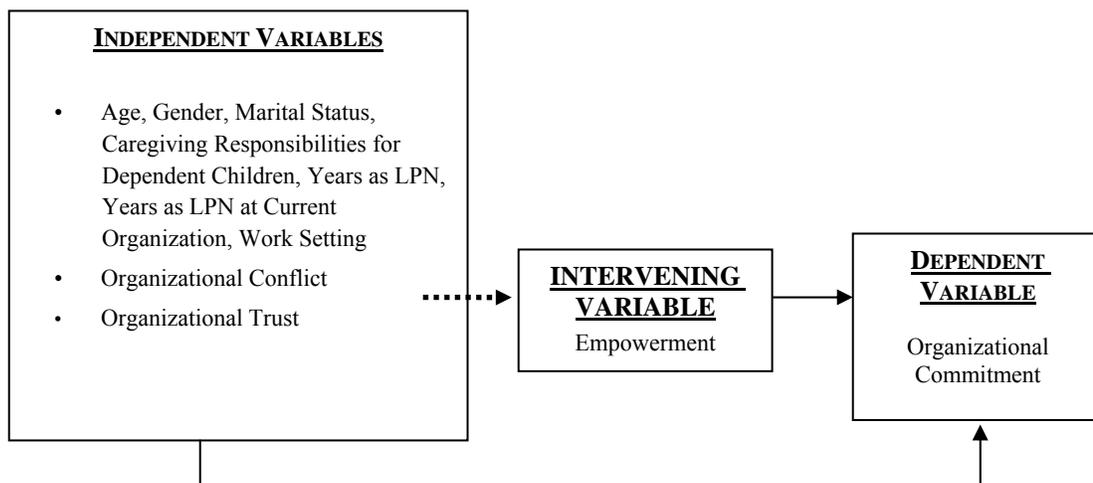


Figure A-1. Conceptual Framework

APPENDIX B
COVER LETTER

January 19, 2010

Mary Tobin RN, MA PhD (c)

Dear Licensed Practical Nurse (LPN),

I am writing to invite you to participate in a research study on the *work environment* for LPNs. I am a nurse and doctoral student at the University of Iowa conducting research related to how LPNs view their work. Such research has been done for other health professionals, such as RNs, but never for examining the work environment of LPNs.

I am inviting all 5486 LPNs in Iowa to be in this study who are listed on the Iowa Board of Nursing (IBON) Roster List as registered and actively working full-time as an LPN. This study is for my dissertation and is not endorsed by or conducted for the IBON.

If you agree to participate, I ask that you complete the enclosed questionnaire. The questionnaire will take approximately ten minutes to answer by checking the response boxes in pen or pencil. Return the questionnaire in the self-addressed stamped envelope. You may skip any questions you do not wish to answer.

I will send one reminder postcard about three weeks from now. **Please return your questionnaire postmarked by March 2, 2010.** If you do not wish to participate in the study, you may return a blank questionnaire and I will remove your name from the list.

I will keep the information you provide confidential; however, federal regulatory agencies and the University of Iowa Institutional Review Board (a committee that reviews and approves research studies) may inspect records pertaining to this research. I will minimize the risk of loss of confidentiality of the study data in that your identifying information will not be stored with the study data. Only a code number will be used to identify your responses. The link between the code number and your identifying information will be stored separately and destroyed when no longer needed for the study. Each survey will have a form number to link returned surveys and help me know who will need to be mailed a non-response postcard in Week 3. I will keep all data confidential and store data in locked offices and in password-protected computer files. If I write a report about this study, I will do so in a way that you cannot be identified.

There are no known risks from participating in this study, and you will not benefit personally. However, I hope that others may benefit in the future from what we learn as a result of this study.

You will not have any costs for being in this study. You will be entered into a drawing to receive one of eight \$25 gift-cards from a major department store of your choice. Complete the enclosed return ticket and place the ticket in the envelope with

your questionnaire and return them both to me. Return tickets received postmarked after March 2nd will not be eligible for the drawing. If your name is drawn, I will contact you by phone and ask for your preference of a store for the gift card. The gift card will be mailed to the winners.

