Nurses' and Midwives' Understanding and Experiences of Empowerment in Ireland

Final Report
September 2003

DEPARTMENT OF HEALTH AND CHILDREN
AN ROINN SLÁINTE AGUS LEANAÍ

A report prepared for the Empowerment of Nurses and Midwives Steering Group – An Agenda for Change

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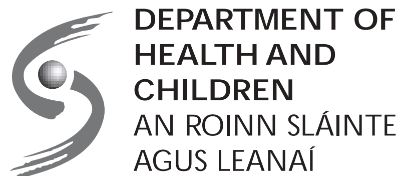

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Preface

Irish nurses and midwives are a very valuable resource. We make up over 40% of the entire health service workforce. Thus effective, efficient use of this resource is of paramount importance. The Commission on Nursing Report (1998) in its recommendations on the meaningful involvement of nurses and midwives in the management and provision of services, gave significant indications of areas where further work was needed to strengthen the nursing and midwifery contribution (for example 7.12,7.14, 7.17, 7.20, 7.29, 7.38, 7.40, 7.41). Enabling nurses and midwives to contribute to their full potential is a key requirement in the management of an effective health service for the Irish population.

To further this objective a high level Steering Group on the Empowerment of Nurses and Midwives was established in 2000. The steering group identified four central areas that required attention in moving forward into the twenty-first century: management development, service planning, communication and empowerment. A sub-group was set up to explore the meaning of empowerment and to examine nurses' and midwives' understanding and experience of empowerment within the context of the Irish health service. This sub-group recommended a national study on empowerment which was commissioned by the Department of Health and Children in 2001.

The study was undertaken by a research team led by Professor Anne Scott, School of Nursing, Dublin City University. This report entitled ***Nurses' and Midwives' Understanding and Experiences of Empowerment in Ireland*** presents the results of the study. The study makes an important contribution to Irish health services research, providing a baseline from which the further development and contribution of nursing and midwifery in Ireland can be measured.

Mary McCarthy
Chief Nursing Officer
Chair of the Empowerment of Nurses and
Midwives Steering Group

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This sub-group provided very valuable support and advice throughout the duration of the study and during preparation for publication.

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- Most importantly I wish to thank each nurse and midwife who participated in the focus group discussions, the two pilot studies and the main survey. Without their generous input this study could not have been conducted.

I hope that the results of this study will stimulate discussion throughout the profession. I also hope these results will inform policy makers and managers as they endeavour to ensure the most effective use of the nursing and midwifery resource in the Irish health service.

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Executive summary

With the recently launched national health strategy (Department of Health and Children, 2001) and a tightening fiscal policy there is a requirement for a more innovative use of existing resources dedicated to healthcare in Ireland. Nurses and midwives, one of the largest professional groups within the health service, will play a critical role in developing this "new" health service. To this end a study of nurses' and midwives' understanding and experiences of empowerment in Ireland was commissioned by the Health Research Board on behalf of the Steering Group on the Empowerment of Nurses and Midwives in December 2000. Funding was provided for an eighteen-month study. A research team in the School of Nursing, Dublin City University, headed by Professor P. A. Scott was awarded the research contract in March 2001 and the study commenced in April 2001.

This study highlights that empowerment can become a key requirement to encourage the innovative practise that will underpin healthcare provision. The challenge facing senior management in the health service is to harness the positive attitudes and skills of nurses and midwives in Ireland as elemental in providing the direction necessary for effective implementation of the health strategy.

The objectives of the study were

- to explore the meaning of empowerment from the perspective of nurses and midwives
- to identify nurses' and midwives' experiences of empowerment
- to identify factors which enhance nurses' and midwives' experiences of empowerment
- to identify factors which inhibit nurses' and midwives' experiences of empowerment
- to identify opportunities for further enabling the empowerment of nurses and midwives.

The study was carried out in two phases:

- phase 1: focus group discussions to elicit nurses' and midwives' understanding and experiences of empowerment
- phase 2: a national survey of nurses and midwives again focusing on nurses' and midwives' understanding and experiences of empowerment, to test the findings of the focus group discussions.

An in-depth literature review highlighted two major and one emerging approach to the understanding of empowerment. These were

- organisational/management theory approaches to empowerment
- psychological approaches to empowerment
- critical social theory approaches to empowerment in nursing and midwifery.

Our conclusion, based on the literature, was that to understand empowerment properly in terms of its development and implications would likely require the development of a model that took into account the potential influences of all three approaches.

The purpose of phase 1 of the study, focus group discussions, was to gain insight into how practising nurses and midwives understood and experienced empowerment within the Irish

context, test this against the literature review and use the outputs to design the national survey. Ten focus groups were established, including representation across all divisions of the nursing register and all grades of nursing and midwifery staff from staff nurse/midwife to directors of nursing.

The results indicate that Irish nurses and midwives are quite clear that empowerment requires the presence of individual personal factors and environmental factors. This was evident in both focus group and survey data. The findings from the focus groups articulated nurses' and midwives' experiences of empowerment in terms of six key and three interweaving themes. The key themes were: individual factors, interpersonal factors, professional issues, organisational issues, management, historical legacy.

The interweaving themes, so called because they permeated the key themes, were education, professional respect, and control.

Phase 2 of the study – the national survey – set out to test the focus group findings on a national basis. There was a useable sample of 1,781 respondents (46% response rate) to the survey. Within study constraints there was equitable representation across nursing divisions and geographical location. Regarding understanding of empowerment, factor analysis of survey data revealed once again the influence of both individual and environmental factors, articulated in this study as personal factors and an enabling environment. In terms of experience of empowerment, the overall empowerment and job satisfaction levels revealed through the survey suggest a moderately empowered and satisfied workforce. The survey indicated a more optimistic picture than the focus group discussions suggest and revealed many positive aspects of nursing and midwifery practice in Ireland. The factors perceived to enhance empowerment most frequently mentioned by survey respondents were

- education
- skills
- knowledge
- self-confidence.

Those factors identified most frequently as inhibiting empowerment were

- poor management style
- lack of education
- lack of support from management
- lack of recognition (from management and other professions).

The factors suggested by survey respondents echoed the findings of the focus group discussions. Interestingly while individual factors were deemed by survey respondents to be the most important factors in enhancing empowerment, environmental factors were the most frequently mentioned inhibiting influences.

Overall the findings supported the ideas emerging from the literature review, and more critically supported our approach of integrating the three theoretical perspectives.

In our conclusions there are four key points emerging.

- The findings from the literature review, the focus groups and the national survey support each other and provide Irish nursing with a model of empowerment that takes a holistic approach – individual, organisational and historical – that is unique and provides direction for future actions.
- A prerequisite for an empowered organisation is individual factor conditions such as self-esteem and self-confidence. These factors will drive both the formal and informal structures of any organisation. An enabling environment, one in which management encourages initiatives such as supporting staff development and innovation, can lead to a more empowered organisation. Promoting staff development in line with the strategic objectives of the health service and individual organisations/divisions is central to this.
- The model highlights that the concept of empowerment is dynamic and needs to be shaped to suit each organisation's strategic requirements. There will always be interactive elements between the personal factors, the enabling organisational factors and the historical legacy of how healthcare provision has traditionally been delivered.
- Irish nurses have a positive view generally of the importance of self-esteem and self-confidence to empowerment. They also show high scores on internal versus external locus of control and high levels of affective commitment. These individual traits are essential if empowerment is to develop and flourish. A key challenge is enhancing the organisational culture to enable empowerment to become a positive element of healthcare in Ireland.

The recommendations of this study build on these conclusions and are articulated under five headings: organisational development, management development, practice development, education, areas requiring further research.

The nursing profession in Ireland has provided us with very interesting and relevant data and it is essential that we use this, build on the insights offered, and provide a ore effective and robust healthcare service for Ireland in the twenty-first century.

Chapter 1

Literature Review

In this chapter literature that explores the notion of empowerment from the perspectives of organisational management, social psychology, and nursing is reviewed. The review traces the origin of the concept, suggests possible definitions of empowerment, outlines the major theoretical approaches to empowerment and highlights previous empirical work that set out to define empowerment in nursing. This sets the context for the study and the findings that are reported in chapters 2 and 3.

1.1 Origin of the term empowerment

Falk-Rafael (2001) indicates that the term empowerment originates from the health promotion domain. The World Health Organisation's Alma Ata Declaration of 1977 stated that health was a social issue and that people had a right to participate in the planning and implementation of their own health care. Empowerment therefore became institutionalised within the "new public health" that called for people to increase control over their own health. Empowerment thus became a concept central to health promotion, community psychology and health education.

Since the 1980s the concept of empowerment has been widely discussed in the nursing literature. These discussions relate to the empowerment of patients/clients, nurses and/or managers. Indeed many have highlighted the reciprocal nature of the empowerment of these groups (empowered nurses will empower patients, empowered managers will empower nurses etc).

Because there are as many definitions as authors on the subject of empowerment, it may be useful to explore, briefly, some of the definitions of the concept found in the literature.

1.2 Definitions of empowerment

The concept of empowerment has been described as a complex, multi-faceted, ambiguous, subjective and contested one (Gilbert (1995), Rodwell (1996), Ryles (1999), Lewis and Urmston (2000)). Kieffer (1984) argues "while the idea of empowerment is intuitively appealing for both theory and practice, its applicability has been limited by continued conceptual ambiguity". Lewis and Urmston (2000) see empowerment as a multi-faceted contested concept, more easily understood by its absence: powerlessness, helplessness, alienation, victimisation, subordination, oppression, paternalism, marginalisation, loss of sense of control over one's life and dependency.

Kuokkanen and Leino-Kilpi (2000) point out that empowerment is intuitively a positive concept. It is both a process and result, thus the process of empowerment leads to empowerment. However such a claim may further confuse rather than clarify the issue. It may be more useful to suggest that certain factors and/or certain environments facilitate the development of an empowered individual or facilitate the exercise of empowerment in an employee.

Rodwell (1996) for example describes what she considers to be related concepts, antecedents and consequences of empowerment. The related concepts she includes are autonomy,

responsibility, accountability, power, choice, advocacy, motivation and authority. The antecedents of empowerment identified are mutual trust and respect, education and support, and participation and commitment. As consequences of empowerment Rodwell includes positive self-esteem, ability to set and reach goals, a sense of control over life and change processes and a sense of hope for the future.

1.3 Theoretical approaches to the concept of empowerment

There are two main theoretical approaches to empowerment found in the literature. These are organisational/management theories and social psychological theories. The critical social theory perspective has also been discussed in the literature on nursing empowerment and as a result it is described below.

Organisational/management theories see organisational and management structures as being core to empowerment; i.e. such structures are essential in enabling staff to function in an empowered manner. Professor Heather Laschinger, who runs the Workplace Empowerment Program at the School of Nursing, University of Western Ontario, uses an organisational approach to empowerment. Laschinger (1996) states that from the organisational management perspective, employee work behaviours are responses to work conditions and situations, not manifestations of inherent personality traits. She uses Kanter's (1979) theory of structural power in organisations as the basis for her work on empowerment. Kanter defined power as "the ability to get things done, to mobilise resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet". Kanter's theory is concerned with both formal and informal power within the organisation. **Formal power** is found in jobs that are visible, central to the purpose of the organisation and that allow for discretion in decision-making. **Informal power** is derived from the alliances individuals form within the organisation – alliances with superiors, peers and subordinates. Such alliances result in the co-operation required to get things done. Kanter claims that such forms of power determine access to **opportunity, resources, support and information** within the organisation.

In the mid-1980s a number of studies reporting support for the appropriateness of using Kanter's model to research empowerment in nursing appeared in the nursing literature (for example, Chandler (1986), Moscato (1987)). Since then considerable empirical work based on this model has been conducted within nursing. Professor Laschinger devised scales to measure empowerment based on Kanter's theory as follows: ***Conditions for Work Effectiveness Questionnaire*** (CWEQ) (comprising four sub-scales to measure access to opportunity, resources, support and information); ***Job Activities Scale*** (JAS) (to measure formal power); ***Organisational Relationships Scale*** (ORS) (to measure informal power). She also included two global statements relating to workplace empowerment. These statements were "Overall my current work environment empowers me to accomplish my work in an effective manner" and "Overall I consider my workplace to be an empowering environment". Laschinger (1996) provides a review of the studies in nursing empowerment that had used these scales to that date. Of the eight studies reviewed three had used convenience samples, and all of the studies that included managers had a sample size of less than thirty managers. There was a range of organisational settings, size of organisation and nursing specialties. In total thirty-three studies at the Workplace Empowerment Program at the School of Nursing, University of Western Ontario have

used these scales and Laschinger reports the results of these studies and other studies that have used the scales (http://publish.uwo.ca/~hkl/descrip.html).

Laschinger's empowerment scales are validated tools, that have been used to investigate empowerment in nursing. They are limited in that being based on Kanter's structural theory of power they exclusively deal with empowerment from an organisational perspective. Laschinger (1996) acknowledged this limitation and has included measures of psychological empowerment in her more recent work on empowerment (Laschinger et al, 2001a, 2001b). This work uses Laschinger's empowerment scales and also includes a locus of control measure to balance their focus on external factors.

Social psychological theories view empowerment from the point of view of the individual, seeing it essentially as a process of personal growth and development. Conger and Kanungo (1988) believe that leadership and management theory was too narrow to explain empowerment. Irvine et al (1999) state that the psychological view of power contrasts with Kanter's view of power (as used by Laschinger in her model of empowerment) in which she posited that power in organisations is derived from structural conditions and not personal characteristics or socialisation effects. For Kanter (1993) power is external to the person whereas for Conger and Kanungo (1988) and Spreitzer (1995) it comes from within the person. Thomas and Velthouse (1990) and Spreitzer (1995) further developed Conger and Kanungo's work, resulting in the development of a model of psychological empowerment. This comprises impact (a sense of being able to influence important outcomes within the organisation); competence (having confidence in one's job performance abilities); meaning (congruence between the requirements of the job and the employee's beliefs, values and behaviours); and self-determination (feelings of control over one's work). This model of psychological empowerment is used by Kuokkanen and Leino-Kilpi (2001) in their most recent work on empowerment (see page 17).

Critical social theory relates a social phenomenon to the history and structure in which it is found. Those who consider empowerment in nursing from a critical social theory perspective believe that the presence or absence of empowerment can only be understood in relation to the history and structures within which nurses find themselves (Fulton, 1997). The critical social theory approach involves an exploration of the historical development of the profession and its position relative to other professions and social structures.

Lack of empowerment is related to the negative, patriarchal authoritarian concept of power (Gilbert 1995). To successfully engage in empowerment there is a need to understand the complex social, political and economic forces that shape people's lives. Writers in this tradition present evidence that supports a view of nursing as an oppressed group, by dint of gender, class and occupation (Gilbert (1995), Fulton (1997) Ryles (1999)). The claim is that to meet the needs of an oppressed group a liberationist philosophy is required; thus empowerment is equated with liberation. Patient empowerment is central to this approach.

It may be useful to consider definitions from the three theoretical perspectives described above. Within the organisational/management perspective Kanter's theory maintains "work environments that provide access to information, resources, support and the opportunity to learn and develop are empowering and enable employees to accomplish their work" (Laschinger et al 2000). Within the social psychological approach Conger and Kanungo (1988) offer one

definition of empowerment. They describe empowerment as the "process of enhancing feelings of self-efficacy through the identification of conditions that foster powerlessness and through their removal by both formal organisational practices and informal techniques of providing efficacy information". From a critical social theory standpoint empowerment is equated with liberation from oppression and lack of empowerment is related to the negative, patriarchal authoritarian concept of power (Ryles 1999).

1.4 Empirical work exploring empowerment in nursing

Fulton (1997) carried out "the first" study into British nurses' views on the concept of empowerment, using a critical social theory approach. This was a "small-scale" study using two focus groups, composed of participants in an Empowerment for Practice course which was led by Fulton at Southampton University School of Nursing and Midwifery. The course had a curriculum based on critical social theories.

The data was analysed "focusing on oppressed group behaviour". On the basis of the findings Fulton identified four core categories regarding empowerment as follows: "empowerment"; having personal power; relationships with multidisciplinary team; and feeling right about oneself. Fulton does not comment on the use of the category "empowerment" in a study exploring empowerment itself. She indicates that the category "empowerment" includes the themes of decision-making, choice, authority; that empowerment is both a process and an outcome; and the reciprocal nature of empowerment. The category "having personal power" includes the themes of assertiveness, knowledge and that power had had negative connotations for participants. Included in the category "relationships with multidisciplinary team" are themes of medical power, autonomy of the medical staff; and the team. The category "feeling right about oneself" includes the themes of confidence, self-esteem and the potential to be manipulative towards patients.

Fulton acknowledges the limitations of her small-scale study with a self-selected sample of participants who were about to undergo an educational programme on empowerment together, with the focus group moderator as course leader and assessor. However there is some mirroring of the data in the focus group data of our study as discussed in chapter 2, mainly in relation to decision-making, relationships with the multi-disciplinary team (particularly the medical profession) and confidence (see page 26 below).

A study of patient/client empowerment was undertaken by Falk-Rafael (2001) in which a series of three focus group discussions each were held with three groups of public health nurses in south-western Ontario. This study defined (patient/client) empowerment as "an active internal process of growth that was rooted in one's own cultural/religious/personal belief systems reaching towards actualising one's full potential, occurring within a nurturing nurse-client relationship". The outcomes of empowerment were said to be changes in self, relationships and behaviour. Falk-Rafael concludes that nurses conceptualised empowerment in terms of freedom, to make decisions with authority, and to have choices. There were perceived negative connotations to personal power. Autonomy was perceived to be seriously limited by unequal power relationships with medical staff. Although the study related to patient/client empowerment it offers a useful definition of empowerment, which emphasises the active,

internal nature of the process. Again decision-making and medical power are issues that were also raised by focus group participants in our study (see page 26).

Attridge (1996) carried out a critical incident study on the experiences of powerlessness among a sample of sixty-four nurses working in hospitals in British Columbia. She identified the following themes: basic human situations, emotion, life and death; an unsafe situation for the nurse; loss of control of situation; competing serious demands; the nurse felt alone or abandoned; the situation demanded negative choice/action; and a underlying contributing factor was lack of resources. Nurses knew what they should do but were unable to do it. Control over work appeared to be a critical component of their definition of power. A similar finding is reported in our study (see page 26). Power in Attridge's research was therefore defined as "the ability to have control over my work situation such that I can successfully bring about more effective patient care or other work-related activity". She characterised this power as "power to" fulfil a goal, rather than "power over" others, the latter being a more negative conceptualisation of power, with which nurses have been uncomfortable.

Attridge claimed that while the nurses acted very powerfully in impossible situations, they felt guilt and self-blame rather than taking the matter to organisational level or beyond. She gave the example of one nurse who was moved to ICU for one hour (which turned out to be eight hours looking after two patients on ventilators) when she had no critical care experience. Other examples related to being overwhelmed by work, new admissions, critically ill patients and not being listened to by management when concerns about the effects on patient care of these demands were raised. Attridge concludes that this self-blame may also serve powerful others who may benefit from nurses taking this responsibility.

Kuokkanen and Leino-Kilpi (2001) investigated the qualities of an empowered nurse, how an empowered nurse acts and the factors that promote and prevent empowerment. Their conceptual framework employed the concepts of meaning, impact, competence and self-determination from Thomas and Velthouse (1990) which was further developed by Spreitzer in her work on empowerment (see page 15 above). Kuokkanen and Leino-Kilpi's study involved interviews with "the first thirty nurses who presented themselves" from a sample of 125 nurses who had participated in a career advancement project at a university hospital in Finland. Half of the thirty participants in the study were "head nurses". The authors report that the participants "considered themselves strongly motivated in their work, as well as active in participating in further training". Participants were asked as part of the research to evaluate their own state of empowerment and "with just one exception all considered themselves empowered nurses". The findings are presented in Table 1 below, under the core categories that were identified by the authors, namely: moral principles (based on respect, honesty and equity); personal integrity (involving courage, flexibility, ability to act under pressure); expertise (competence, autonomy, having personal power, responsibility); future-orientatedness (innovation and creativity); and sociability (conspicuous within work-unit, active).

The authors claim that this study approaches empowerment from the individual nurse's point of view, in contrast to studies that describe it from an organisational starting point. The authors used a psychological perspective on empowerment to frame the interview themes, and the emphasis on internal or personal "qualities, values and endeavours" balances the focus on external factors found within the organisational/management literature described above (see page 14). "Changes in working conditions require changes in the workers too" the authors

conclude. This captures the two facets of empowerment – the internal and external ones. Both the focus group participants and survey respondents in our study similarly stress these two facets of empowerment, signalling a sophisticated approach that avoids a simplistic externalisation of responsibility for empowerment.

Table 1: Qualities of an empowered nurse and "ways to act as an empowered nurse"

	Qualities of an empowered nurse	Ways to act as an empowered nurse
Moral principles	Respect for individuals Honest Equitable	Treats others with respect Acts honestly Acts justly
Personal integrity	Mental resources Courageous, assertive Able to act under pressure Broadminded, flexible	Looks after own well-being Dares to say and act Acts effectively under pressure Acts flexibly
Expertise	Competent Has personal power Autonomous	Acts skilfully Makes decisions Acts independently Consults and teaches colleagues
Future orientatedness	Personally responsible	Finds creative solutions Promotes new ideas at work Acts after planning, assesses effects
Sociability	Open-minded Respected by others Socially responsible	Discusses openly Works for the common goal Solves problems

Source: Kuokkanen and Leino-Kilpi (2001)

1.5 Factors that influence empowerment

As indicated in the Executive Summary (p. 10 above) one of the objectives of this study of Irish nurses' and midwives' understanding and experiences of empowerment, is to explore the factors that Irish nurses and midwives believe enhance and inhibit empowerment. In the literature some authors directly discuss the factors that prevent and promote empowerment.

For example Conger and Kanungo (1988) outline factors that lead to a potential lowering of self-efficacy belief (i.e. that prevent empowerment, according to their definition). These include

organisational factors

- significant organisational changes/transitions
- start-up ventures

- competitive pressures
- impersonal bureaucratic climate
- poor communications/network forming systems
- highly centralised organisational resources

supervisory style
- authoritarian (high control)
- negativism (emphasis on failures)
- lack of reason for action/consequences

reward systems
- non-contingency (arbitrary reward allocations)
- low incentive value of rewards
- lack of competence-based rewards
- lack of motivation-based rewards

job design
- lack of role clarity
- lack of training and technical support
- unrealistic goals
- lack of appropriate authority/discretion
- low task variety
- limited participation in programs, meetings, decisions that have a direct impact on job performance
- lack of appropriate/necessary resources
- lack of network-forming opportunities
- highly established work routines
- high rule structure
- low advancement opportunities
- lack of meaningful goals/tasks
- limited contact with senior management.

According to Conger and Kanungo (1988) leadership and/or supervision practices that are identified as empowering include
- expressing confidence in subordinates accompanied by high performance expectations
- fostering opportunities for subordinates to participate in decision-making
- providing autonomy from bureaucratic constraint
- setting inspirational and/or meaningful goals.

In their study Kuokkanen and Leino-Kilpi (2001) also identified factors that promote and prevent empowerment. These are presented in Table 2.

Table 2: Factors that prevent and promote empowerment

	Empowerment is promoted by	Empowerment is prevented by
Moral principles	Shared values	Conflicting values
	Esteem for others	Nullification
	Concerted care philosophy	No concerted policy
Personal integrity	Delegated responsibilities	Authoritarian leadership
	Confidence	Distrust
	Feedback	Non-responsiveness
Expertise	Evaluation and development	Resistance to innovation
	Co-operation	Lack of co-operation
	Training	Unprogressiveness
Future orientatedness	Continuity of work	Short working periods
	Position opportunities	Hierarchy
	Access to information	Lack of information
Sociability	Collegial support	Raising barricades
	Problem solving	Controversy
	Open ambience	Lack of openness

Source: Kuokkanen and Leino-Kilpi (2001)

1.6 Conclusion – towards a clearer understanding of empowerment?

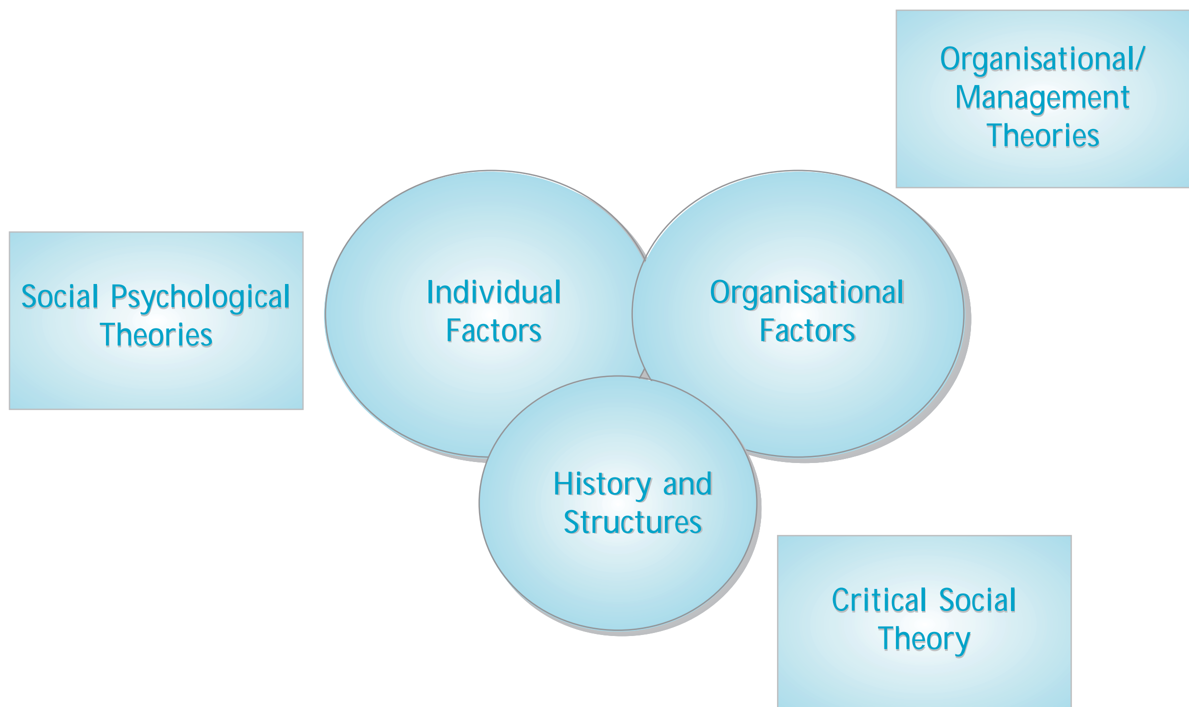
Downie (1994), in a useful discussion of our quest for definitions, concludes that we should retain the label "definition" for "real definitions that capture the essence or nature of a phenomenon". How, therefore should one define empowerment in order to capture its essence or nature. Lexical (word-word) definitions, for example "empowerment is enablement", may prove circular and ultimately unhelpful given the complexity of the phenomenon. Ostensive definitions which point to a thing to explain it (like Kuokkanen and Leino-Kilpi's (2001) descriptions of the qualities of an empowered nurse and the way an empowered nurse acts) go some way towards illustrating the phenomenon without perhaps capturing its essence.

It is useful to distinguish between empowerment itself (both as a process and an outcome) and (a) the conditions that will promote or prevent empowerment (or its antecedents) and (b) the consequences of empowerment (or empowered ways of acting). Clearly certain conditions relating to management, organisations, interpersonal relationships, personal characteristics and professional issues for example, will promote or prevent (enhance or inhibit) the development and/or exercise of empowerment. According to the literature reviewed above these conditions relate to both the organisational/management and individual domains and in this sense are both external (resources, information and support, after Kanter (1979)) and internal (honesty, flexibility and personal responsibility, after Kuokkanen and Leino-Kilpi (2001)). The empowered nurse or midwife will consequently act in particular ways, making decisions, solving problems, daring to say and act, as described by Kuokkanen and Leino-Kilpi. Individual empowerment, though, can arguably only be an "active internal process of growth ... towards actualising

one's full potential" (from Falk-Rafael, 2001) for the individual, facilitated by the necessary conditions (antecedents) and resulting in particular ways of acting.

On the basis of the literature discussed above, it is possible to conclude that a number of factors appear to be influential in determining the presence, absence, or level of empowerment. What is not at all clear from the literature is the relative weight of these factors or indeed how they may interact with each other in determining the presence or absence of empowerment in individual action. Figure 1 presents a diagrammatic representation of the three approaches to empowerment identified in the literature. All of the factors are reflected in varying strengths in the data obtained from both our focus group interviews and our national survey presented in chapters 2 and 3 below.

Figure 1: Diagrammatic representation of factors that influence the presence or absence of empowerment derived from literature review



This exploration of the literature relating to the complex concept of empowerment sets the context for the presentation of the findings of this study. The first phase of the study involved focus group discussions with nurses and midwives throughout Ireland on their understanding and experiences of empowerment. A summary of these findings is presented in the next chapter, where ninety-three Irish nurses and midwives describe what they understand by empowerment and what their experiences of empowerment have been.

Chapter 2

Focus group discussions

The aim of conducting the focus group discussions was to obtain qualitative data on the understanding and experiences of empowerment of nurses and midwives in Ireland and to provide a basis from which to develop the data collection tools for phase 2 of the study. This chapter presents a review of the data collection process and a summary of the findings of the focus group discussions.

2.1 Methodology

Recruitment of the sample for focus group discussions

In an effort to obtain a national distribution of nurses and midwives, the country was divided by health board regions. Participants included staff employed in health board hospitals and services, voluntary hospitals and appropriate voluntary services in each region. Between 17 May and 12 June 2001, ten focus group discussions were held across Ireland. The focus group discussions were generally very well attended with a good distribution across the divisions of nursing, as shown in Table 3 below.

Participants were nominated by directors of nursing and other relevant managers. While time constraints necessitated this approach, it was not ideal given the topic for discussion, and the potential for participant bias given the selection and nomination method. Some participants found out that they were to attend only the night before the discussion and furthermore some stated that they were told to go to the focus group discussion, which they found ironic given the topic for discussion.

Table 3: Attendance at focus group discussions by region and area of practice

Geographical area	General	Midwives children's nurses	Sick health	Public nurses	Psychiatric handicap nurses	Mental	Total
NEHB	4	2	1	2	2	2	13
WHB	2	1	1	2	-	-	6
ECAHB	4	1	-	2	3	-	10
NAHB	3	2	-	2	2	2	11
MWHB	4	2	1	1	3	2	13
SHB	1	-	-	2	2	-	5
SWAHB	3	-	1	1	2	2	9
MHB	2	1	1	2	2	1	9
SEHB	1	1	1	2	2	-	7
NWHB	1	1	1	2	3	2	10
Total	25	11	7	18	21	11	93

Note: The divisions are named here and throughout the report as they appear on the An Bord Altranais register, while it is acknowledged that practitioners within some divisions use other titles (for example, intellectual disability nurses, mental health nurses).

The groups were heterogeneous in nature comprising representatives from each of the divisions of nursing, across a wide range of specialties. Nurses and midwives practising in both rural and urban settings were invited to attend. There was representation also from line managers at three of the group discussions. Many of the participants stated that they wished to be acknowledged by name in the final report of the study. Some, on the other hand, did not wish to be identified and stated that what they said would be "held against them" in their workplaces. This perception by the participants is of note given the subject under exploration. In the interest of upholding the anonymity and confidentiality assured to all participants, the names of all focus group participants are withheld. The research team would again like to take this opportunity to express gratitude to all who contributed in the focus group discussions.

Methods

The focus group discussions were carried out in accordance with best practice. A moderator conducted the discussions, with a note-taker in attendance. The discussions were recorded and this was explained to participants. Participants' anonymity was assured. Each discussion lasted approximately one hour. A question guide prepared by the research team was used, with probing questions following up contributions that required further clarification.

Data analysis

The taped discussions were transcribed. Preliminary computer-assisted analysis of the data was undertaken using ***ATLAS/ti***, a computer package for qualitative data analysis. Particular attention was given to issues that were raised in all or most of the focus group discussions and issues that were discussed to the greatest extent within groups. A list of the most frequently assigned codes is included in Appendix A. While this list gives a flavour of the issues that were raised most frequently and across most groups, clearly it does not indicate the intensity or extent of the discussions that took place around these issues, which is shown in Appendix B. In addition to computer-assisted analysis further manual content analysis was undertaken because of the complex nature of the data obtained and the concept under exploration. Content analysis and coding of the data facilitated the identification of themes within and thereafter across focus groups. The thematic framework emerging from this analysis is presented below in Figure 3 (page 25).

2.2 Findings of the focus group discussions

Nurses and midwives were invited to take part in focus group discussions to elicit their understanding and experiences of empowerment. Regarding their understanding of empowerment, it appeared that this was not easily conceptualised by participants or that their conceptualisations were not easily expressed. Instead, participants consistently used examples from practice to illustrate their understanding of empowerment. There was also some uncertainty and even suspicion expressed regarding the term; with some concern that it was just a buzz-word. Notwithstanding uncertainty and the tendency to exemplify or illustrate understanding with particular experiences, it was possible to isolate aspects of what nurses and midwives understood as empowerment. Analysis of the focus group discussions suggests that nurses' and midwives' understanding of empowerment centres around the following elements:

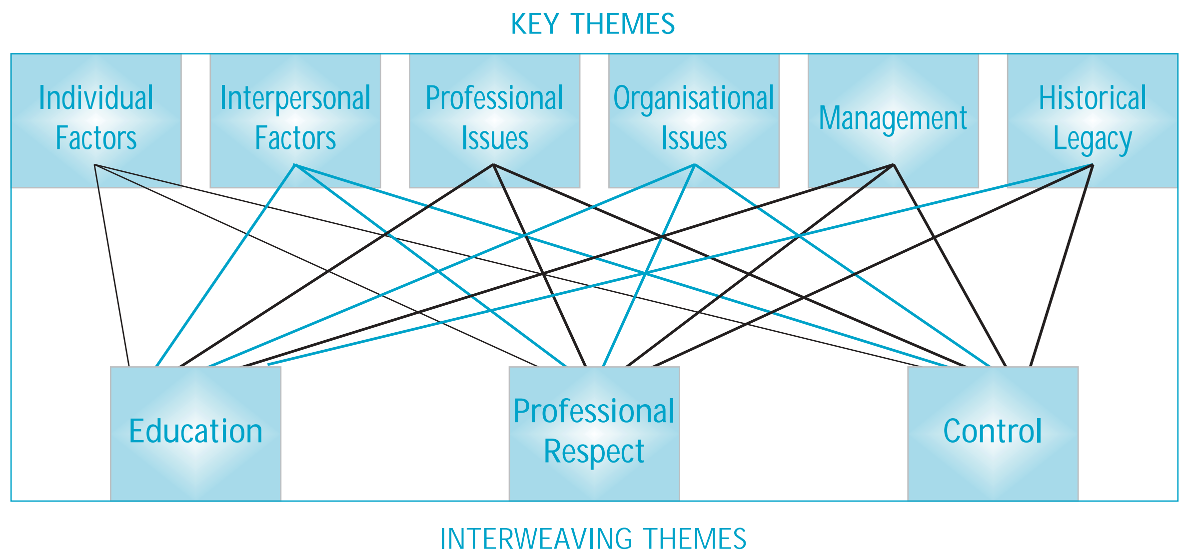
- being involved in decision-making about patients, autonomy, authority, responsibility, accountability, control
- being listened to, supported, respected
- working within, being listened to and feeling a part of the multi-disciplinary team
- job satisfaction, ideal practice
- education for practice.

These elements are represented diagrammatically in Figure 2.

Figure 2: Diagrammatic representation of focus group participants' understanding of the meaning of empowerment

A clear distinction between data relating to participants' understanding and experience of empowerment is not possible because participants did not make this distinction. What may be useful, however, is to develop a diagrammatic representation of the themes relating to empowerment that emerged from the data in its entirety. This representation is presented below in Figure 3. It was derived as follows. On analysing the focus group discussions, it appeared that six strong themes emerged from the data, comprising a number of related issues that were extensively and/or intensively discussed by participants. However, there were also more subtle, linked themes that permeated the data. These are referred to as ***key themes*** and ***interweaving themes*** respectively. These themes are further expounded in Appendix B.

Figure 3: Diagrammatic representation of themes that emerged in the focus group discussions



2.3 Discussion of focus group findings

In line with the terms of reference of the study, the aim of phase 1 of the research was to explore the understanding and experiences of empowerment held by practising nurses and midwives in Ireland. The findings obtained from the focus group discussions were themselves very interesting and they also provided a basis on which to frame phase 2 of the study.

Analysis of the focus group data facilitated the development of the diagrammatic representation shown in Figure 3 comprising the themes that emerged from the focus group discussions. This thematic representation encompasses all the empowerment influencing elements identified in the literature, as shown in Figure 1 (page 21). These are the organisational, individual and historical factors which were identified from the organisational/management, social psychological and critical social theory perspectives respectively.

Within the key theme **Individual actors**, the importance of the "willingness to be empowered" was raised by participants, highlighting personal responsibility for empowerment, as found in the social psychological literature (page 15). This finding has echoes of Kuokkanen and Leino-Kilpi's (2001) description of an empowered nurse who "dares to say and act" and has personal responsibility (page 18). It also lends support to the definition of empowerment as an "active internal process" (Falk-Rafael, 2001, page 16 above).

Empowerment for the focus group participants is not therefore a passive occurrence but involves elements of personal action and responsibility. The other five key themes emphasised external influences on empowerment: **Professional Issues**, **Interpersonal Factors**, **Management**, **Organisational Factors** and the **Historical Legacy of Nursing**. The management and organisational issues raised in the focus groups mirrored those found in the management/organisational literature on empowerment. Conger and Kanungo (1988) (see page 18 above) identify authoritarian supervisory styles, centralised resources, lack of role clarity and limited participation as factors that prevent empowerment. Experiences of these factors were

reported by focus group participants. The key theme **Historical Legacy** supports the demand, of those working from a critical social theory perspective (see page 15 above), that current nursing issues must be related to the history and structure within which they are found. Participants in the focus groups clearly identified and articulated this link.

When the interweaving themes (**Education**, **Professional Respect** and **Control**), identified from the data, are related to the work of Rodwell (1996) (see page 13 above) it appears that they are linked to what Rodwell identifies as the antecedents of empowerment (especially respect, education and support) and to some extent the consequences of empowerment (especially relating to control). Attridge (1996) also concludes that control over work appeared to be a critical component of the definition of power of her participants. Equally there are echoes in these findings of Fulton's (1997) study (see page 16 above) in which she identified the four core categories of "empowerment", having personal power, relationships with multidisciplinary team and feeling right about oneself. Common to the findings of Fulton's study and this one are issues of decision-making, knowledge, the multidisciplinary team, medical power and confidence.

As also discussed above (page 13) Lewis and Urmston (2000) see empowerment as a concept more easily understood by its absence, characterised by powerlessness, helplessness, alienation, victimisation, subordination, oppression, paternalism, marginalisation, loss of sense of control over one's life, and dependency. Control was identified as important in the focus group discussions, with participants also vividly describing experiences of powerlessness, subordination, marginalisation and helplessness. Focus group participants described examples of powerlessness in similar terms to Attridge's participants (page 17), specifically in relation to being moved around clinical areas and not being listened to by management when concerned about such issues as staff shortages.

The National Turnover Study in Nursing and Midwifery (Department of Health and Children, 2002) investigated rates of and reasons for turnover in nursing and midwifery in Ireland. Negative issues raised in relation to reasons for leaving a job included increasing demands and an increasing workload, a lack of support from nursing management and not being able to make decisions. These issues also emerged during the focus group discussions as being related to disempowerment.

It has been shown that the findings presented in this chapter resonate with those of previous work on the subject of empowerment: as described in the literature reviewed in chapter 1 above. These findings begin to give an impression of how empowerment is understood and experienced by practising nurses and midwives in Ireland. This data provided the basis for the development of the national survey. Key sentences relating to focus group participants' understanding of the meaning of empowerment were selected for inclusion in a questionnaire relating to understanding of empowerment. These reflected the list of issues raised most frequently and in most or all focus groups (Appendix A), and also those issues that were raised with most intensity. Historical factors, while identified by participants as key to how empowerment has been and indeed is being experienced, do not appear in this list, because they were not identified as being part of the meaning of empowerment. The sentences that were included in the pilot survey are shown in Table 4, grouped under the key theme to which they relate. The experiences of empowerment reported in the focus groups also facilitated the selection of instruments to measure empowerment in phase 2 of the study.