Taking part in this study is completely voluntary. If you decide not to be in this study, or if you stop participating at any time, you won't be penalized or lose any benefits for which you otherwise qualify.

If you have any questions or to report a research problem, please contact me at (319) 624-3272 or contact my faculty advisor, Lelia Helms, PhD., J.D., at the University of Iowa (lelia-helms@uiowa.edu).

If you have any questions about the rights of research subjects, please contact the Human Subjects Office, 300 College of Medicine Administration Building, The University of Iowa, Iowa City, IA 52242, (319) 335-6564, or e-mail irb@uiowa.edu. To offer input about your experiences as a research subject or to speak to someone other than the research staff, call the Human Subjects Office at the number above.

I am grateful to you for your consideration of this project and look forward to your response.

Completion and return of the questionnaire indicates your willingness to participate in the study. Please keep this cover letter for your records.

Sincerely,

Mary Tobin, RN, MA
Ph.D. Candidate, The University of Iowa

APPENDIX C
LPN WORK ENVIRONMENT SURVEY

Section 1 Instructions:

Please indicate the extent to which you agree or disagree with the following statements. Use the following scale to respond to each statement:

	1.Strongly Disagree	2.Disagree	3.Neutral	4.Agree	5.Strongly Agree
	1	2	3	4	5
1. The work I do is very important to me .	<input type="checkbox"/>				
2. My job activities are personally meaningful to me.	<input type="checkbox"/>				
3. The work I do is meaningful to me.	<input type="checkbox"/>				
4. I am confident about my ability to do my job	<input type="checkbox"/>				
5. I am self-assured about my capabilities to perform my work activities	<input type="checkbox"/>				
6. I have mastered the skills necessary for my job	<input type="checkbox"/>				
7. I have significant autonomy how I do my job	<input type="checkbox"/>				
8. I can decide on my own how to go about doing my work	<input type="checkbox"/>				
9. I have considerable opportunity or independence and freedom in how I do my job.	<input type="checkbox"/>				
10. My impact on what happens in my organization is large	<input type="checkbox"/>				
11. I have a great deal of control over what happens in my department	<input type="checkbox"/>				
12. I have significant influence over what happens in my organization	<input type="checkbox"/>				

Section 2 Instructions:

Please indicate the extent to which you agree or disagree with the following statements regarding the work organization that employs you as an LPN. Use the following scale to respond to each statement.

	1.Strongly Disagree	2.Disagree	3.Neutral	4.Agree	5.Strongly Agree
	1	2	3	4	5
13. I am willing to put in a great deal of effort beyond that normally expected in order to help my organization of employment be successful	<input type="checkbox"/>				
14. I talk up this organization to my friends as a great organization to work for	<input type="checkbox"/>				
15. I feel very little loyalty to this organization	<input type="checkbox"/>				
16. I would accept almost any type of job assignment in order to keep working for this organization	<input type="checkbox"/>				
17. I find that my values and the organization's values are very similar	<input type="checkbox"/>				
18. I am proud to tell others that I am part of this organization	<input type="checkbox"/>				
19. I could just as well be working for a different organization as long as the type of work were similar	<input type="checkbox"/>				
20. This organization really inspires the very best in me in the way of job performance	<input type="checkbox"/>				
21. It would take very little change in my present circumstances to cause me to leave this organization	<input type="checkbox"/>				
22. I am extremely glad that I chose this organization to work for over others that I was considering at the time I joined.	<input type="checkbox"/>				
23. There's not too much to be gained by sticking with this organization indefinitely.	<input type="checkbox"/>				
24. Often I find it difficult to agree with this organization's policies on important matters relating to it's employees	<input type="checkbox"/>				
25. I really care about the fate of this organization	<input type="checkbox"/>				
26. For me this is the best of all organizations for which to work	<input type="checkbox"/>				
27. Deciding to work for this organization was a definite mistake on my part.	<input type="checkbox"/>				

APPENDIX D
GIFT CARD

\$ 25 Gift-Card Random Drawing Ticket

- If you wish to be entered into a random drawing for one of eight \$25 gift cards, please fill in your name and phone number on the lines below. You may participate in the study without entering the drawing.
- You must fill out the ticket and return it with your questionnaire in the enclosed envelope with your questionnaire **postmarked by March 2nd** to be eligible for entry into the drawing.
- Winners will be telephoned March 3rd and asked to identify the major department store of their choice for the gift card. The gift card from the selected store will be mailed to the winner

Name: _____

Phone Number: _____

APPENDIX E
NON-RESPONSE POSTCARD

Hello Iowa LPN:

This is a reminder to you to please consider participation in my study by completing the LPN Work Environment Survey that I mailed to you in the last 3 weeks. My records indicate that you have *not* yet returned your study materials. If you have returned the materials and they crossed in the mail, thank you for your participation.

If you have misplaced your study materials, please telephone me immediately at **319-624-3272** and I will mail you a replacement. Please leave me a message with your name, address, and phone number and I will call you back to let you know that your replacement materials are on the way.

Return the study materials in the enclosed envelope postmarked by March 2nd. I will close the study enrollment at that time.

I am grateful for your consideration of this project,

APPENDIX F
TWO TYPES OF ENTRY-LEVEL LICENSED NURSES
IN THE UNITED STATES

Table F-1. Contrast and Description of the Two Types of Entry-Level Licensed Nurses in the United States

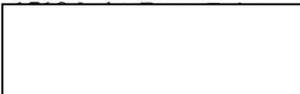
	Education needed to take the national board exam	Name of board exam to work as a nurse in the U.S.	Skills allowed	Skills <i>not</i> allowed	Typical skills and cares included in the nursing role
Registered Nurses (RN)	High school diploma & either a 2-year (Associate Degree) or a 4-year (Bachelors Degree)	All RN program graduates take the same NCLEX-RN exam	According to state RN Practice Acts	Skills designated for master's-prepared or nurse practitioners (e.g., nurse practitioners have advanced education, may prescribe routine medications for routine illnesses, and have advanced skills such as giving anesthesia and suturing wounds)	RNs: - perform advanced patient assessments and initial care plan construction of newly admitted patients; - are required to discontinue the plan of care; - write nursing diagnoses statements and form plans of cares to meet the patient's holistic care needs.
Licensed Practical Nurses (LPN)	High school diploma & a 12-18 month educational program generally from a community college	NCLEX-PN	According to state LPN Practice Acts	Skills designated only for RNs in state RN Practice Acts; e.g., most LPNs: - cannot initiate or discontinue the patient's initial admission plan of care. - cannot start IVs unless certified in that skill. Advanced nasal tubes may not be inserted by LPNs because they need advanced critical assessment skills.	Assessments/cares prescribed by RNs and according to state LPN Practice Act. LPNs may perform some advanced skills that require critical thinking (e.g. arterial blood gas analysis, cardiac monitoring, tracheostomy chest tube cares), But most LPN cares are given to stable patients who require routine skilled care.

APPENDIX G
IRB MATERIALS

FOR IRB USE ONLY APPROVED BY: IRB-02 IRB ID #: 200911774 APPROVAL DATE: 02/05/10 EXPIRATION DATE: 01/08/11
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January 19, 2010

Mary Tobin



Dear Licensed Practical Nurse (LPN),

I am writing to invite you to participate in a research study on the *work environment* for LPNs. I am a nurse and doctoral student at the University of Iowa conducting research related to how LPNs view their work. Such research has been done for other health professionals, such as RNs but never for examining the work environment of LPNs.

I am inviting all 5486 LPNs in Iowa to be in this study who are listed on the Iowa Board of Nursing (IBON) Roster List as registered and actively working full-time as an LPN. This study is not endorsed by or conducted for the IBON.

If you agree to participate, I ask that you complete the enclosed questionnaire. The questionnaire will take about ten minutes to answer by checking the response boxes in pen or pencil. Return the questionnaire in the self addressed stamped envelope. You may skip any questions you do not wish to answer.

I will send one reminder post-card about three weeks from now. Please return your questionnaire postmarked by March 2nd, 2010. If you do not wish to participate in the study, you may return a blank questionnaire and I will remove your name from the list.