Table 4: List of statements relating to understanding of empowerment included in pilot survey

To me, empowerment includes:	
Individual factors	Being accountable for my practice Being confident when dealing with members of the multidisciplinary team Having high self-esteem Having autonomy in my practice Being adequately educated to perform my role Having control over my practice Being assertive Standing by my professional decisions Being self-directed in my practice Being able to say no when I judge it to be necessary Having the authority required to practice effectively
Interpersonal issues	Having effective communication with members of the multidisciplinary team Having support from my colleagues Being involved in decision-making about patient care Being listened to by members of the multidisciplinary team Being respected by members of the multidisciplinary team Being consulted about patient care by members of the multidisciplinary team Being recognised as a professional by the medical profession Being recognised for my contribution to patient care by the medical profession
Professional issues	Having a Scope of Practice document Being an advocate for my patients/clients Being involved in nurse/midwife-led clinics Empowering my patients/clients Performing tasks that were previously performed by doctors and other professionals Having the skills to carry out my role Practising patient/client-centred care Knowing what my scope of practice is Having a clearly defined role Having responsibility for patient care Delegating non-nursing tasks to auxiliary staff Knowing that my patients/clients are satisfied with my care Having freedom to practice within my scope of practice
Organisational issues	Having access to resources for patients'/clients' needs Having adequate staffing levels in my unit Having access to continuing education Having access to resources for staff education and training Being informed about changes in my organisation that will affect my practice
Management	Having a supportive manager Having a nurse manager who gets things done Getting constructive feedback from my manager on my performance Being valued by my manager Being respected by my immediate manager Being recognised for my contribution to patient care by my manager Having the back-up of my manager Having effective communication with management
	I don't really understand what empowerment means

Chapter 3

National survey

Within the study design, the purpose of phase 2 of the study – the national survey – was to build on and test the findings of the focus group discussions of phase 1. This chapter briefly describes the issues relating to the pilot survey and then presents the findings of the national survey.

3.1 Pilot survey

In preparation for the national survey, piloting was required for a number of reasons. It was necessary to test the usability of the survey instruments. It was also necessary to test the use of the Live Register of An Bord Altranais as a sampling frame, in terms of response rate and the ability to obtain representation from all areas of practice. A description of the pilot survey process, including a description of the scales used and a discussion of the findings, is given in Appendix C.

Preparation for the pilot survey included the selection of demographic questions, the development of a questionnaire on the understanding of empowerment (based on the focus group data, as described on page 25 above) and the selection of scales to measure empowerment, job satisfaction, affective commitment, burnout and locus of control. Laschinger's (1996) empowerment scales (Conditions for Work Effectiveness, Job Activities Scale and Organisational Relationships Scale, two global empowerment items) were used to measure empowerment. Warr, Cook and Wall's (1979) Job Satisfaction sub-scale was used to measure job satisfaction, included to complement the data on empowerment. Affective commitment was measured using Meyer and Allen's (1984) Affective Commitment sub-scale, to investigate the extent to which respondents wanted to stay in their current jobs, to provide valuable information on this issue itself and also to test the relationship between empowerment and affective commitment. On the basis of the emotive language used in the focus groups it was decided to investigate burnout and Maslach's Burnout Inventory was included for this purpose. Levenson's Internality, Powerful Others and Chance Scale was included to measure perceptions about control and causality. This provides a context within which to consider the responses to the empowerment scales used, which focus on external factors that affect an individual's experience of empowerment.

The response rate to the pilot survey was 34.6% (137 replies from 395 questionnaires posted). One hundred and six respondents completed questionnaires while the other 31 (22.6% of replies) indicated that they were not in current practice. On the basis of the analysis of the responses received, revisions were made to the questionnaire for the main survey. In particular, factor analysis facilitated the reduction of the list of items relating to the understanding of empowerment from 47 items to 24. To address the positive skew of responses, the wording of the scale was revised, to reflect degrees of importance to empowerment, with a further option to indicate that the item was not related to empowerment. In addition a ranking exercise was included, with respondents asked to rank from 1 to 10 in descending order the ten items (from the 24 provided) that they felt were most important to empowerment. To test these revisions, and specifically the usability of the ranking exercise, a second pilot survey with a convenience sample of 54 practising nurses attending further education was carried out on this part of the questionnaire only. Analysis of skew statistics showed that responses to the new scale were less

skewed than in the first pilot. Therefore the new wording of the scale was retained. It was also decided to include the ranking exercise in the main survey because pilot respondents successfully carried out this exercise.

Because the relationship between high burnout and both low job satisfaction and low empowerment was shown in the pilot, Maslach's Burnout Inventory was not included for the main survey. This enabled a reduction in the length of the questionnaire to encourage an increased response rate for the main survey.

3.2 Sample for the main survey

In order to ensure sufficient responses for meaningful statistical analysis to take place, a target minimum of 100 respondents from each area of practice (general, psychiatry, mental handicap, public health, midwifery and sick children's nursing) was set. A concerted attempt was made to address the response trends of the pilot survey, particularly in relation to the variation (across divisions of the Register) in the relationship between the division of the Register from which respondents had been sampled and their current area of practice. It appeared to be possible to target nurses currently working in general, psychiatric, mental handicap and public health nursing through the general, psychiatric, mental handicap and public health nurse divisions of the Register respectively. For example 11 of the 13 respondents who were currently in public health nursing practice were selected from the public health division (from a total of 45 sent). However of the 26 respondents selected from the midwives' division of the Register who completed questionnaires (from a total of 65) only 6 were in midwifery practice. Similarly only two of the nine respondents selected from the Sick Children's Nurses' division (total of 45) who completed questionnaires were in Sick Children's Nursing practice. This suggested that there would be particular problems obtaining sufficient responses from midwives and sick children's nurses. Thus weighted sampling measures were adopted whereby disproportionately high numbers from these two divisions were sampled for the main survey. In total 4,050 questionnaires were sent out to a sample of nurses and midwives on the Live Register of An Bord Altranais in January 2002. The number of questionnaires sent, by division of the Live Register, is shown in Table 5.

Table 5: Main survey sample by division

Division of the An Bord Altranais Live Register	Number sent
General Nurses	900
Psychiatric Nurses	600
Midwives	750
Sick Children's Nurses	750
Mental Handicap Nurses	650
Public Health Nurses	400
Total	**4,050**

As in the pilot survey, it was again stipulated that a geographical spread across the country was required of the sample. However, it was acknowledged that because the addresses held by An Bord Altranais were home addresses it was not possible to guarantee a spread by workplace location.

A covering letter introducing the project and guaranteeing anonymity was included with the questionnaire and pre-paid envelope. Participants were asked to respond even if they were not in current practice and if this was the case to return the cover letter indicating such. Participants were asked to respond within two weeks of receiving the letter. A unique identifying number (though anonymous to the research team) was recorded on the return envelopes for the purposes of a follow-up mailing for non-responders. This also allowed identification of the division from which a respondent was selected (1-900 = General Nurses etc). A follow-up mailing to non-responders was carried out at the end of January 2002.

In an attempt to raise the profile of the research project, a poster describing the background, objectives and timeframe of the project was displayed at the National Council's annual conference in November 2001, and over one thousand leaflets describing the project were distributed. The survey was also advertised on the National Council and Irish Nurses' Organisation websites and in the Psychiatric Nurses' Association of Ireland newsletter, at both the time of the mailing of the questionnaire and the subsequent follow-up mailing.

3.3 Response rate

A sample of 4,050 was requested from An Bord Altranais. However 86 persons from the selected sample had addresses outside of the Republic of Ireland and so were excluded from the sample. In addition to this, 36 of those who responded reported that they had received two or more questionnaires and 37 questionnaires were "returned to sender". There was therefore a total valid sample of 3,854.

There were 1,781 replies in total, a response rate of 46%. Four hundred and forty-one respondents recorded that they were not in practice (25% of respondents), with 1,340 respondents returning completed questionnaires (33.1%). Seventy-five people removed the number which would have identified the division from which they were selected (0.4%) ("Unknown", below). This appeared to stem from their concerns about the anonymity of their response, about which the research team received numerous enquiries. Anonymity was assured to those who raised this issue with the research team and this was further clarified in the follow-up mailing cover letter.

Table 6 shows a breakdown of responses by the division from which respondents were selected.

Table 6: Survey responses by division from which respondents were selected

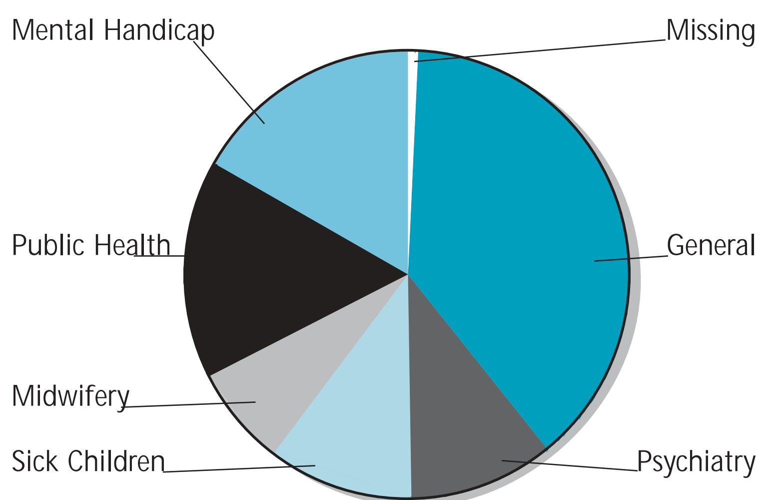
Division from which selected	Number sent	Total replies from that division	Replies: completed questionnaires	Replies: not in practice
General	900	411	311	100
Psychiatry	600	221	173	48
Midwives	750	348	266	82
Children	750	290	207	83
Mental Handicap	650	232	179	53
Public Health	400	178	129	49
Unknown	101	75	26	
Total	4,050	1,781	1,340	441

The division from which a respondent was selected is not necessarily the same as that in which she/he is currently practising. The number in each area of practice is shown in Table 7 below. Data is missing for 12 cases. There is no national data available with which to compare the percentages shown. This distribution is also shown in Figure 4.

Table 7: Percentage of respondents from each area of practice

Area of current practice	Total	Valid % of total respondents
General	514	38.7
Psychiatry	142	10.7
Sick Children	141	10.6
Midwifery	95	7.2
Public Health	212	16
Mental Handicap	223	16.9
Total	1,328	100

Figure 4: Area of practice of respondents



As can be seen from the totals for each area of practice, there were more than 100 respondents in each area of practice, except midwifery, with 95 in that group. A decision was made to work with the six areas of practice listed above, for statistical comparison purposes. Therefore those who stated that they were working in Geriatrics, as Practice Nurses and in Palliative Care were included in the "General" category. Geriatrics, Practice Nursing or Palliative Care was thereafter recorded as the area of specialist practice of the respondent.

Of the number who completed questionnaires it was deemed useful to relate the division from which they were selected to their current area of practice. The proportion in each area of practice that was selected through the corresponding division of the register is shown in Table 8. This shows for example that 71% of the respondents currently practising in Mental Handicap were found through the Mental Handicap division of the register, while only 49% of practising Midwives were found through the Midwifery division of the register.

Table 8: Percentage of main survey respondents in each area of practice selected from the corresponding division of the Register

Area of practice	% who were selected through the corresponding division of the register (e.g. midwives from midwifery register)
General	42
Psychiatry	80
Midwives	49
Sick Children	73
Mental Handicap	71
Public Health	55

3.4 Survey findings

Demographic profile of respondents

The findings relating to the demographic profile of respondents are given in Appendix D. These can be summarised as follows: in terms of sex, work status, geographical location of practice and employer the sample was broadly representative of the population of nurses practising in Ireland. Similar to the pilot sample, respondents were found to be older and had more qualifications than the national picture. This is likely to be a result of the weighted sampling used to ensure representation of all areas of practice, which necessitated 2 qualifications for midwives, 3 for public health nurses etc. Two-thirds of the sample had between 10 and 29 years experience, again somewhat related to the weighted sampling measures adopted. On the basis of this high level of experience it is likely that the historical aspects of nursing identified by focus group participants have been directly experienced by this group. Just over half of the respondents reported working in a specialist area, with a wide range of specialist areas reported. Almost half of the respondents had practised overseas.

Respondents' understanding of the meaning of empowerment

Respondents were asked to consider 24 statements related to empowerment which were derived from the focus group discussion data, as described above (see page 28). Respondents were first asked to rate the items according to a Likert-type scale with options ranging from "crucial to empowerment" to "a little important to empowerment", with a further option to indicate that they did not think that the item was related to empowerment. They were then asked to choose and rank (from 1 to 10) the ten items from the list of 24 that they considered most important

to empowerment. They were also given the opportunity to add additional comments relating to their understanding of empowerment that they felt were not covered in the list provided. Analysis of the responses to both of these exercises facilitated a clearer picture of what respondents saw as important to empowerment than either one alone would have permitted.

Analysis of responses to the rating exercise permits the identification of the degree of importance assigned to each item by respondents. To summarise this picture, it is useful to consider items that were deemed "crucial" (and indeed "not related to empowerment") by the greatest number of respondents. Factor analysis of responses to this rating exercise was also performed. This resulted in the creation of a theoretical model, comprising the factors which were composed of items that were rated in a similar manner by respondents.

As described above (see page 28), given the positive skew of the responses to the pilot survey and the source of the list of items (focus group data), the ranking exercise was also included to, in some sense, force respondents to prioritise items. The analysis of this data allowed the identification of those items ranked highest (1) by the greatest number of respondents. It is also useful to consider the items that were most frequently ranked (somewhere between 1 and 10) by most respondents and indeed those that were left out of the ranking exercise by most respondents. Related to this the total ranking scores per item can be calculated. This analysis allows the exploration of the relative importance of items using a number of approaches.

Rating of items relating to the understanding of empowerment

Respondents were first asked to rate each item on a Likert-type scale with options ranging from "crucial to empowerment" to "a little important". They also had the option to indicate that they did not think that the item was related to empowerment. The results are shown in Appendix E (Table E1). The items that were ranked "crucial to empowerment" by more than 50% of respondents were as follows.

- Having the skills to carry out my role (80.8%).
- Being accountable for my practice (72.6%).
- Being adequately educated to perform my role (71.8%).
- Knowing what my scope of practice is (65.6%).
- Having effective communication with management (60%).
- Being informed about organisational changes that will affect my practice (58.7%).
- Being an advocate for my clients/patients (57.7%).
- Being able to say no when I judge it to be necessary (57.6%).
- Having the back-up of my manager (57.2%).
- Being recognised as a professional by the medical profession (56%).
- Having a supportive manager (55.1%).
- Having control over my practice (54.2%).
- Being listened to by members of the multidisciplinary team (52.3%).
- Having support from my colleagues (50.1%).

Items which were rated as "not being related to empowerment" by the largest number of respondents included the following.

- Performing tasks that were previously performed by doctors and other professionals (28.3%).
- Being involved in nurse/midwife-led practice (6%).

- Empowering my clients/patients (3.8%).
- Being recognised as a professional by the medical profession (3.1%). (It is_interesting to note however that 56% of respondents did say that this item was crucial to empowerment, suggesting some degree of ambiguity in the attitude of nurses to medical colleagues).

Respondents were also invited to include anything else that they felt was related to empowerment that was not covered in the statements offered. One hundred and twenty-eight (almost 10%) respondents replied to this section. In many cases respondents repeated items that were already included in the statements, namely relating to the following (in order of decreasing frequency): management, education, support, recognition, being valued, being listened to, autonomy, meeting patient/client needs and patient/client empowerment, expanding the role of the nurse. Respondents were perhaps emphasising their strong support for the items that were included in the list. These issues are also reflected in the focus group data.

Some other issues were raised that had not been included in the list. The main one was self-confidence, with a wide range of other personal factors also mentioned. These included self-awareness, self-knowledge, being comfortable and present with oneself, the ability to admit mistakes, a dynamic personality, courage, empathy and several references to assertiveness. Another issue that was raised by several respondents was involvement in decision-making at many levels, from patient care to government level. This was also a key finding of the focus group discussions, under the theme of organisational factors.

Ranking of items relating to the understanding of empowerment

Respondents also ranked the ten items (of the 24 provided) that they considered most important for empowerment, from 1 to 10, with 1 being the most important and 10 being the least important. One hundred and eighty seven respondents (13%) did not complete this section of the questionnaire or completed it incorrectly. While this was included in the second pilot survey specifically to check its usability, clearly for some it proved difficult to complete. The results for this ranking exercise are shown in Appendix E (Table E2). It is also useful to examine the items that were ranked highly by respondents and also those that were not ranked.

The five items ranked 1, "the most important to empowerment", by the highest number of respondents are as follows.
- Having the skills to carry out my role (21%).
- Knowing what my scope of practice is (14.3%).
- Being an advocate for my patients/clients (12.6%).
- Being adequately educated to perform my role (9.7%).
- Being valued by my manager (9.1%).

Those items that were ranked (anywhere from 1 to 10) by more than 50% of respondents are as follows.
- Having the skills to carry out my role (77.7%).
- Being adequately educated to perform my role (68.7%).
- Being accountable for my practice (64.5%).
- Having effective communication with management (59.5%).
- Knowing what my scope of practice is (59.2%).

On the other hand, some items were not ranked (in the "top 10") at all by a large number of respondents.

- Performing tasks that were previously performed by doctors and other professionals (93%).
- Delegating non-nursing tasks to auxiliary staff (86%).
- Being recognised for my contribution to patient care by management (78.8%).
- Being involved in nurse/midwife-led practice (76.5%).
- Being recognised for my contribution to patient care by the medical profession (75.7%).

The total score for each item was calculated by adding the ranking scores for each item of each respondent (an item ranked 1 was given 10 points, ranked 2 it was given 9 points etc and where an item was not ranked it got 0 points). This resulted in the ranking of the 24 items, as shown in Appendix E (Table E3). The 5 items having the highest and lowest total scores are shown below.

The five items with highest total score in ranking:

- Having the skills to carry out my role
- Being adequately educated to perform my role
- Knowing what my scope of practice is
- Being accountable for my practice
- Being an advocate for my patients/clients.

The five items with lowest total score in ranking:

- Being recognised for my contribution to patient care by my manager
- Being involved in nurse/midwife-led practice
- Being recognised for my contribution to patient care by the medical profession
- Delegating non-nursing tasks to auxiliary staff
- Performing tasks that were previously performed by doctors and other professionals.

The results from the rating and ranking exercises carried out by respondents that have been described above and the "top five" items from each of these sets of results are shown in Table 9.

Table 9: Results relating to understanding of empowerment

Rating scale: items judged to be "crucial to empowerment" by highest number of respondents	Items ranked number 1 by the most respondents	Ranked (anywhere 1-10) by most respondents	Sum of ranking scores of all respondents: top scores
Skills	Skills	Skills	Skills
Accountability	Scope of practice	Education	Scope of practice
Education	Advocate for patients	Accountability	Accountability
Scope of practice	Education	Effective communication with management	Education
Effective communication with management	Valued by manager	Scope of practice	Advocate for patients

Thus the following items are judged to be most important to empowerment by respondents.

- Having the skills to carry out my role.
- Knowing what my scope of practice is.
- Being adequately educated to perform my role.
- Being accountable for my practice.

Factor analysis was performed on the rating responses to this section of the questionnaire, in order to build a theoretical model of empowerment. The resulting four factors and their component items are shown in Table 10 below. These factors explained 45.45% of the variance in the responses to their component items. Items that had a factor loading of greater than 0.40 were included. The factors were named inductively on the basis of their component items.

Table 10: Factors emerging from factor analysis on responses relating to the understanding of empowerment

Factor 1: Professional support and recognition

Having a supportive manager
Being recognised for my contribution to patient care by my manager
Having the back-up of my manager
Being valued by my manager
Having support from colleagues
Having effective communication with management
Being recognised for my contribution to patient care by the medical profession

Factor 2: Professional preparedness

Having the skills to carry out my role
Being adequately educated to perform my role
Knowing what my scope of practice is
Being accountable for my practice
Being informed about changes in my organisation that will affect my practice

Factor 3: Role clarity

Delegating non-nursing tasks to auxiliary staff
Performing tasks that were previously preformed by doctors and other professionals
Being involved in nurse/midwife-led practice
Having autonomy in my practice
Being recognised as a professional by the medical profession
Having access to resources for staff education and training

Factor 4: Patient/client advocacy and empowerment

Being an advocate for my patients/clients
Empowering my patients/clients
Having access to resources for patients/clients

The first factor comprises items relating to **professional support and recognition** from management, the medical profession and colleagues. This encompasses being valued, supported, recognised for one's contribution to patient care and having effective communication. It is interesting to note that "being recognised for my contribution to patient care by my manager" and "being recognised for my contribution to patient care by the medical profession" were among the five items with lowest total score in the ranking exercise but are nonetheless components of this factor. This perhaps reflects the complexity of the issue of recognition, whereby perceptions that external recognition is not required for empowerment may be challenging the call for recognition that was articulated in the focus group discussions.