I will keep the information you provide confidential, however federal regulatory agencies and the University of Iowa Institutional Review Board (a committee that reviews and approves research studies) may inspect and copy records pertaining to this research. I will minimize the risk of loss of confidentiality of the study data in that your identifying information will not be stored with your study data. Only a code number will be used to identify your responses. The link between the code number and your identifying information will be stored separately and be destroyed when no longer needed for the study. Each survey will have a form number. This form number will be the link to match returned surveys and help me to know who will need to be mailed a non-response post-card in week 3. The list and all questionnaire forms will be destroyed after analysis. I will keep all data confidential and store the data in locked offices and in password protected computer files. If I write a report about this study I will do so in such a way that you cannot be identified.

There are no known risks from being in this study, and you will not benefit personally. However I hope that others may benefit in the future from what we learn as a result of this study.

You will not have any costs for being in this study. You will be entered into a drawing to receive one of eight \$25 gift-cards from a major department store. Complete the enclosed return ticket and place the ticket in the envelope with your questionnaire and return them both to me. Return tickets received postmarked after March 2nd 2010 will not be eligible for the drawing. If

FOR IRB USE ONLY APPROVED BY: IRB-02 IRB ID #: 200911774 APPROVAL DATE: 02/05/10 EXPIRATION DATE: 01/08/11
--

your name is drawn, I will contact you by phone and ask for your preference for the store for the gift card. The gift card will be mailed to the winners.

Taking part in this study is completely voluntary. If you decide not to be in this study, or if you stop participating at any time, you won't be penalized or lose any benefits for which you otherwise qualify.

If you have any questions or to report a research related problem, please contact me at (319) 624-3272 or contact my faculty advisor, Lelia Helms Ph.D., J.D. at the University of Iowa (lelia-helms@uiowa.edu).

If you have questions about the rights of research subjects, please contact the Human Subjects Office, 300 College of Medicine Administration Building, The University of Iowa, Iowa City, IA 52242, (319) 335-6564, or e-mail irb@uiowa.edu. To offer input about your experiences as a research subject or to speak to someone other than the research staff, call the Human Subjects Office at the number above.

I am grateful to you for your consideration of this project, and look forward to your response.

Completion and return of the questionnaire indicates your willingness to participate in the study. Please keep this cover letter for your records.

Sincerely,

Mary Tobin, RN, MA
Ph.D Candidate The University of Iowa

APPENDIX H
NATIONAL, IOWA, AND VERMONT LPN
DEMOGRAPHIC DATA
COMBINING FULL- AND PART-TIME LPNS

Table H-1. National/State Demographic Data Combining Full- and Part-Time LPNs

Variables	Frequencies (%) or Numeric
Gender (Iowa data)	
Female	95%
Male	5%
Gender (Vermont data)	
Female	94%
Male	4%
Gender (National)	
Female	96%
Male	4%
Age (Iowa data)	
Less than 29	18%
29 – 38	24%
39 – 48	19%
49 – 58	25%
59 – over	14 %
Age (Vermont data)	
Mean age	47.9 years
Age (National)	
Mean age	43 years
Married(National)	
Yes	60%
No	40%
Current work-setting (Iowa data)	
Hospital	14%
Office	19%
LTC/Skilled	42%
Home Care	8%
Other	17%
Current work-setting (Vermont data)	
Hospital	17%
Office	14%
LTC/Skilled	39%
Home Care	3%
Other	27%
Current work-setting (National)	
Hospital	32%
Office	12%
LTC	32%
Home Care	1%
Other	23%

Note: National LPN data source: Seago, J. A., Spetz, J., Chapman, S., Dyer, W., & Grumbach, K. (2004). *National Center for Health Workforce Analysis: Supply, demand, and use of licensed practical nurses*. Retrieved Jan 15, 2010, from <http://bhpr.hrsa.gov/healthworkforce/reports/nursing/lpn/default.htm>

State LPN data sources: Vermont State Board of Nursing Website retrieved Jan 15, 2010 from <http://www.vtprofessionals.org/opr1/nurses/>

Iowa Board of Nursing Website retrieved Jan 15, 2010 from <http://www.state.ia.us/nursing/>

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