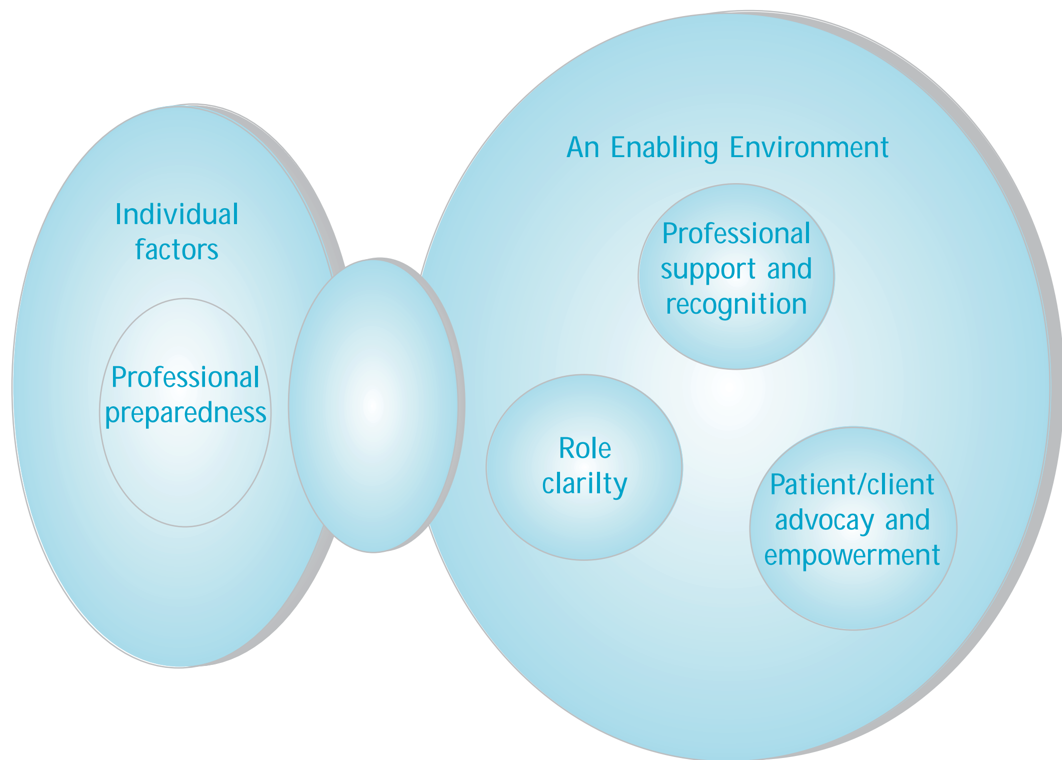
The second factor is seen to comprise items that pertain to the individual and his/her **professional preparedness** for practice. Thus having the necessary skills and education, knowing one's scope of practice, being accountable and being informed about changes that affect one's practice can be viewed as prerequisites for practice.

The third factor comprises items relating to **role clarity**, in terms both of the role of the nurse and role boundaries with other professionals. Being recognised as a professional and having access to the resources for professional development are elements of this factor. Three components of this factor (being involved in nurse/midwife-led practice, delegating non-nursing tasks to auxiliary staff and performing tasks that were previously performed by doctors and other professionals) were also among the five items with lowest total score in the ranking exercise. Again this may reflect the complexity of the issue of role boundaries and to some extent the uncertainty that accompanies the current period of specialist practice development, in which the implications for role expansion and/or extension may be unclear.

The fourth factor comprises items relating to **patient/client advocacy and empowerment** and incorporates having access to resources to enable the nurse or midwife to carry out these functions.

Thus the second factor clearly relates to **individual factors** associated with empowerment and the other three comprise elements of an **enabling environment** that would facilitate empowerment. This suggests a model of empowerment that encompasses the individual and environmental domains and the factors described above, as illustrated in Figure 5 (page 38). This group of Irish nurses and midwives would appear to explicitly acknowledge the two facets of empowerment (relating to the individual and the organisation) identified in the literature on empowerment in nursing reviewed in chapter 1.

Figure 5: Model of empowerment emerging from factor analysis



Respondents' experiences of empowerment

Empowerment

Respondents' experience of empowerment, during the survey period, was measured using empowerment scales developed by Laschinger (1996). An overall empowerment score is calculated by summing the means of the four sub-scales (information, resources, support, opportunities), as described on page 14 above, within the ***Condition for Work Effectiveness Questionnaire*** (CWEQ), with a range of 4 to 20 (Laschinger et al, 2001). The mean for respondents in the survey was 11.30 (Standard Deviation (SD): 2.542), almost mid-way between the minimum and maximum scores (See Appendix G, Table G5 for information pertaining to mean scores for all scales). Within this scale, the means for the subscales (range 1-5, from "none" to "a lot") were as follows.

	Mean	Standard Deviation
Opportunity sub-scale	3.59	(.884)
Information sub-scale	2.63	(.972)
Support sub-scale	2.47	(.951)
Resources sub-scale	2.62	(.811)

On the 3-item Job Activities Scale (measuring formal power) the overall score is also obtained by averaging the scores for the 3 items (range 1-5, from "none" to "a lot"). The mean score for respondents is 2.67 (SD: 0.897), just past midway in this scale, suggesting that respondents have "some" formal power within their organisations.

On the 3-item Organisational Relationships Scale (measuring informal power) the mean overall score of 3.32 (SD: 0.936) is again past the mid-way between minimum and maximum scores (range 1-5, from "none" to "a lot"), suggesting that respondents have between "some" and "a lot" of informal power.

On the global empowerment items 51.6% agreed (8% strongly agreed, 43.6% agreed) that their current work environment empowers them, 23.1% disagreed with this statement, with 25.3% who "neither agreed nor disagreed". And 38.2% (6.1% strongly agreed, 32.1% agreed) that they consider their workplace to be an empowering environment, 32.9% disagreed with this statement, with 28.9% neither agreeing nor disagreeing.

The overall scores suggest moderate empowerment as measured by the CWEQ, JAS, ORS and the global empowerment items. Respondents had higher levels of informal power than formal power. They had greater access to opportunities (in terms of challenging work, gaining new skills and knowledge on the job and using all their skills and knowledge) than to information, support and resources.

Individual items from these scales can be examined in Appendix G (Table G1) and key findings from these are as follows.

Conditions for Work Effectiveness Questionnaire (measuring empowerment, comprising sub-scales relating to Opportunities, Information, Support and Resources)

Opportunities sub-scale (items 1-3)
- 41% of respondents have "a lot" of challenging work in their present job (2.7% have none).
- 16% have "a lot" of opportunities to gain new skills and knowledge on the job (6.3% have none).
- 26.2% perform "a lot" of tasks that use all their own skills and knowledge (3.3% have none).

Information sub-scale (items 4-6)
- 12% have "a lot" of information about the current state of their organisation (6.2% have none, 41.1% have some).
- 4.8% have "a lot" of information about the goals of top management (27.6% have none).
- 4.3% have "a lot" of information about the values of top management (29.9% have none).

Support sub-scale (items 7-9)
- 5.1% have "a lot" of specific information about things they do well (30.6% have none).
- 3.7% have "a lot" of specific comments about things they could improve (27.3% have none).
- 4.8% have "a lot" of helpful hints or problem-solving advice (20.5% have none).

Resources sub-scale (items 10-12)
- 3.5% have "a lot" of time available to do necessary paperwork (15.6% have none).
- 3.9% have "a lot" of time to accomplish job requirements (8.2% have none).

- 3.8% have "a lot" of experience of acquiring temporary help when required (26.4% have none).

Job Activities Scale (measuring formal power)
- 5.3% have "a lot" of rewards for innovation on the job (35.7% have none).
- 11% have "a lot" of flexibility in their job (12.6% have none).
- 6.3% have "a lot" of visibility of their work-related activities within their organisation (12.1% have none).

Organisational Relationships Scale (measuring informal power)
- 20.3% have opportunity for "a lot" of collaboration with doctors (8.8% have none).
- 21.4% have "a lot" of opportunity for being sought out by peers for information (5.7% have none).
- 19.2% have "a lot" of opportunity for seeking out ideas from professionals other than doctors (10.7% have none).

In summary, respondents report that they have "a lot" of a limited number of items (which relate to access to opportunities and informal power) as follows:
- challenging work
- tasks using skills and knowledge
- collaboration with doctors
- being sought out by peers
- seeking ideas from other professionals.

On the information, support and resources sub-scales there appear to be large deficits, with very small numbers reporting high levels of information about the organisation, feedback and access to resources.

Affective Commitment

Affective commitment was measured using Meyer and Allen's Affective Commitment sub-scale. Total scores are obtained by summing and averaging the scores across the nine items (having reversed the scoring for the negatively worded items 1 and 5), with a range of 1 (high commitment) to 7 (low commitment). The mean score on this scale was 2.69 (SD: 0.685), indicating a reasonably high level of commitment. A summary of respondents' responses to this scale are shown in Appendix G (Table G2).

Within the scale, the individual items are also of interest.
- 35.2% agreed or strongly agreed that they were emotionally attached to their workplace.
- 58.8% agreed or strongly agreed that working at their workplace has a strong degree of personal meaning for them.
- 56.5% agreed or strongly agreed that they feel a strong sense of belonging to their workplace.
- 13.3% agreed or strongly agreed that their workplace does not deserve their loyalty.
- 46.2% agreed or strongly agreed that they would be happy to work at their workplace until they retire.
- 39% agreed or strongly agreed that any problems faced by their workplace are also their problems.

- 22.6% agreed or strongly agreed that they do not feel like a part of a family at work.
- 69.9% agreed or strongly agreed that they are proud to tell others that they work at their workplace.
- 24.5% agreed or strongly agreed that they enjoy discussing their workplace outside of it. This may seem surprising in light of the above but should be taken in the context that several respondents commented that this would be in breach of the patients'/clients' confidentiality, one interpretation of this statement.

The above findings indicate a high level of commitment, particularly in relation to personal meaning, belonging and pride in their workplace. There was lower emotional attachment and intention to work at their current workplace until they retire. These findings are discussed in relation to job satisfaction and empowerment below.

Job Satisfaction

Warr, Cook and Wall's Job Satisfaction sub-scale was used to measure job satisfaction. Overall job satisfaction scores were obtained by summing and averaging the scores across the 17-item scale, with a range of 1 (extremely dissatisfied) to 7 (extremely satisfied). The mean score was 4.49 (SD: 1.012). The mean for intrinsic factors was 4.5 (SD: 1.157) and for the extrinsic factors was 4.48 (SD: 0.998).

74% were satisfied with their "job as a whole, taking everything into consideration" (item 17 on the scale) (ranging from a little satisfied (27.4%) to extremely satisfied (9.8%)). 73% were satisfied with the amount of challenge in their jobs (item 16) (with 22.8% a little satisfied and 13.2% extremely satisfied).

It is useful to look more closely at the satisfaction (including the categories "a little satisfied", "very satisfied" and "extremely satisfied") results for the individual extrinsic and intrinsic factors. In addition dissatisfaction results are given for a number of selected items of particular interest to this study. The complete results for this scale are shown in Appendix G (Table G3).

Extrinsic factors

- 83.4% of respondents were satisfied with their job security (85.2% were permanent)
- 71% were satisfied with their hours of work
- 65.5% were satisfied with their fellow workers
- 63.2% were satisfied with their immediate boss (27.5% were dissatisfied, 9.3% were not sure)
- 51.3% were satisfied with the physical conditions of work
- 51.2% were satisfied with their rate of pay
- 41.5% were satisfied with industrial relations between management and workers
- 36.4% were satisfied with the way their organisation is managed (52.4% were dissatisfied, 11.3% were not sure).

Intrinsic factors

- 77% were satisfied with the amount of responsibility they are given
- 73.3% were satisfied with the amount of variety in their job
- 67.4% were satisfied with the freedom to choose method of working
- 65.8% were satisfied with the opportunity to use their abilities

- 49.5% were satisfied with the attention paid to suggestions they make (39.1% were dissatisfied, 11.4% were not sure)
- 46.3% were satisfied with the recognition they get for good work (41.5% were dissatisfied, 12.1% were not sure)
- 35.8% were satisfied with their chance of promotion (27.5% were dissatisfied, 9.3% were not sure).

These scores reveal overall job satisfaction, with 74% satisfied with their job as a whole, taking everything into consideration and 73% satisfied with the amount of challenge in their jobs. The extrinsic factors with which respondents are most satisfied are job security, hours of work, their fellow workers and their immediate boss. They are least satisfied with the way their organisation is managed and with industrial relations. This may be related back to the findings of CWEQ which found deficits relating to understanding of and involvement in the organisation. The focus group discussions also revealed concern about a lack of involvement in decision-making within participants' organisations. The intrinsic factors with which they are most satisfied are the amount of responsibility they are given and the variety in their jobs. They are least satisfied with the recognition they get for good work and their chance of promotion. This again links with the organisational participation and visibility issues raised in the focus groups.

Locus of control

Levenson' Internality, Powerful Others and Chance sub-scales were used to measure perceptions about control and causal beliefs. Scores on the sub-scales of Levenson's scale are best viewed in relation to each other and are as follows.

Internality

The average overall score for this 8-item sub-scale has a range of 1 (high sense of control over one's own life) to 5 (low sense of control over one's own life). The mean was 2.56 (SD: 0.451), almost exactly midway between these extremes.

Powerful Others

The average overall score for this 8-item sub-scale has a range of 1 (strong belief that others control one's life) to 5 (weak belief that others control one's life). The mean for respondents was 3.52 (SD: 0.593), indicating a weaker belief that others control their lives than their belief in their own control over their lives, as suggested by the mean Internality score (2.56) shown above.

Chance

The average overall score for this 8-item sub-scale has a range of 1 (strong belief that chance affects his/her experiences and outcomes) to 5 (weak belief that chance affects his/her experiences and outcomes). The mean was 3.45 (SD: 0.546), again suggesting a weaker belief that chance controls their lives than in their own control over their lives.

The results for this scale are shown in Appendix G (Table G4).

The findings of this scale indicate that respondents have stronger belief in their own control over their lives than in the power of others and in chance. This is of particular interest to a study on empowerment, where both internal and external factors are considered. A tendency to

externalize responsibility for empowerment would have been reflected here as a stronger belief in the power of others. This is an important finding and will be discussed further in chapter 4 below.

Correlations between scales

A summary table of significant correlations between scales and sub-scales is shown in Appendix H.

Strong correlations (>0.7) are shown to exist between the following scales:

- Global empowerment items 1and 2 (.761)
- Job satisfaction and Global job satisfaction item 2 (.710)

Moderate correlations (>0.5) are found between the following scales:

Conditions for Work Effectiveness Questionnaire

- CWEQ and Job Satisfaction scale (.633)
- CWEQ and Global empowerment item 1 (-.517)
- CWEQ and Global empowerment item 2 (-.588)
- CWEQ and Job Activities scale (.629)

Job Activities Scale

- Job Activities scale and Global empowerment item 2 (-.515)

Job satisfaction scale and global items

- Job Satisfaction scale and Job satisfaction global item 1 (.594)
- Job Satisfaction scale and Global empowerment item 1 (-.608)
- Job Satisfaction scale and Global empowerment item 2 (-.627)
- Job Satisfaction scale and Job Activities scale (.619)
- Job satisfaction scale and Affective commitment (-.558)
- Job satisfaction global item 1 and Job satisfaction global item 2 (.590)
- Job satisfaction global item 2 and Global empowerment item 1 (-.572)
- Job satisfaction global item 2 and Global empowerment item 2 (-.527)
- Job satisfaction global item 2 and Affective commitment (-.584)

Levenson's scales

- Levenson's Chance and Powerful Others sub-scales (.558)

The strong correlations reported above are between Global Empowerment items 1 and 2 and the Job Satisfaction Scale and Global Job Satisfaction item 2. This offers reassurance of validity of the scales and of the global items.

There is moderate correlation between the total CWEQ score and the two global empowerment items. Laschinger et al (2001) also report a similar positive correlation between CWEQ and global empowerment scores. There was also moderate correlation between Laschinger's CWEQ and Job Activities Scale which measures formal power. The job satisfaction scale and the overall total for Laschinger's CWEQ scale were moderately correlated, indicating a relationship between job satisfaction and empowerment that could be expected. This was further tested by regression analysis reported below (see page 45 below).

A positive relationship between empowerment and commitment was shown by Laschinger et al (2000) and Laschinger et al (2001a). In our study these scales are not strongly or moderately correlated. This may be explained by the fact that respondents are moderately empowered but have high affective commitment, suggesting that they are more committed to their jobs than their empowerment levels, as measured in this study, would predict. There is moderate correlation between the Job Satisfaction and Affective Commitment scales, suggesting a stronger relationship between job satisfaction and affective commitment than between empowerment and affective commitment.

There is moderate correlation between the Powerful Others and Chance sub-scales only. Similar correlations between these two sub-scales have been reported by Lefcourt (1991), with similar lower correlations between these and the Internality sub-scale.

Univariate analysis of variance

The demographic variables that were deemed to be of interest in investigating variance of responses to the scales used were

- area of practice
- educational qualification
- number of qualifications
- geographical region of practice
- grade
- practised overseas or not
- employer
- sex
- years in current job
- age.

These were examined in relation to all of the scales used in this study. Univariate analysis of variance was carried out to test these scores in relation to each of the demographic variables listed above. The results are shown in Appendix I, indicating those significant (<0.001) in bold. A stringent significance level was chosen in view of the large number of tests performed, which increases the chance of spurious significant results, or Type I errors.

The demographic variables showing the largest differences across the most scales are Grade and Employer and these are therefore reported here. A summary of all other significant results can also be found in Appendix I.

Grade

Empowerment

Empowerment levels are shown to rise with higher grades, with public health nurses' (n=200) scores lying generally between senior staff nurse (n=231) and CNM1 (n=62). Formal power (as measured by the Job Activities Scale) falls from staff nurse/midwife (n=579) to senior staff nurse/midwife and then rises with grade. Informal power (as measured by the Organisational Relationships Scale) rises from staff nurse/midwife to CNM1, and then falls until director of nursing grade (n=12, therefore results must be considered with caution).

It is interesting to note that for all of Laschinger's scales except for the Resources sub-scale of CWEQ there was significant (<0.001) variance by grade. In fact the significance level for the resources sub-scale was 0.005. Scores persistently fall between staff nurse/midwife and CNM2 (n= 170) grades, then rising to assistant director of nursing grade (n=18, again a small number), falling again for director of nursing grade. This is the only scale on which PHNs have the lowest score.

Job satisfaction
In all of the job satisfaction scales and items, CNM2s (n= 170) show high levels of job satisfaction. For the two global items their satisfaction score is higher than that of the director of nursing grade. For the Intrinsic and overall satisfaction scales it is higher than for the assistant directors of nursing and for extrinsic it is equal to that score of that grade. Director of nursing grade scores are highest on intrinsic, extrinsic and overall job satisfaction scales. Overall job satisfaction scores also initially rise with grade level until CNM3 (n=22) level where they drop, again falling for assistant director of nursing and rising for director of nursing. PHNs' mean score lies between CNM1 and CNM2 levels.

Affective commitment
The highest commitment is found for director of nursing grade and the lowest for staff nurse/midwife. In order of highest to lowest commitment the grades are ordered as follows: directors, CNM1 and CNM2, assistant director, senior staff nurse/midwife, CNM3, PHN and staff nurse/midwife. Once again CNM2s (and this time CNM1s also) have higher affective commitment than assistant directors.

Locus of control
Directors of nursing have the highest belief in chance affecting outcomes (though the small sample must be borne in mind), while CNM1s have the lowest belief in chance. Between these groups lie (in order of high to low belief in chance) assistant director, PHNs and CNM2s, CNM3s, senior staff nurse/midwife and staff nurse/midwife.

Employer
Respondents working for a health board/area health board had least access to support (measured by support sub-scale of CWEQ), least formal power and least job satisfaction. Those working in the private sector had least access to opportunities (in terms of challenging work, gaining new skills and knowledge on the job and using all their skills and knowledge), while those working in voluntary hospitals had highest access to opportunities. Those working in the private sector had the highest support, formal power and job satisfaction. Those working for a health board/area health board had lowest empowerment levels as measured by the scales used in this study. Those employed in the private sector had the highest empowerment levels.

Regression analysis was carried out to supplement the information gained from the Univariate Analysis of Variance. Those variables showing significant variance (see Appendix I) were included in the regression analysis. As can be seen from Appendix J very little of the variance for these scales (between 1.2% and 13.1%) was explained by the demographic factors listed. Therefore this offers little predictive value and is not reported further here.

Further regression analysis was carried out to seek to explain the variance not explained by the

demographic variables as described above. Appropriate scales were entered into a regression model for each of the Conditions for Work Effectiveness Questionnaire (empowerment), job satisfaction scale and affective commitment scales. The results are shown in Appendix J (Table J3) and can be summarised as follows.

- 49.8% of the variance on the CWEQ (empowerment) scale is explained by Job Satisfaction Scale and Job Activities Scale (formal power) scores.
- 55.9% of the variance on the Job Satisfaction Scale can be explained by CWEQ (empowerment), Affective Commitment and Job Activities Scale scores.
- 31.9% of the variance on the Affective Commitment Scale can be explained by scores on the Job Satisfaction Scale, Levenson's Internality Scale, CWEQ and Levenson's Chance Scale.

This reinforces the relationship between job satisfaction and both empowerment and affective commitment found in the correlations shown above (page 43). A relationship between control and causal beliefs (as measured by Levenson's Internality, Chance and Powerful Others Scale) and affective commitment is also suggested.

Responses to open questions

Open questions to elicit respondents' views on the factors that enhanced and inhibited empowerment were also included. In addition to this, comments on empowerment or on the questionnaire itself were invited. The responses to these open questions are given below.

Factors that enhance empowerment

A total of 1,029 (77%) respondents suggested factors that enhance empowerment. The factors that were offered by the largest number of respondents are shown in Table 11:

Table 11: Factors that enhance empowerment (in order of decreasing frequency)

education (***including continuing education***)
skills
knowledge
self-confidence
effective communication
support from management
being valued by management
the ability of the nurse/midwife
support from colleagues
good management style
good teamwork
a good working environment
access to resources

There were many other personal and external factors mentioned by fewer respondents than those items in Table 11 and these include

- personal factors: self-esteem, motivation, strong personality, good communication skills, openness, experience, autonomy, assertiveness, competence, accountability, ability to make decisions, adaptability to change, honesty, motivation, a positive attitude, dedication, good interpersonal skills
- management factors: good leadership, open management style, approachable, feedback, being listened to, delegation, fairness, allows freedom to use initiative, has respect for patients
- organisational factors: adequate staffing levels, being informed about organisational changes, participation in decision-making, having written policies, adequate wages
- interpersonal factors: trust, mutual respect, good working relationships, shared goals
- professional issues: understanding your scope of practice, unity as a profession, giving high standards of care, having control over practice, evidence-based practice.

All of these factors were highlighted by respondents from all areas of practice. Midwives also mentioned midwife-led practice. Some mental health respondents mentioned budgetary autonomy and geographical access to education. Public health nurses also mentioned independence practice.

Factors that inhibit empowerment

A total of 1,041 (78%) respondents responded to this part of the questionnaire. Many participants simply said that the factors that inhibit empowerment are the opposite of those that they said would enhance empowerment. The factors that were offered by the largest number of respondents are shown in Table 12.

Table 12: Factors that inhibit empowerment (in order of decreasing frequency)

- poor management style (***described as authoritarian, autocratic, overpowering, undermining, intimidating, disinterested, nepotistic, unfair, unfriendly, indecisive, over-involved, command and control, dogmatic, domineering, unprogressive, self-serving, oppressive, closed, removed, resistant to change and critical***)
- lack of education and education opportunities (***time off, geographical access***)
- lack of effective communication between management and staff and within multidisciplinary team
- lack of support from management
- lack of recognition from management and other professionals
- lack of confidence
- lack of knowledge
- staff shortages
- bullying by management
- lack of skills
- lack of information
- lack of support from colleagues
- not being valued by management
- poor teamwork
- lack of resources (***for staff and patients/clients***)
- hierarchical organisational structures
- poor interpersonal relations
- being overworked, no time to carry out job
- a poor working environment (***described as hostile, blaming, forbidding, secrecy***)
- resistance to change

There were many other factors highlighted by fewer respondents than those included in Table 12 and these include

- personal factors: low self-esteem, low morale, personality, negative thinking, fear, lack of commitment, home/family problems, lack of assertiveness, stress
- interpersonal factors: conflicts, doctors' poor attitudes to nurses, lack of trust, power struggles
- professional factors: past socialisation of nursing in Ireland, lack of unity in profession, task-oriented practice, not valuing our own profession, no control over practice
- management factors: rigid supervision, poor feedback, not being listened to
- organisational factors: bureaucracy/red tape, lack of planning, lack of information on organisational changes, poor skill mix, long hours, poor working conditions, industrial relations issues of non-nursing personnel, low pay, being moved around the organisation, not being consulted, lack of involvement in decision-making, bed shortages, being in an "acting up" position, lack of facilities

The responses do not differ across area of practice. However midwives and psychiatric nurses also mentioned working within the medical model and public health nurses mentioned working in isolation and shortages of other professionals. Bullying was directly mentioned by an equal number of respondents from each area of practice.

Additional comments

Three hundred and fifty-eight (27%) respondents included additional comments, as invited, at the end of the questionnaire. Most of the comments were to welcome this research and to express their satisfaction at participating. Many respondents indicated that they wanted personal feedback on the results (which is not possible given the anonymity of responses) and also that the results be given to health boards and the Department of Health and Children.

In addition to this, most of the issues raised in this section related to poor management, and organisational structures. Some positive organisational experiences were also reported, for example a "home from home" environment in a nursing home was described. Personal factors involved with empowerment were again discussed. Several respondents expressed uncertainty about the relevance of Levenson's questionnaire, but some related this to the importance of personal factors in empowerment. Staff shortages were raised by some respondents in terms of the effects both on staff and on patient care.

Other issues raised to a lesser extent included the importance of communication, experience of not being valued and recognised, the legal aspects of practice, stress and burnout, the pressure of family life, intention to leave nursing, and satisfaction with the Commission on Nursing. Bullying was directly mentioned again by a number of respondents in this section, almost all of whom were midwives. In addition midwives who had worked in the UK reported having more autonomy in their practice there than in Ireland. Several respondents expressed the view that nurses must first value themselves before being valued by others. Issues of others recognising

and valuing nurses were also raised. The issue of reciprocal empowerment (of empowered nurses being able to empower patients/clients) was expressed by some respondents. Public health nurses raised particular concerns relating to increased caseloads and lack of support staff.

Chapter 4

Discussion of research findings

This report has presented findings from the focus group discussions and the national survey on nurses' and midwives' understanding and experiences of empowerment in Ireland. The picture emerging from the focus group and survey data is discussed below.

Understanding of empowerment

One of the aims of the study was to elicit what nurses and midwives in Ireland understood by the term empowerment. Exploration of the issue was begun in the focus group discussions and continued in the survey. Findings from both the focus group and the survey data indicate a level of awareness of the concept of empowerment and strong impressions of its most important components. Both focus group and survey respondents were quite clear that empowerment required the presence of individual, personal and environmental factors.

The items relating to skills, education, scope of practice and accountability were rated to be most crucial to empowerment by survey respondents. These items were also highlighted as key for empowerment in the focus group discussions. It is perhaps no surprise that issues of skills and education feature so strongly in a practice-based profession. The importance of being adequately skilled and educated for practice is affirmed by respondents in this study. Issues relating to "scope of practice" and accountability are currently topical within nursing in Ireland, and were highlighted by both focus group and survey respondents. Related concerns about the legal vulnerability of nurses were also raised in the focus groups.

Factor analysis on the results relating to the survey respondents' understanding of the meaning of empowerment revealed four factors:

- Professional Preparedness
- Professional Support and Recognition
- Role Clarity
- Patient/client Advocacy and Empowerment (see Table 10, page 36).

These factors are encompassed in the model of empowerment developed from the findings of this study and illustrated in Figure 5 (page 38). The model, grounded in the survey findings, suggests that from the perspective of nurses and midwives in Ireland both individual and environmental factors are necessary for empowerment, while neither on its own is sufficient. This is an important finding, because respondents explicitly acknowledge the two facets of empowerment identified in the literature. These findings also suggest the need to see empowerment of the individual as the result of a dynamic interaction of the person with the environment.

The themes emerging from the focus group discussions and the factors emerging from the survey data are mutually supportive. The Professional Preparedness factor links with the key theme of Individual Factors (See Figure 3, page 24 above). The items within this factor (skills, education, accountability, knowing scope of practice) were judged by survey respondents to be most "crucial" to empowerment, indicating an emphasis on taking personal responsibility for empowerment that was also identified in the focus group discussions.

The importance of the environment in which nurses and midwives practice was also highlighted in both the focus groups and the survey. The factors emerging from the survey data that were identified as comprising an enabling environment (**Role Clarity, Professional Support and Recognition, Patient/Client Advocacy and Empowerment**) can be linked with key themes from the focus groups discussions (namely Interpersonal Factors, Professional Issues, Management and Organisational Factors). In particular Role Clarity is linked with many components of the key theme of Professional Issues. Patient/Client Advocacy and Empowerment is also linked to the Professional Issues key theme, within which participants voiced their central concern for patients/clients. Professional Support and Recognition is linked with the key themes of Interpersonal Issues and Management, which both highlight issues of recognition and support.

The interweaving themes: Education, Professional Respect and Control, emerging from the focus group discussions are mirrored in the factors which emerged from the survey data, linking with Professional Preparedness, Professional Support and Recognition and Role Clarity respectively.

The findings relating to nurses' and midwives' understanding of empowerment that emerged from the focus groups and the survey mirror some of those in the literature review described in chapter 1. As discussed above (see page 25) the findings of the focus groups highlight several important aspects of empowerment found in the literature, including individual responsibility for empowerment, control and education. The survey findings relating to the understanding of empowerment also mirror aspects of the literature. In particular **Professional Preparedness** mirrors Kuokkanen and Leino-Kilpi's category of "Expertise" (see Table 1, page 18). The elements of the **Enabling Environment** that emerged from the survey data are also found in the work of Conger and Kanungo (page 18) and Fulton (page 16). Conger and Kanungo explicitly name role clarity as a factor that influences empowerment (page 10). Fulton (page 16) included the category "relationships with the multidisciplinary team", which reflects aspects of the **Professional Support and Recognition** factor that forms part of the Enabling Environment.

Experiences of empowerment

The overall empowerment and job satisfaction levels revealed through the survey suggest a moderately empowered and satisfied workforce. Laschinger (2002) reports similar empowerment levels from other studies using the empowerment scales included in this survey, with scores rising with grade, as was also found in this study. Respondents in this study reported satisfaction with many aspects of their work, for example with their colleagues, the amount of challenge in their jobs and their job security. Their levels of affective commitment were higher than their levels of empowerment might predict, because these scales were not strongly correlated, though job satisfaction and affective commitment were moderately correlated. This finding should be noted because it reflects positively on the commitment of the nursing and midwifery workforce. Respondents also appeared to have a greater sense that they, rather than other persons or chance, control their own lives. It should be noted that this perceived control was measured with a global measure rather than a work specific one, which may have revealed a different picture, given the concerns with lack of control voiced in the focus groups in particular.

The survey findings perhaps indicate a more optimistic picture than the focus group discussions suggested and indeed reveal many positive aspects of nursing and midwifery practice in Ireland. However the overall levels of empowerment and job satisfaction, as measured by the tools used

in the survey, may conceal some critical issues which can be revealed by examining responses to particular questions in more detail, as has been described (see page 39 above). For example, the findings relating to empowerment revealed higher informal power (collaboration with doctors, peers and other professionals) than formal power (visibility within the organisation, rewards for innovation and amount of flexibility). Respondents had higher access to opportunities (viewed in terms of challenging work, gaining new skills and using all of their abilities and skills) than to resources (time and human resources), information (about their organisation) and support (feedback and assistance). These findings are supported by qualitative data from both the focus groups and survey, particularly relating to perceived shortages of time and staff, lack of visibility within the organisation and lack of support from management.

Regarding job satisfaction, the intrinsic factors with which respondents are most satisfied include the amount of responsibility they are given, the variety in their job, freedom to choose their working method and the opportunity to use their abilities. Findings on the empowerment scales showed similar levels of satisfaction with performing tasks that use respondents' skills and knowledge. There was least satisfaction with their chance of promotion, the recognition for good work and the attention paid to suggestions they make. Recognition and being listened to were also important components of what focus group respondents understand by empowerment.

The job satisfaction scores found in this survey are slightly higher than those reported for the DATHs (2000) study. There are many similarities between the findings of the DATHs study and the results presented above. In relation to extrinsic factors, there was highest satisfaction in both studies with job security, fellow workers and immediate boss (or line manager), while there was lowest satisfaction with industrial relations and the way their organisations are managed. Again there are similarities regarding intrinsic factors in both studies, highest satisfaction being recorded with responsibility and variety in their jobs and lowest satisfaction with chance of promotion, recognition and the level of attention paid to suggestions.

Significant variance in levels of empowerment and job satisfaction was found in relation to employer. In particular private sector employees had the highest levels of empowerment, job satisfaction, support and formal power, while Health Board/area Health Board employees had lowest levels of empowerment, job satisfaction, support and formal power (see page 45 above). These findings suggest that the public sector can learn from the private sector in this regard. For example, formal power is found in jobs that are visible, central to the purpose of the organisation and that allow for discretion in decision-making (see page 14 above). Exploring how the private sector has facilitated the realisation of higher levels of these features would be of benefit to other employers.

Factors that enhance and inhibit empowerment

In relation to study objectives 3 and 4 survey respondents suggested factors that enhance and inhibit empowerment. The factors perceived to enhance empowerment, most frequently mentioned by survey respondents, were education, skills, knowledge and self-confidence. These are similar to the items deemed to be the most crucial components of empowerment (page 33). Those identified as inhibiting empowerment were poor management style (see Table 12, page 47, for descriptors), lack of education, lack of support from management and lack of recognition (from management and other professionals). The latter are among the elements that the literature also identifies as likely to inhibit empowerment (see pages 18-19). In particular

Conger and Kanungo similarly highlighted centralised access to resources, authoritarian management, negativism, lack of role clarity, lack of training (education) and limited organisational participation as factors that influenced empowerment (page 18). Survey respondents highlighted poor communication systems, bureaucracy, role clarity, training (education) and authoritarian management. Indeed role clarity emerged as a factor from survey respondents on their understanding of empowerment (see page 37). Mirroring Kuokkanen and Leino-Kilpi's factors (page 18), focus group participants and survey respondents also stressed lack of information, authoritarian leadership and lack of training.

The factors suggested by respondents in the survey echo the findings of the focus groups. Interestingly while individual factors are deemed by survey respondents to be the most important factors in enhancing empowerment, environmental factors are the most frequently mentioned inhibiting influences. Relating this to the model of empowerment developed from the factor analysis (Figure 5, page 38), this suggests the potential power of a "disabling" environment to inhibit an otherwise professionally empowered individual. For empowerment, individual factors are essential. If one has the individual factors/characteristics for empowerment the environment can either inhibit or enhance these factors. Inhibiting them will lead to disempowerment and frustration at best. An enhancing environment will support empowered action, enabling it to flourish.

Concluding comments

Many organisational issues can be identified from the findings of this research. These include lack of nurses' and midwives' visibility within the organisation, lack of information about the organisation and dissatisfaction with the way the organisation is managed. These findings are the perceptions of the respondents of this study. It is not possible to pass comment on the accuracy or otherwise of the perceptions/issues identified. However, these were also key issues raised by focus group participants. Nurses and midwives' lack of involvement in decision-making was raised in both sources of qualitative data – the focus groups and the open questions in the survey – though it was not explicitly measured by any of the scales used in this study. Related issues (for example, attention paid to suggestions you make) are addressed in the job satisfaction scale in addition to the organisational issues discussed above.

Critical management issues that were raised in the survey and focus group data were a lack of support, recognition and feedback, with little reward for innovation. These findings are crucial, given that the new Health Strategy (Department of Health and Children, 2001: 175) explicitly calls for responsive innovation in addressing locally-identified priorities and needs. Kuokkanen and Leino-Kilpi (page 37 above) also identify resistance to innovation as a factor that will prevent innovation. In relation to the findings regarding management it is not always clear from the qualitative data which level of management was being referred to, rather a global "management" term was used. In relation to quantitative data, one item on the job satisfaction scale indicted that two-thirds of survey respondents were satisfied with their immediate manager (page 41). However the findings on the empowerment support sub-scale (page 39) indicate low levels of feedback and problem-solving advice, which might reasonably be expected to come from one's immediate manager. Almost two-thirds of survey respondents are staff nurse/midwife or senior staff nurse/midwife grades, who might have most day-to-day contact with front-line service or mid-level management and therefore their comments may relate to their experiences of management at these levels rather than top-level management. However it is not possible to establish the from this data. Another item on the job satisfaction scale gives

clear indications that 52.4% of respondents were not satisfied with how their organisation was managed, suggesting dissatisfaction with top-level management, perhaps both nursing and administrative.

From our findings education might also be described as a core component of empowerment. This was highlighted by both survey respondents and focus group participants. Focus group participants also made the link between education and personal and professional confidence. The qualitative data reveals major concerns about the lack of access to the educational opportunities that are apparently available. This lack of access results from staff shortages, staff having to find their own replacement staff and geographical constraints.

This study presents both qualitative and quantitative data relating to the meaning and experiences of empowerment for nurses and midwives in Ireland. The study design allowed the rich data from the exploratory phase to feed into the national survey, which tested and quantified those findings. The findings that emerged are an important contribution to research on empowerment in nursing and to Irish healthcare research. The study had a tight time-frame. This unavoidably influenced decisions around sampling and the use of previously developed data collection tools where appropriate, as described in this report. However, in relation to sampling for both the focus groups and the survey, representation geographically and by area of practice was achieved. In relation to the data collection tools, the use of several scales and the inclusion of open questions ensured that the perceived limitations of any one measure were addressed and furthermore that this study provides a wealth of information around the complex phenomenon of empowerment.

Previous research on empowerment in nursing is described in chapter 1 (pages 13-18 above). Many of those findings are echoed in this study, particularly in relation to issues around the medical profession, decision-making, control and access to resources. Indeed the findings from this research encompass all the factors which influence empowerment identified in the literature, as shown in Figure 1 (page 21), that is the organisational, individual and historical factors which were identified from the organisational/management, social psychological and critical social theory perspectives respectively. The key finding from this research is that both individual, professional preparedness (including having adequate skills and education) and an enabling environment (support and recognition, role clarity and patient/client focus) are central to empowerment (Figure 5, page 38). This encapsulates the previous research and wider literature on empowerment in nursing and offers a clear conceptual model that is of practical use. For instance this model, in conjunction with all of the findings of this study, assists in the identification of ways to facilitate the further empowerment of nurses and midwives in Ireland, which is addressed in chapter 5.

Chapter 5

Conclusion and recommendations

The study objectives were

- to explore the meaning of empowerment from the perspective of nurses and midwives
- to identify nurses' and midwives' experiences of empowerment
- to identify factors which enhance nurses' and midwives' experiences of empowerment
- to identify factors which inhibit nurses' and midwives' experiences of empowerment
- to identify opportunities for further enabling the empowerment of nurses and midwives.

This report presents the findings of the research carried out to address the above objectives. The focus group discussions comprised the exploratory phase of the study while the national survey tested the focus group findings.

The themes emerging from the focus group discussions, presented in chapter 2, offer some insights into the complexity of the concept of empowerment as understood and experienced by nurses and midwives in clinical practice in Ireland. A web of six key themes and three interweaving themes emerged from the focus group data (Figure 3, page 25). The key themes that emerged were

- individual factors
- interpersonal factors
- professional issues
- organisational issues
- management
- historical legacy.

The interweaving themes identified were

- education
- professional respect
- control.

Building on the themes that emerged from the focus group data, the national survey continued the exploration of the understanding and experiences of empowerment held by nurses and midwives in clinical practice in Ireland. The nurses and midwives who participated in the focus group discussion and in the national survey understood empowerment in terms of both **individual factors** and an **enabling environment** (Figure 5, page 38). The **individual factors** relate to the notion of **professional preparedness**, while the **enabling environment** comprises **professional support and recognition**, **role clarity** and **patient/client advocacy and empowerment**. These key components suggest the importance and value to the health service of having an empowered nursing and midwifery workforce. Indeed the vision of the recent national health strategy (Department of Health and Children, 2001) sees an empowered community receiving quality healthcare delivered by a highly committed and skilled workforce. Based on these findings, an empowered nursing and midwifery workforce will contribute towards the realisation of this vision.

Respondents appear to be a moderately empowered group. They experience some satisfaction with their current jobs, which they stay in because they want to (affective commitment) to a higher degree than would be expected from their empowerment levels, as measured in this study. This commitment will be required for the successful implementation of the national health strategy. It is therefore vital to invest in the human capital of the nursing and midwifery workforce to capitalise on this commitment. Issues relating to organisational structures and management style appeared to be those with which there was least satisfaction. Self-reported empowerment and job satisfaction increased as grade increased, indicating a possible relationship between employment, job satisfaction and grade. In particular, CNM2s show high levels of job satisfaction. There are also indicators of a relationship between employment setting and empowerment. Private sector employees were the most empowered and health board employees least empowered, as measured by the tools used in this study.

The study asked nurses and midwives directly about their understanding and experience of empowerment. From our findings it is possible to identify opportunities for further enabling the empowerment of nurses and midwives in Ireland. In order to do this, our findings suggest that it is critical that the empowerment of nurses and midwives is viewed in terms of both the personal responsibility of the nurse or midwife and also the responsibility of those in the environment in which nurses and midwives work. The ***Frameworks for Change*** of the national health strategy include developing human resources and organisational reform. The findings presented in this report support these frameworks and their actions (Department of Health and Children, 2001:93). Developing human resources aims at harnessing fully the vital contribution made by all health service staff. This includes nurses and midwives. The evidence in this report suggests that such an investment in the human capital of the nursing and midwifery workforce will reap substantial dividends in terms of an empowered workforce.

On the basis of the findings presented above a set of recommendations to further enable the empowerment of nurses and midwives in Ireland is made, subject to availability of resources. These relate to the key areas of **organisational development**, **management development**, **practice development**, **education** and **areas requiring further research**.

Recommendations to further enable the empowerment of nurses and midwives in Ireland

Organisational development

- Our findings suggest that nurses and midwives perceive themselves to be invisible in their organisations, in terms of their lack of involvement in organisational decision-making and their lack of information about their organisations. The importance of effective communication within organisations was identified by focus group and survey respondents as key to addressing this problem.

  ACTION: Review existing organisational communication strategies and take measures to ensure the existence of meaningful strategies to address the issue of perceived invisibility in the organisation of nurses and midwives. In particular this should take cognisance of the need to balance medical, nursing/midwifery and administration input to strategic planning and decision making.

- Nurses perceive a lack of recognition and reward for innovation in practice. This, if accurate, could significantly inhibit the successful implementation of the national health strategy (Department of Health and Children, 2001).

  ACTION: Establish and implement best practice in areas of enabling, recognising and rewarding effective innovation in clinical practice.

- Staff shortages were highlighted in this study as being a barrier to being able to provide quality nursing care and to accessing continuing education.

  ACTION: Implement effective workforce planning to meet existing and future predicted human resource and service needs. Performance feedback and objective setting should be linked to the objectives of the organisation and strategic needs assessment. The work of the Nursing and Midwifery Resource Group is acknowledged in this regard and the implementation of the action plan outlined in its final report is likely to assist in the realisation of this recommendation.

Management development

- Participants in this study identified management style as being an important influence on empowerment.

  ACTION: Adopt a systematic approach to the identification of nursing and administrative management training and development needs. Deliver appropriate training and development programmes to meet these needs.

- Our findings suggest that nursing management is influential in enabling clinical staff to function in an empowered manner. This notion of reciprocal empowerment is found in the literature (see page 13 above) and was also raised in our study.

  ACTION: Provide ongoing appraisal and support to nurse managers across the health service. Wider usage of the Nurse Management Competencies Framework (Office for Health Management), which addresses all levels of nursing management and highlights ***inter alia*** competencies towards the facilitation and enablement of staff, is likely to be of value in addressing this recommendation.

Practice development

- Nurse/midwife-led practice was identified as an empowering and enabling innovation in this research, by focus group participants in particular.

  ACTION: Build on ongoing existing initiatives to further enable innovation in nurse/midwife-led services and extend these practice models across all nursing and midwifery divisions and areas of practice. Appropriate support for education, research and pilot projects is required. This recommendation is in keeping with the recommendations of the Report of the Commission on Nursing and will support the implementation of the national health strategy. Nurses and midwives must themselves seize the opportunities offered by these developments.

- Personal and professional confidence was identified by research participants as being central to empowerment.

  ACTION: Explore, identify and implement interventions as a means of fostering the professional and personal confidence and self-esteem of nurses and midwives.

- Difficulties accessing the resources they require for client needs were described by participants, particularly those working within the area of intellectual disabilities.

  ACTION: Review and develop as necessary systems to ensure appropriate access to the resources required to meet client needs, particularly in the area of intellectual disabilities.

- Nurses and midwives reported difficulties in meeting increased public expectations of and demands for health services, which appear to be heightened by health service publications into which nurses and midwives have no input.

  ACTIONS: Provide staff with appropriate preparation in order to deal effectively with increased public expectation and demand.

  Ensure clinical nursing/midwifery input into the development of health service information material aimed at the general public, especially those publications dealing with health service provision and consumer rights.

Education

- Adequate and appropriate education, including continuing education, was judged to be critical to empowerment. Barriers to accessing education include staff shortages, with nurses/midwives having to find their own replacement cover, geographical distances and lack of resources for staff development and training.

  ACTIONS: Safeguard access to appropriate, continuing professional education, by identifying and meeting resource (both human and financial) and geographical requirements. There is a significant opportunity to provide a focus for an e-learning initiative which in the longer term should be more effective and will optimise the use of resources.

  Promote a greater emphasis in the use of informal and on-the-job learning, recognising that much of nurses' and midwives' learning takes place in the clinical setting. Greater usage of personal development plans may facilitate this. Mechanisms to deliver training might include coaching, mentoring (internal and external), action-learning and clinical supervision. Centres for nurse education potentially have a primary part in promoting the professional development of all staff. Their evolving role should assist in meeting needs identified in this report.

- Nurses and midwives appear to have some concerns and uncertainties about the scope of practice, accountability and legal issues that are involved in their practice.

  ACTION: Provide continuing and accessible education about the scope of practice and practitioner accountability within the evolving legal framework in which nursing operates.

Areas requiring further research

Organisational development

- As described in the first recommendation above, the findings of this study suggest that nurses and midwives perceive themselves as invisible within the organisation, in terms of lack of involvement in decision-making and lack of information about the organisation.

  ACTION: Further research on organisational culture and structures is required in order to investigate nurses' and midwives' level of involvement in organisational decision-making and service planning.

  If the findings of this research, which suggested a lack of such involvement, are confirmed, this indicates a requirement to plan organisational change, on a partnership basis, to enable meaningful involvement for nurses and midwives in decision-making and service planning. The work of the sub-group on service planning (of the Steering Group on Empowerment) is acknowledged as a potentially important step in meeting this objective in relation to service planning.

  If organisational change is implemented, use diagnostic interventions, such as employee attitude surveys and organisational climate surveys, to systematically measure organisational change and staff morale as related to empowerment of nursing and midwifery staff.

- The employer is identified as having a significant influence on nurses' and midwives' experiences of empowerment.

  ACTION: Further research is required to explore precisely how the employer interacts with nurses' and midwives' experiences of empowerment in the practice setting.

Management

- While our findings suggest some dissatisfaction with management style, it is not always possible to identify from the data the level of management with which participants are dissatisfied.

  ACTION: Further research is required to explore the experiences of nurses and midwives regarding the relative influence of nursing and non-nursing management at different levels on the day to day experience of empowerment by the practitioner.

Practice development

- Control emerged as an important component of empowerment in this research. This emerged as critical in a number of different contexts, for example in relation to decision-making about patients/clients.

  ACTION: Further research is required on nurses' and midwives' spheres of control within practice, for example in relation to rostering and clinical decisions. This should clarify the current situation and identify best practice to enhance nurses' and midwives' control within their practice setting.

- Nurses and midwives expressed dissatisfaction with their roles within current multidisciplinary

teams, articulating a need to be listened to and involved in teamwork and decision-making to a greater extent.

ACTIONS: Examine current multidisciplinary team interactions and working methods in order to clarify nurses' and midwives' roles within these. Identify as necessary mechanisms to facilitate more effective involvement of nurses and midwives in the multi-disciplinary team decision-making activities. Provide greater investment in and promotion of training to facilitate interdisciplinary teamwork as required. To fulfil this recommendation nurses and midwives themselves must value and demonstrate their unique contribution to the healthcare team, taking a lead role as required and appropriate. This is particularly important in view of the recent primary care strategy which emphasises an integrated interdisciplinary team-based approach within which community-based nurses and midwives will operate.

It will also be important to establish roles and responsibilities in relation to the implementation of the detail of all of the above recommendations. Key stakeholders in the process include: practising nurses and midwives, the Department of Health and Children, health boards, the ERHA, area health boards, other health service employers, An Bord Altranais, the National Council for the Professional Development of Nursing and Midwifery, the Office for Health Management, the Health Service Employers' Authority and the Health Services National Partnership Forum.

This far-reaching study has unearthed the interesting and compelling findings presented in this report. The recommendations set out above have highlighted much needed changes in the areas of organisational development, management development, practice development, education, as well as the identification of key areas for further research that were raised by this study. The scale of the challenge involved in implementing these recommendations is significant. However the human, social and economic implications of not implementing them are considerable and require that this challenge be met.

Next steps

The report and its recommendations should be forwarded to the Action Plan for People Management Monitoring Committee, which will oversee the implementation of all aspects of the Action Plan for People Management.

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Appendix A

List of most frequently assigned codes, focus group data

Code title	Number of groups in which code assigned	Total number of times code assigned
Accountability	7	14
Assertiveness	9	26
Authority	9	25
Autonomy	9	33
Back-up	7	7
Being listened to	9	41
Change	10	91
Changing role	6	13
Clinical experience	8	22
CNS	6	31
Colleagues	6	21
Collegial support	7	20
Communication	10	75
Confidence	10	49
Consultants	9	31
Consultation	7	31
Contact/Interactions with other professionals	8	32
Continuing education	8	52
Control	10	24
Decision-making	10	79
Doctors	10	38
Education	10	84
Empowering practice	10	44
Expanding role	8	19
Families of patients	8	21
Fear	9	36
Geographical variance	7	25
Having a voice	9	23
Hierarchy	8	20
History	10	39
Industrial relations	8	8
Information	10	27
Knowledge	10	62
Management role	9	47

Management structure	7	20
Management style	10	74
Medical model	9	24
Multidisciplinary team	6	25
New nurse training	7	23
Non-nursing duties	6	20
Nurse management	8	22
"On the ground" nursing	9	17
Organisational factors	9	23
Patient/client-led care	10	50
Perceptions of nursing	10	81
Personal factors affecting nursing	10	48
Power	10	45
Reciprocal empowerment	6	15
Recognition	9	43
Remuneration	8	20
Resources	10	66
Respect	6	43
Responsibility	9	53
Restrictions to practice	8	31
Role	10	44
Role definition	8	42
Saying no	7	24
Service development	8	38
Skills	7	23
Specialist nursing	9	24
Staffing levels	10	70
Structures	10	55
Support	9	57
Teamwork	7	27
Time for work	8	28
Training	9	36
Valued	8	29
Workload	9	59

Appendix B

Themes emerging from focus groups discussions

Key Theme 1: Individual Factors

This key theme emerged from participants' acknowledgements that individual factors had a significant part to play in their experience of empowerment. It was clear from the participants that it was as important to want to be empowered as a person as it was to be empowered in the workplace. Most of the participants stated that it was up to the individual to be empowered.

> "Something to go on yourself ... It's not given to you." (FGD 6)

Nearing the end of one focus group discussion, the moderator asked what factors need to change for empowerment to occur. The immediate response was 'ourselves' by a number of participants. This suggests an awareness of the impact personal issues have on the individual's experience of empowerment. The following are some more issues which emerged from the discussions:

- confidence
- willingness for empowerment
- morale.

Confidence

Being confident in practice was felt to be an enhancing factor for empowerment. An identified link was visible between confidence, education and empowerment. This was articulated frequently by the participants.

> "If you have the education you're able to get it sorted ... and increase your level of confidence and so it empowers you, it's like a chain reaction you know." (FGD 7)

> "Confidence has a lot to do with empowerment and if your confidence is knocked so far down you just don't feel you can empower yourself." (FGD 3)

The need to be assertive in voicing opinions was also mentioned by a number of participants.

> "The most empowering thing in the world is to be able to say no." (FGD 7)

Linked closely with increased workload, being able to say "no" featured in two of the discussions. Nurses and midwives felt that they were disempowered by being unable to refuse an increased workload despite feeling already overworked. Another dimension of this issue stems from nurses and midwives traditionally not questioning the tasks which were delegated to them.

Some very honest contributions were made in relation to the individual feeling insecure compared to others who were perceived to be more empowered. This issue is of real interest given the change in the education and training of nurses and midwives in Ireland.

> "Sometimes I feel very threatened, you know, oh she's newly qualified, she has a degree or a masters – and I'm here I've been doing the work for how many years." (FGD 2)

Valuing oneself was felt to be an important aspect of empowerment.

> "At times we don't know how to accept a thank you – we say, no no that's alright, it's nothing." (FGD 2)

Willingness for empowerment

There appeared to be a perception among participants that there is some degree of control over how an individual experiences empowerment. This featured in all of the focus group discussions. A lot of indications were directed towards the individual being unwilling to "take on" empowerment. This was linked with a perception expressed about taking on extra work. More subtly, it linked with nurses' and midwives' fears of repercussions and being seen as disruptive. The following illustrates the issues expressed by the participants about why individuals may not be willing to "take on" empowerment.

> "I think with regard to people not willing to be empowered, the more that you're going to be afraid that you are going to get a reputation for being outspoken and whatever, causing ripples ... the other thing is that if you show an interest in one particular thing suddenly you're inundated with extra on top of your ... 12 hour day ... so you really want to pick and choose what you put your hand up for because you know you're going to get lumbered with it." (FGD 2)

The need for nurses themselves to take responsibility albeit with the support and back-up of management was discussed and met with agreement in a number of focus group discussions.

> "I think it's up to nurses as individuals to take responsibility but they won't do that unless they know when they take that responsibility they will have the support of senior people." (FGD 2)

Changing one's attitude was felt to be an enhancing factor for empowerment. Some participants verbalised that many of their colleagues or managers would be unwilling to change their attitudes.

> "It's amazing how staff will become institutionalised in that they're not willing to change, or they're afraid to change a system or policy or anything and I mean for example a law changed, their views are so 'no, that's it, we did that once it worked, leave it that way.'" (FGD 3)

Morale
There were some very emotional contributions from participants about this issue. Having a low morale was felt to be counterproductive to empowerment. Some participants gave examples of how their morale is knocked in practice.

> "I've been battling here ... my energy has gone ... if I express an opinion or have an idea about something I expect to be listened to and its very wearing battling all the time." (FGD 3)

Key Theme 2: Interpersonal Factors

Interpersonal factors are categorised as such because they relate to interactions between individuals. There are specific interpersonal interactions outlined which are of particular relevance to the research question and the participants, namely interactions with the medical profession and the general public. These fall into the following categories:

- being valued
- being respected
- being supported
- having a voice
- interaction with the medical profession
- interaction with the general public
- communication.

Being valued
Although there was some consensus that being valued was an enhancing factor for empowerment, there were varying experiences among the participants about being valued as a professional. The perceptions voiced by the participants regarding the concept of being valued ranged from awareness by the general public to views at governmental level.

> "I think that's very important, that you really feel valued in yourself if you are valued by peers, by other members of the team and your manager and by the public in general." (FGD 2)

> "The government is only now realising what a valuable resource we are ... they got rid of us all in the 1980s ... we're very valuable ... and we are not being utilised to the fullest of our potential." (FGD 10)

Being respected
Several examples of individuals lacking in respect for nurses and midwives in practice were also given. There were some strong comments made in one focus group discussion regarding nurses and midwives leaving the profession as a result of not being respected.

Being supported
It was felt that being supported by others was empowering.

> "I think it is very important that we as nurses would be supported by our colleagues and also by other members of the team, whether it be a dietician or a psychologist or a doctor or whoever it is." (FGD 1)

In relation to the above theme, most of the contributors outlined negative experiences where colleagues did not support or stand up for each other. This echoed throughout all of the discussions. It was clear from the participants that having collegial support is an important factor in empowerment and not having support is consequently disempowering.

> "I think nurses ourselves are our own worst enemies." (FGD 7)

Some participants gave examples of colleagues holding a grudge against nurses and midwives who undertake continuing education.

> "I think that, you know, nurses who have specialist skills or who have done specialist courses or specialist education can be disempowered by their colleagues because there will be a bit of begrudgery there, 'who does this one think she is' syndrome ... you're not given credit or recognition by your colleagues for all the effort that you've put into your career you know, it's for your own personal benefit and the benefit of your client ... there's a lot of begrudgery out there." (FGD 1)

Having a voice

According to the participants, not having a voice was considered disempowering. Most of the examples given related to nurses and midwives in practice not having a voice in relation to patient care. Linking closely with having a voice, being listened to by others, particularly members of the multidisciplinary team, was felt to be potentially empowering.

> [Within the multidisciplinary team] "being listened to ... and ... being asked ... rather than being told." (FGD 1)

Interactions with the medical profession

The responses from the participants about their experiences with the medical profession were predominantly experiences of disempowerment. It is interesting to note also that the majority of contributions included examples of conflicts in practice. From the participants' responses, there also seems to be an undercurrent of high expectations both on behalf of the practitioners and the medical profession. Many of the focus group participants felt frustration because they felt that they had knowledge and experience to make decisions, yet the consultant always had the final authority. It is clear from the data that the majority of current experiences with the medical profession are of a disempowering nature.

> "We look after clients ... we work together. When I feel ... or one of my colleagues says they're ready for discharge, we go to meetings and we discuss with the consultant and all he does is turn around and say 'ah no we'll keep him for another few days'. When there's no clinical reason why he should be in that place. We're the ones who look after them twenty-four hours a day, not for five minutes a day." (FGD 5)

The general public

The perceptions and expectations of the general public featured a great deal in all of the focus group discussions. From the data, it appears that there is a substantial amount of public expectation placed on the practising nurse or midwife. This links somewhat to the role of the nurse which was presented previously. The fact that the healthcare system is beginning to give responsibility to its consumers was also felt to have caused some public discontent. The participants, as a whole, felt that the increasing demands and expectations placed on practitioners was disempowering. From discussing this issue, there was a felt need expressed to educate the public about the role of the nurse/midwife.

Some participants felt that the general public did not recognise the professionalism of nurses and midwives. It emerged in some of the focus group discussions that the public was cautious and uncertain about the authority of nurses and midwives. This was especially the case in relation to nurse and midwife-led services. Participants who were specialists, stated that a lot of their time is spent re-educating the public in relation to their role.

> "It's just nurse, you know, she's always there at everybody's beck and call, whether it's a patient, or it's a doctor or the relatives or whoever – I think it's just they've no recognition". (FGD 2)

> "The image that [the public] gives you as a midwife is quite funny ... they all think that we're forty, spinsters, ride bicycles and we're absolute hags ... God it's all batty you know – [the public thinks] we're power tripping, very powerful women who will tell you exactly what to do and don't even question it." (FGD 7)

It was felt that the general public had increased expectations of the health service generally and also of nurses and midwives. This afforded much discussion and participant agreement. Better education, information and confidence were attributed as factors which increased the public's expectations. The fact that public health nurses did not hold waiting lists also were expressed as a factor which increased public expectations. In summary, being unable to meet the demands and expectations of the public is disempowering.

> "You might be delivering what's available, but it may not be sufficient for the patient because of what they've read ... they go looking for that extra, and they keep looking and they keep coming back to you ... it's putting terrible pressure on you ... you could have somebody else coming to you and saying 'well she got that, I didn't get that ... I'm now going to my local politician'... politics is a big issue." (FGD 4)

Communication

Again, the theme of communication featured a great deal in all of the focus group discussions. Team and ward meetings were felt to be vital. Interestingly, in one of the focus group discussions, one participant stated that there was a 'ban' on such ward meetings. There appeared to be a strong emphasis by participants on the importance of communicating within the multidisciplinary team. Interpersonal communication was felt to be of great importance to the individual's experience of empowerment.

"Regular staff meetings with multidisciplinary people and the consultants involved would open up more freely …"

"Yeah, better all round communication … I think it would be a good start, better communication, more openness, flexibility." (FGD 2)

Key Theme 3: Professional Issues

Many professional issues arose in the focus group discussions relating to empowerment. This theme encompasses issues relating to the role of the nurse/midwife, and developments within the profession. The theme was divided into three main categories as follows:

- clinical practice issues
- empowering practice
- the role of the nurse/midwife.

Clinical practice issues

The belief that the nurse has unique knowledge of the patient/client permeated all of the focus group discussions and was passionately articulated by the majority of participants. Most of the participants stated that they knew their patients/clients best due to dealing with them over time and the nature of the relationship between nurse/midwife and patient/client. This was echoed when discussing the need for involvement in decision-making; because nurses and midwives felt they had unique knowledge of the patient/client they felt they were uniquely able to contribute effectively in contributing to decisions in the best interest of the client.

"It's like a cake with cream … we're there in every layer, you know. We're like something that goes through the whole … through everything, you know, like the mesh, we'll say … others can come in and go out, and doctors come in and go out and do you know, experts come in and go out, but we're there through the whole system, we are there". (FGD 10)

Ironically the notion was also expressed that being available and accessible was actually disempowering.

"I think that another valuable thing to note is the twenty-four hour cover that is provided, they're there continuously throughout the day … you don't often see that with people who are empowered workers." (FGD 2)

Linked with the belief of nurses having unique knowledge of the patient/client is the value placed by nurses and midwives on clinical experience. Some participants highlighted the fact that they had decades of experience in their particular field and knew more than the medical profession.

"We shouldn't take a back seat when they come down, 'oh there's a doctor, he must be best' – they don't, we're the experts, a number of the staff have twenty-five, thirty years experience, you know. And intuition has a lot to say for itself as well, you know, we all have evidence-based care, it's coming in, but we must never forget that experience is also crucial". (FGD 5)

Closely linked with being assertive, the issue of standing by one's professional opinion arose on a number of occasions throughout the focus group discussion. This was initially mentioned in relation to the medical profession but branched out to encompass management also. Having the knowledge and confidence to stand by one's professional opinion were felt to be vital factors in empowering the practitioner.

The amount, ferocity and emotion expressed in all of the focus group discussions about having an increased workload cannot be overstated in relation to professional practice. Closely linked with staffing levels, almost all of the participants felt that having an increased workload was singularly disempowering. Much frustration was expressed at being unable to provide appropriate care for one's patients. Public health nurses expressed particular distress with regard to their increased workload. Having an ever increasing caseload, dealing with patients through the lifespan and being unable to create a waiting list all featured as disempowering. The following reflects the disempowering experiences felt by these participants.

> "The amount of work ... there are days you'd wonder are you going to spread yourself so thin that you are just going to vapourise and disappear, ***disappear.*** " (FGD 10)

It was also felt that there was an increasing amount of paperwork to contend with which undoubtedly increased the nursing workload. There was a felt need to comply with the added paperwork because of a concern about litigation.

> "I feel computers are chucking out an awful lot of work to us as well and we're still doing Mr Plod on the ground." (FGD 10)

The theme of the reciprocity of empowerment relates specifically to nurses and midwives; they experience empowerment from caring for their patients/clients.

> "If the people we're attending are satisfied, you get a certain empowerment from that." (FGD 4)

There were contradictory positions expressed in relation to the power of nursing as a profession. Some participants felt that nursing and midwifery had little power as professions while others felt that nursing and midwifery were indeed very powerful professions. Several participants stated that nurses and midwives commanded a lot of power over patients and clients. The participants felt that through education and professionalisation, nursing and midwifery could become powerful and respected professions. Internal recognition among colleagues of the power of nursing and midwifery was also seen as important.

The Scope of Practice document, published by an Bord Altranais (2000), featured in two of the ten discussions. The feelings expressed by participants were mixed – some felt that the Scope had empowered them, others felt it had limited their practice and was, as a result, disempowering. Frustrations were voiced at not being able to perform some limited prescribing, for example of IV fluids, paracetamol and pethedine. There was also an awareness of legal vulnerability and "not being covered", with no clear consensus as to what that meant.

It appears that being moved to different practice areas results in individuals feeling

disempowered. Detailed experiences were described by participants who were moved out of their areas. One individual gave a detailed account of her experience of being moved and stated that she felt out of control and extremely vulnerable. At the same time she felt a sense of responsibility to the patients and the staff working in that area.

> "It's some poor patient in the bed ... I might be able to help out ... if it's only just to give them a bedpan." (FGD 6)

Empowering practice

Throughout all of the group discussions, participants gave numerous examples of what they perceived as empowering practice. It was felt by midwives and other participants that midwifery offered the most potential for empowering practice.

Some participants felt simply that being able to do one's job well was empowering. Having continuity of care with patients was also described as an enhancing factor for empowerment.

> "When things are getting done and you're giving service to the client and things are happening you feel more empowered." (FGD 2)

Closely linked with the above theme, several participants stated that working independently was empowering.

In all of the focus group discussions, nurse/midwife-led services were felt to be empowering. The benefits to practitioners and patients/clients were clearly articulated.

> "[patients/clients] always say that they can talk to the nurse ... it's much easier than before and it's much easier to tell us things and describe difficulties that they're having." (FGD 7)

Several participants expressed the view that running a nurse/midwife-led clinic was empowering.

> "As a midwife the fact that I would run a midwife clinic for antenatal patients, where I would have total control of the normal antenatal care, that would be empowerment from a midwife point of view." (FGD 1)

Being able to administer care at home was also perceived as empowering.

> "Recently ... the home-based nursing had been set up, that's where acute care is given at home by a set-up of nurses ... CPNs are now sent out to assess the home situation. That's a new thing and it has given us empowerment, and definitely makes you feel you're useful and you're doing a good job ... that has empowered us, I find that rewarding". (FGD 4)

Being able to triage patients was stated by some participants as empowering.

> "I work in triage in A&E ... this is where patients are assessed on arrival and you decide what treatment they need for the presenting problem. So I would see the patient when he/she checks in and decide if they're urgent or non-urgent, so I'd be making the decision for the patient at that stage". (FGD 2)

The participants felt that having control over some aspects of practice was an enhancing factor for empowerment. On the other hand individuals who stated that they did not have control felt that they were not empowered. The theme of having control links with having a sense of autonomy over practice.

> "You need to feel the autonomy to make decisions ... especially if you're a staff nurse on a ward." (FGD 9)

Related to the theme of involvement in decision-making, participants who had experiences of being able to make decisions in practice felt that this was empowering.

There was much interest and discussion surrounding specialist nurse practice and its potential for empowerment. Generally it was felt that being able to practice as a specialist was empowering.

The role of the nurse/midwife

The role of the nurse/midwife was discussed at length in most of the focus group discussions. Generally speaking, having a clearly defined role was amenable to empowerment and a poorly defined or non-defined role was the opposite. Issues of consistency in defining what a nurse or midwife should be doing arose, as did the long debated issue of performing non-nursing duties.

An Bord Altranais featured on a number of occasions during the focus group discussions. It was generally felt that the board was restrictive in developing or expanding the role of the nurse/midwife.

> "I think the organisation which doesn't at all empower us anyway as professionals is our own Bord Altranais." (FGD 7)

The complexities of the nurse/midwife role were identified, along with the fact that neither nurses nor midwives are good at explaining what they do in practice.

> "With specialisation ... nursing used to be nursing, now it's highly complex ... if we don't know what each of us is doing then how the hell can we explain the complexity of it ..." (FGD 10)

There were varying contributions about what nurses and midwives thought their roles were. A clear need emerged from the participants to have their roles clearly defined in order to enable empowerment to occur. This was echoed at a number of stages throughout the discussions.

> "We don't really have a very clear job description ... one person's interpretation of what I should be doing could be different to mine ... particularly as regards prioritising work ... I would have some difficulties with my management over decisions that I would have made and they would say 'you should be doing that', and I would say 'I just can't'." (FGD 5)

Having autonomy to develop one's role was felt to be empowering.

> "In relation to myself, I suppose the autonomy that we're given within our job description to develop ... within certain latitudes ... having the knowledge

> and skills and the experience to do that ... I think that's a huge part of empowerment for me personally."

> "I feel ... if we had more choice in being more discriminatory about how we develop our practice, we could develop it more interestingly you know, and also be more client led." (FGD 7)

Having to perform non-nursing duties was felt to be disempowering and inimical to the recognition of nursing as a profession. There was discussion also about non-nursing duties adversely affecting the individual's experience of empowerment. In addition it was felt that delegating non-nursing duties to appropriate staff would "give us more time to do what we're trained for".

> "We've taken on every role. If something needs to be done and nobody else is going to do it I just think Jesus, I better do it because there will be trouble if I don't do it". (FGD 4)

This theme links in some ways with the theme of Historical Legacy. The following is an example which may explain why nurses and midwives initially took on non–nursing duties.

> "Because of the hierarchical system that is in us ... I know when I trained I was told not to upset the domestics because student nurses were two-a-penny and a good domestic was hard to find." (FGD 9)

Some participants voiced the reality that their roles were actually evolving and that what was previously part of the role is now not part of it at all.

> "I think it's important for us as nurses to help our colleagues and our other healthcare professionals to see how far we really have come ... we're not mopping the brows anymore." (FGD 3)

Participants felt that supporting student nurses led to a sense empowerment.

Key Theme 4: Organisational Issues

Many issues relating to the organisations within which they worked were raised by participants during the focus group discussions. They are presented under the following headings:

- involvement in decision-making
- access to monetary resources
- staffing levels
- size of the organisation
- practice setting
- remuneration
- planning
- accessing education.

Involvement in decision-making
The need to be involved in decision-making was intensely discussed throughout all of the focus group discussions. Participants felt disempowered by not being involved in decision-making. The identification of this need occurred at different levels and appeared to be based centrally on the best interest of the patient/client. The type of decision-making was that relating to clinical practice, the development of new services and centralisation.

> "I find that the majority in the health service are nursing professionals and when it comes to making critical and strategic decisions there is actually a very small number that have that particular input." (FGD 2)

Participants felt strongly about decision-making in relation to clinical practice. It emerged from the discussions that decisions relating to patient/client care were sometimes made by persons not involved directly in patient/client care.

> "We're experts in our fields in nursing, and I think we're best placed to make decisions in relation to nursing care for patients ... and sometimes that might be expensive, but at the same time we're making decisions from an area of expertise that we're trained in." (FGD 4)

Access to monetary resources
The theme of having access to resources provoked a considerable amount of discussion and debate across all of the focus group discussions. It appeared also that there were regional differences in relation to the issue of resources for continuing education. Some participants from the east of Ireland stated that they had difficulties in accessing monetary resources for continuing education. In general, there did not seem to be a problem among participants in accessing resources for continuing education in the west, north-west and south of the country. However a lack of staff militated against accessing continuing education in these areas. It was stated in one discussion that continuing education courses were cancelled in a particular institution due to a lack of staff.

The bureaucratic difficulties experienced in trying to source money for clients were enumerated particularly by mental handicap nurses. The frustration expressed at not having control of budgets could be attributable to the nature of their nursing practice. The following clearly outlines particular difficulties experienced in relation to this division of nursing.

> "In the field of learning disability, working with empowerment for me is providing a standard of living for those clients ... and again it's down to resources and funding, and like something as simple as having a birthday party ... you need go through the channels to get it funded you know ... because the client you work with is removed from it ... it feels like you're the one that wants it ... that's where apathy comes in." (FGD 2)

Staffing levels
There was much discussion and the voicing of frustrations in all of the focus group meetings at situations arising from inadequate staffing levels in the workplace. It is indeed difficult to convey the frustration and emotion expressed within the discussions relating to this theme.

When asked directly about what would enhance empowerment, most of the immediate responses were "more staff".

> "Really you have a task to be done and very little time in which to do it, and fewer people to help you with it ... maybe in this day and age it is considered a luxury to allow yourself to be empowered." (FGD 2)

Size of the organisation
It appeared that the actual size of the organisation could affect an individual's experience of empowerment. A smaller organisation, according to the participants, is potentially more empowering than a larger one. Participants felt that this was due to numerous factors. Working closely with the medical profession, being able to make independent decisions and having a sense of control over these decisions were felt to be positive aspects gained from working within a smaller organisation. Depersonalisation, a feeling of lack of control and an increased workload were pointed to as negative elements of working within a larger organisation.

Practice setting
Participants felt that particular settings seemed to offer more potential for empowerment than others. Some participants gave examples of their experiences of practising overseas and compared these to the situation in Ireland. Practising in Ireland was felt to be more disempowering compared with practising overseas. The hospital setting appeared to be the least amenable to empowerment within Ireland, and the community setting was described as the most empowering practice setting because it was felt that there was more scope for independent practice. Practitioners revealed a paradox however in the community setting; working independently appeared to bring a feeling of isolation also.

> "I think it's easier if you work in the community to be more empowered than it is to be working in a hospital – there are too many people around who are disempowering, watching everything you are doing – so it is easier in the community to do what you want to do." (FGD 3)

Some participants felt that political influences also affected practice in the community setting.

> "I think there's a difference too in the community and we'll probably be experiencing that. I mean money will be poured into hospitals because they're buildings and they're vote catching I suppose for the politicians ..." (FGD 10)

Remuneration
On a more practical level, not being reimbursed appropriately with petrol and car maintenance allowances was mentioned as disempowering by public health nurses.

> "[public health nurses have been remunerated at] the same rate for twenty years for petrol and car maintenance though these costs have gone up – they are little things but yet they can be very important if you want to empower people." (FGD 2)

Planning
There were several comments in relation to the perceived lack of foresight displayed by organisations in pursuing change. This was felt to be disempowering. For example, despite oncoming new services, there were no changes in resource or staffing levels. This revelation was related to increased workload as well.

According to one participant:

> "The system hasn't progressed as quickly as all the ideas behind it." (FGD 10)

Accessing education
Participants who felt disempowered by being unable to access continuing education courses noted many difficulties. Lack of time, low staffing levels and staff having to find their own relief all impacted on this disempowering factor.

> "If someone within the team is doing a course then the other members of that team have to take over the work load and that can cause a lot of tension at times. It can put quite a large burden on their colleagues ... you can feel very disempowered you know". (FGD 7)

This task of having to cover for colleagues who attend continuing educational courses appears to be indirectly disempowering because of the increased workload exerted on the remaining staff.

Some participants stated that the actual location of educational courses was not suitable.

> " We're only a small hospital ... you're away from Dublin, you've nowhere to go to do any courses." (FGD 5)

Key theme 5: Management

Many contributions related to the effect managers and management have on the individual's experience of empowerment. Focus group participants confirmed that effective management is a key factor in promoting staff empowerment. A number of participants recorded negative experiences of current managers in their workplaces and highlighted examples of conflict with their managers. The following are some areas that were discussed in relation to the key theme of management:

- management structure
- management style
- support
- communication
- recognition
- the "real power" of management.

Management structure
There were some interesting discussions about the current nursing management structure within hospital management.

> "I think the nursing hierarchy disempowers an awful lot of people." (FGD 3)

Several interesting points were made in relation to the impact the new clinical nurse manager structure has had on the practice area. This links to the new management structure outlined by the Commission On Nursing (1998).

> "Now it's too many bosses ... whatever you suggest has to be passed by each one ... then it has to go up even higher again and you just feel like if you suggest anything you just say ah here forget it". (FGD 3)

Management style
Throughout the focus group discussions, participants related differing opinions and experiences about the style of their respective managers. Generally it was felt that a helpful and supportive manager was empowering. Having an authoritarian, regimental manager was felt to be counterproductive for empowerment. The evidence from participants pointed to the fact that authoritarian, dictatorial methods of management were what most participants experienced in their practice. This was felt to be very disempowering.

> "Where I work the management is very autocratic, 'my way and my way only'. I find that incredibly difficult to deal with on a personal and professional basis and I feel my past is totally gone. Not even disempowered, just gone. You might as well pack your bags and go". (FGD 4)

Support
The issue of being supported by one's immediate manager occupied a great deal of the focus group discussions. This particularly related to being supported in clinical decisions made. Interpersonal support was also mentioned. Generally, feeling supported by one's manager appeared to result in an increased experience of empowerment. Not having the support of one's manager on the other hand was felt to be an inhibiting factor which was disempowering for nurses and midwives and resulted in reluctance to deal with particular situations occurring in the practice area. Support from one's manager appears to be an important factor in enabling empowerment.

> "I would know many skilled nurses who hold back – they're wary because they won't have the support of people". (FGD 2)

Communication
Effective communication between management and staff was held up consistently as an enhancing factor for empowerment in the workplace. All participants when speaking about communication, unanimously felt that communication was a very important factor. They voiced a need for managers to divulge information and listen to staff if empowerment was to occur.

> "It's a matter of getting these ideas across to your colleagues at a higher level of management or a lower level. But it's all to do with collaboration and communication across the way rather than up and down." (FGD 4)

Recognition

It was felt in general that being recognised for one's contribution in the workplace was a positively empowering factor. Having a formal staff appraisal was perceived by participants as potentially empowering. This links with the theme of communication and management feedback to staff.

> "I had been staffing on this unit for three years and one of the nurse managers called me and said God you're really doing a great job, great like, you know, you do really feel high up, you do feel like you have empowerment and then someone turns around and says 'what did you do that for' and then you're back down to stage one, so staff appraisals, formally and informally, are so important within a unit". (FGD 3)

Some participants expressed strong emotion concerning the lack of recognition in the workplace.

> "I would see it as a problem from senior management down ... thank you is not enough to me anymore, I'm sick listening to this, you're doing a great job, you're wonderful. I'm now going to tell them to take it off somewhere else and come to me with something constructive, i.e. money and resources, and to get this up and running." (FGD 3)

The 'real' power of management

This theme interestingly emerged from participants recognising a discrepancy between supposed and real influential power. There was questioning of managers' abilities in certain positions also. The theme featured in the majority of the discussions.

> "[in relation to expanding practice] I didn't get the support that I felt I should have got from management. I then began to wonder has management got the real power at all. Are they up against another bureaucracy ... what I'm saying is where is the power? I'm not blaming management or anything like that but, I mean, there must be some blockage somewhere". (FGD 10)

Key theme 6: Historical Legacy

The legacy of the past was discussed in all focus groups. This was usually discussed with reference to how things had changed or hopes for the future. One participant articulated this as follows:

> "How we are socialised and how we are educated and our past, our history, our legacy lives on with us and it is slowly going to change." (FGD10)

Aspects of training, management and the role of the nurse were seen as being products to some extent of a past that was generally felt to be disempowering for nurses. All of the participants who talked about their training pointed to the impact traditional training methods had on disempowering them as professionals. Examples of oppression, and in one case, bullying, are

given to illustrate how nurses and midwives were trained and treated. Abuse of the role of the nurse also came up.

> ***Participant 1:*** "I'm talking about our training years ago."
> ***Participant 2:*** "It was one of fear really wasn't it?"
> ***Participant 1:*** "One of fear exactly." (FGD 6)

> "I was trained in a system where it was 'do as you're told and if you don't like it there's the gates and out you go and we don't have jobs for the likes of you around here'." (FGD 3)

The new training structures for nurses and midwives were generally felt to be a positive step forward. There was a perception that students were going to be more assertive and research orientated.

> " I trained in the 60s ... I think that the new training has to be good from that point of view, that they're going to question more." (FGD 6)

Interestingly, there was acknowledgement from participants that there was some resistance in the clinical area to the new methods of training nurses and midwives.

> "It's interesting because a lot of the new nurses coming through, you know, a lot of the resistance they feel is from existing staff, because staff nurses who weren't empowered or didn't speak out themselves, you know, they almost resented the younger people coming in and doing it, and that'll take time to change as well." (FGD 6)

Several participants related confusion about the role today compared to the past when nurses were "Jack of all trades", doing the jobs that no-one else would do.

Many negative experiences of past management were raised. These related to poor communication, doing what managers ordered out of fear and having to work within the nursing hierarchy.

> "I think for years in a lot of Irish hospitals there was this hierarchical system, you did what the matron said and it worked its way down along." (FGD 7)

Interweaving Themes

The above presentation of key themes demonstrates that a large number of important and interesting issues which currently affect their experiences of empowerment in the workplace were raised by the participants. There were also themes that can be described as interweaving, in that they capture the web-like connections which exist among the key themes. The interweaving themes cannot be characterised easily. The detection of these themes arose from analysing both the content and context of the contributions. Listening to the tone of the participants' inputs together with observing of the level of agreement (both verbal and non-verbal) played a part in the emergence of these themes. What characterised the interweaving themes was the fact that they arose in all of the focus group discussions and had relevance to

all of the key themes. Three themes in particular were identified as interweaving themes. These are listed and briefly discussed below:

- education
- professional respect
- control.

Education

Despite the fact that education was mentioned within the key themes presented previously, issues surrounding the theme of education spanned all of the group discussions and were mentioned to a much greater extent than it was previously possible to indicate. It was unanimously felt that education was vitally important for empowerment. It was interesting to note that few difficulties were voiced with regard to funding for further education; it was predominately problems in accessing education which seemed to cause the greatest number of difficulties. This suggests that despite the positive financial support at governmental level regarding relevant educational courses, there seems to be ground-level difficulties which are restricting access to this potentially empowering element for nurses and midwives.

> "I think education is empowerment." (FGD 1)
>
> "[people who are educated for practice] They're more empowered to carry out their day to day work ... there are certain types of training that people can use so they're more able to deal with those issues and therefore you're more confident and you're more empowered to work within those areas...with proper skills you're not as afraid, so you're more inclined to go to work and do your job." (FGD 4)

It was felt that being educated was good for the profession. The role of clinical nurse specialists particularly featured in this area. It was felt that being educated increased nurses' and midwives' ability to practice effectively. Education was felt to lead to improved communication within the multidisciplinary team. Finally, as stated previously, all of the participants expressed a clear link between education and confidence.

Professional respect

It emerged throughout all of the discussions that the perception of being respected as a professional directly affected the individual's experience of empowerment. This was illustrated by the numerous statements about being valued, respected and listened to in the workplace. While connecting with all of the key themes, being respected as a professional links closely with the key theme of Interpersonal Factors. Perceptions of how nurses and midwives were actually respected or not as professionals emerged throughout all of the focus group discussions. Staying with these issues, participants gave examples of how they were treated from organisational, management, interpersonal and personal perspectives.

> "Why do nurses have to fight so hard, you know, to be valued?"
>
> "That constant, that constant battle of trying to get as you say other professionals that you're working with, not so much their approval but just their assistance and just their respect." (FGD 9)

The key theme of Historical Legacy also highlights participants' experiences of being unvalued and disrespected historically.

Control

Participants clearly believed that individuals who have a sense of control (or possibly perceive that they have control) experience a greater sense of empowerment. Numerous examples were given throughout all of the focus group discussions, which illustrated the importance participants placed on having a sense of control. The most obvious examples of having control came from practitioners' experiences of being able to make independent decisions. Conversely, not being in control afforded a sense of frustration and subsequent disempowerment. Most of the negative contributions relating to this theme included references to situations where the individual practitioner had no control and where managers or indeed the organisation held the control and power over practioners' experiences. This interweaving theme of sense of control is found throughout all of the key themes.

> "I suppose empowerment means ... being confident in what you do, in your practice, you know, and I suppose really having control." (FGD 8)

The identification of and the resulting discussion surrounding interweaving themes serve to highlight the fact that nurses' and midwives' understanding and experiences of empowerment appear to be more complex than one might imagine.

Appendix C

Pilot survey

This Appendix will outline the components of the pilot survey and why and how particular research instruments were chosen for inclusion in the main survey.

Demographic information

While it was essential to identify the current area of practice of respondents it was also thought to be of value to ascertain certain other demographic characteristics of respondents, relating to personal characteristics, educational qualifications and current workplace. The aim was to gain a comprehensive and useful demographic profile while also being mindful of keeping the questionnaire user-friendly and therefore as concise as possible.

Demographic information sought:

- sex
- nationality
- age
- divisions on which registered and year(s) of registration
- further educational qualifications
- years of nursing/midwifery experience
- workplace type, size of hospital (if appropriate)
- job title
- length of time in current post
- current area of practice
- years of experience in current area of practice
- specialist practice
- full/part-time work
- temporary/permanent job
- urban/rural work setting
- employer
- practice outside Ireland, length of time is relevant.

Most questions were closed, with relevant options (including "other") presented, while some questions were open (job title, area of specialist practice).

Understanding of the meaning of empowerment

As described in chapter 3, on the basis of the focus group discussion findings an exhaustive list of forty-seven statements relating to the meaning of empowerment was compiled (see Table 4, page 27). Respondents were asked to indicate their level of agreement with each statement using a five-point Likert-type scale with the following options: Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree. It was intended to carry out factor analysis on the pilot survey data, with the aim of reducing the number of items for the main survey.

Following the list of statements an open question was included which invited respondents to include anything else relating to their understanding of empowerment that had not been covered in the list.

Literature review: measuring empowerment

The literature on empirical research into empowerment in nursing was reviewed in order to explore the instruments previously used to investigate this topic. A summary indicating the tools used in relevant studies is presented in Table C1. On the basis of the studies reviewed a number of scales were considered to be appropriate for the survey and these are described in the next section.

Table C1: Previous empirical research on nursing empowerment

Author/Year (See Bibliography)	Instruments used
Laschinger, H. K. S., Finegan, J., Shamian, J. and Wilk, P. (2001)	Conditions of Work Effectiveness Questionnaire II Spreitzer's Psychological Empowerment Questionnaire Job Content Questionnaire (modified) Global Satisfaction Scale
Laschinger, H. K. S., Finegan, J., Shamian, J. and Almost, J. (2001)	Karasek's Job Content Questionnaire Conditions of Work Effectiveness Questionnaire II Spreitzer's Psychological Empowerment Questionnaire Meyer and Allen's Organisational Commitment Questionnaire Global Satisfaction Scale Health Professions Stress Inventory
Fletcher, C. (2001)	The Specific Satisfaction Sub-scale: Hackman and Oldham's Job Diagnostic Survey The Immediate Supervisor Scale
Adams, A. and Bond, S. (2000)	Ward Organisational Features Scale
Ellesfen, B. and Hamilton, G. (2000)	Conditions of Work Effectiveness Questionnaire Job Activities Scale Organisational Relationship Scale Global Empowerment Scale
Laschinger, H. K. S. et al (2000)	Conditions of Work Effectiveness Questionnaire II Job Activities Scale II Organisational Relationships Scale II Interpersonal Trust at Work Scale Organisational Commitment Scale
Irvine et al (1999)	Self-management Leadership Questionnaire (Manz and Sims)
Laschinger, H. K. S. et al (1999)	Conditions of Work Effectiveness Questionnaire Job Activities Scale Organisational Relationship Scale Leader Empowering Behaviour Scale Lyons Job Tension Index Global Work Effectiveness Scale

Laschinger, H. K. S. et al (1997)	Conditions of Work Effectiveness Questionnaire Job Activities Scale Organisational Relationships Scale Work Unit Description Scale (Lashbrook)
Morrison, R. S. et al (1997)	Bass's Multifactor Leadership Questionnaire Spreitzer's Psychological Empowerment Questionnaire Warr, Cook and Wall's Job Satisfaction Questionnaire
Haugh, E. B. and Laschinger, H. K. S. (1996)	Conditions of Work Effectiveness Questionnaire Organisational Description Opinionnaire
Matrunola, P. (1996)	Job Satisfaction Questionnaire (specifically developed) Beck's Hopelessness Scale (negative expectancies) Maslach's Burnout Inventory
Klakovich (1995)	Organisational Culture Inventory (Cook and Lafferty) Achieving Styles Inventory (Lipman-Blumen) Klakovich Reciprocal Empowerment Instrument
Becker (1994)	Empowerment Measure Self-concept Motivation Nurses' Perceptions of Empowerment-related Factors
Chandler (1991)	Conditions of Work Effectiveness Questionnaire (developed for nursing from Kanter (1979))

Scales included in the pilot survey

The participants in the focus groups discussed their experiences of empowerment as described in chapter 3. On the basis of the experiences discussed, the literature on previous research in nursing on empowerment, job satisfaction, affective commitment, burnout and locus of control was consulted. This facilitated consideration of scales that had previously been used to measure these topics. Scales that were selected to address the issues being researched in the survey are outlined below.

Empowerment

Laschinger (1996) has reviewed the studies which had (to that date) tested Kanter's theory of structural power in organisations in nursing contexts. In 1980, 1983 and 1986 doctoral dissertations reported support for Kanter's model for nursing. In 1992 a programme of research was initiated at the University of Western Ontario to systematically test hypotheses derived from Kanter's theory in the nursing population. This involved the development of the Conditions for Work Effectiveness Questionnaire (CWEQ) which was used to measure perceived access to job-related empowerment structures in organisations. This contained forty items requiring responses on a Likert-type scale, with four sub-scales (support, information, resources and opportunity) with an overall empowerment score obtained by summing the four sub-scale scores.

In 1994 it was determined that two additional constructs were needed to adequately test Kanter's theory. The Job Activities Scale (JAS) was developed to measure formal power and the Organisational Relationships Scale (ORS) was developed to measure informal power in organisations, as described by Kanter. Subsequent studies tested this expanded model. Thirteen

independent studies were carried out in total. Laschinger (1996) states that the findings show "substantial evidence for the validity of Kanter's theory of organisational behaviour in both staff nurse and nurse manager populations". In most cases response rates were only 40 to 50%. Further empirical work was done on the CWEQ, JAS and ORS and the number of items in each was reduced, with the validity of the revised scales (CWEQ-II, JAS-II, ORS-II) also established (Laschinger, 1996).

On the basis of this empirical work it was decided to include the CWEQ-II, JAS-II, ORS-II and the two-item global empowerment scale in the pilot questionnaire. Professor Laschinger was contacted and permission was granted to use the questionnaires. Small changes to language for cultural sensitivity were permitted. An enquiry was made about excluding or adapting two of the items from the "access to information" sub-scale (relating to values and goals of the organisation) that were felt not to be widely used terms in the Irish healthcare setting. While it was not deemed possible to remove this sub-scale, permission was granted to substitute terms purpose, mission, objectives. However it was decided to use the original sub-scale in the pilot survey. The positive nature of all of the statements was also queried and the possibility of negatively wording some items was suggested. It was however reported from the research team that the questionnaire had been tested numerous times in a variety of settings with different populations and has been found to be a very valid and reliable instrument and that therefore such changes were not permitted.

The first three of these scales (CWEQ-II (12 items), JAS-II (3 items) and ORS-II (3 items)) are measured on a five-point Likert-type scale with three headings – None (score of 1), Some (score of 3) and A Lot (score of 5). The other two points (between these three, scores 2 and 4) are not named though respondents can select them. The 2-item global empowerment scale's five-point Likert-type scale reads from Strongly Agree to Strongly Disagree.

Affective Commitment

The affective commitment sub-scale from Meyer and Allen's (1984) organisational commitment scale was included. Affective commitment means staying in a job because one wants to, rather than needs to (continuance commitment). This scale was used by Laschinger et al (2000) and Laschinger et al (2001a). It is a 9-item five-point Likert-type scale reading from Strongly Agree to Strongly Disagree

Job Satisfaction

The recent Dublin Academic Teaching Hospitals' ***Nursing Recruitment and Retention Group Report 2000*** reported research into job satisfaction that was carried out in October 1999. This used the Job Satisfaction sub-scale of Warr, Cook and Wall's (1979) Work, Life and Attitudes Survey Scale. This Job Satisfaction sub-scale itself includes Intrinsic and Extrinsic sub-scales. The Intrinsic sub-scales includes items on freedom of method of working, recognition, responsibility, opportunities, promotion chances, attention to suggestions made and variety within your job. The Extrinsic sub-scale includes items on physical work conditions, fellow workers, immediate boss, rate of pay, industrial relations, organisation management, hours of work and job security. Since these are some of the many issues that arose during focus group discussions it was judged that it would be useful to include this scale. The Job Satisfaction sub-scale is a 15-item 7-point scale ranging from Extremely Satisfied to Extremely Dissatisfied.

The DATHs survey also included two extra items used in a previous survey into the experience

of stress among Irish Nurses' Organisation members (Wynne et al, 1993). These items related to challenge and how you feel about your job as a whole. For comparative purposes it was deemed useful to include the sub-scale and these two extra items. Permission was granted by the authors for the use of the two items from the INO survey.

Burnout

On the basis of the degree of emotion expressed in some of the focus group discussions (e.g. one public health nurse's reference to the danger of spreading one's self so thin "that you are just going to vapourise and disappear") it was decided to include the Burnout Inventory of Maslach and Jackson (1981). This incorporates three sub-scales – Emotional Exhaustion (9 items), Personal Accomplishment (8 items) and Depersonalisation (5 items). Burnout has been characterised as a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do "people-work" (Maslach and Jackson, 1981). Maslach and Jackson report on the reliability and validity of the scale. The scale has two dimensions, namely Frequency and Intensity. Given the need to keep the questionnaire as short as possible it was decided to use only the Frequency scale. This is a seven-point Likert-type scale, ranging from Never to Every Day.

Locus of control

The scales described above focus on external factors that may affect an individual's experience. It was deemed important to also measure perceptions about beliefs about control and causal beliefs. The Internality, Powerful Others and Chance Scale of Levenson (1981) was included to achieve this. The Internality sub-scale measures the extent to which people believe they have control over their own lives; the Powerful Others sub-scale concerns the belief that other persons control the events in one's life; and the Chance sub-scale measures the degree to which a person believes that chance affects his/her experiences and outcomes. Each of the sub-scales has 8 items and uses a five-point Likert scale (Strongly Agree to Strongly Disagree). The scale is reported to have been used with a variety of samples and Lefcourt (1991) reports satisfactory reliability and validity of the scale.

Open questions included

Factors that enhance and inhibit empowerment

Two open questions relating to the factors that may inhibit and enhance empowerment were also included to fully address the objectives of the project.

Comments section

An open question inviting comments on the questionnaire was included to give the opportunity for comments on the topic of empowerment or the questionnaire itself.

Method of distribution of pilot survey

The dearth of reliable and accurate national and local data on the numbers of nurses and midwives in practice has been highlighted in the ***Interim Report of the Nursing and Midwifery Resource Steering Group*** (Department of Health and Children, 2000). This report usefully outlines the sources of data on the numbers of nurses and midwives employed throughout the country. These sources include the Annual Census of the Department of Health and Children and the Register of an Bord Altranais. One of the functions of the newly created regional

Nursing and Midwifery Planning and Development Units is to compile an up-to-date database of nurses and midwives in practice in the public, private and voluntary sectors of each region. However because this work has not been completed it could not yet be exploited. Discussions were held with a number of people who have been involved in large-scale nursing research in Ireland, including the Scope of Practice Project. Following these discussions the following issues regarding the use of the Live Register of an Bord Altranais were highlighted.

- Previous postal nursing surveys have had low response rates. The Scope of Practice Survey had a response rate of 8% (An Bord Altranais, 1999).
- Only the home addresses of nurses and midwives on the Register are available, with no indication of workplace location.
- There is no record of area of practice on the Live Register, just of the divisions in which a nurse/midwife is registered.
- A proportion of nurses on the Live Register are not actually in current nursing/midwifery practice. This has not been quantified but has been estimated to be about 25%.

It was decided that the pilot survey should test the Live Register for these potential problems.

The pilot survey was sent out on 5 November 2001 to a random sample of 395 nurses and midwives on the Live Register of An Bord Altranais as shown in Table C2 below.

Table C2: Pilot survey sample by division

Division of the An Bord Altranais Live Register	Number in division *(on date of pilot mailing)*	Number sent
General Nurses	44,565	130
Psychiatric Nurses	8,794	65
Midwives	13,015	65
Sick Children's Nurses	3,471	45
Mental Handicap Nurses	3,431	45
Public Health Nurses	1,827	45
Total	75,103	395

Almost 400 questionnaires, arguably a high number for a pilot survey, were sent out in an effort to ensure an adequate response rate and in particular to carry out factor analysis on the items within the "understanding of empowerment" section of the questionnaire.

It was stipulated that a geographical spread across the country must be a feature of the sample. However, it was acknowledged that because addresses held by An Bord Altranais were home addresses it was not possible to guarantee a spread by workplace location.

A cover letter introducing the project and guaranteeing anonymity was included with the questionnaire, as well as a pre-paid envelope. Participants were asked to indicate if they were not in current practice and to return the cover letter indicating this to us if so. Participants were asked to respond within two weeks. An appropriate letter (G for General, P for Psychiatric etc) indicating the division of the Register from which the respondent was selected was printed on the return envelope to identify the division from which the respondent was selected in order to analyse this vis-à-vis their current area of practice.

Pilot survey results

Response rate

A total of 137 replies from the 395 questionnaires posted was received. This is an overall response rate of 34.6%. One hundred and six people (26.8% of the total 395) returned completed questionnaires while thirty-one stated that they were not currently in nursing/midwifery practice. This “not in practice” group represented 22.6% of the total returns. The breakdown of replies by originating division is shown below in Table C3.

Table C3: Survey responses by division from which respondents were selected

Division from which selected	Number Sent	Total replies from that division	Replies – completed questionnaires	Replies – not in practice
General	130	40	32	6
Psychiatry	65	23	16	6
Midwives	65	32	26	6
Children’s	45	15	9	6
Mental Handicap	45	13	9	3
Public Health	45	15	13	2
Not Known		3	1	2
Total	395	137	106	31

Of course the division from which a respondent was selected is not necessarily the area in which that respondent is practising now. Of the number who completed questionnaires it was deemed useful to relate the division from which they were selected to their current area of practice. This cross-tabulation by originating division (from which they were selected, identifiable from return envelope) and current area of practice for the 106 cases which were analysed is given in Table C4 below. One person removed the letter identifying the division from which selected (“Unknown”, below). Regarding the area of current practice the category “Other” included Geriatrics, Theatre, Occupational Health and a number of combined areas such as General/Midwifery.

Table C4: Division from which selected and current area of practice

Division from which respondent was selected	Current area of practice								
		GEN	PSY	MID	SC	MH	PH	Other	Total
	Unknown			1					1
	GEN	19	1	4	1	1		6	32
	PSY		12				1	3	16
	MID	8		6		1	4	7	26
	SC	2			2		2	3	9
	MH	1	1			7			9
	PH		1				11	1	13
	Total	30	15	11	3	9	18	20	106

Key: GEN= General, PSY= Psychiatric, MID= Midwifery, SC= Sick Children’s, MH= Mental Handicap, PH= Public Health.

This raises a number of interesting points:

- General, Psychiatric, Mental Handicap and Public Health Nurses may be targeted by selecting respondents from those divisions respectively (i.e. 11 of the 13 respondents in current Public Health practice were selected from the Public Health division).
- Only two of the nine respondents selected from the Sick Children's Nurses' division who completed questionnaires are in sick children's nursing practice. Therefore targeting this division may not guarantee responses from RSCNs in current practice in sick children's nursing.
- Of the 26 respondents selected from the Midwives' division who completed questionnaires only six of them are in midwifery practice. In addition four respondents from the General division are currently in midwifery practice.

These points informed the sample selection and size from the six relevant divisions for the main survey.

Discussion of pilot survey results

In discussing the findings of the pilot survey the low overall response rate (36.4%) and low number of completed questionnaires (106) must be borne in mind. The findings merely indicated trends to be explored and helped in selecting items for inclusion in the main survey.

Notwithstanding the differences highlighted, the demographic profile of the pilot survey respondents was broadly similar to the overall Register profile, notably regarding age and sex. Respondents had a relatively high number of qualifications and high level of specialist practice and overseas experience. It could be hypothesised that nurses and midwives with these characteristics may be more interested in this topic and therefore more motivated to complete and return the questionnaires. However given the size of the sample and the low response rate to the pilot survey, this can only be tested with the higher response rate obtained in the main survey.

Regarding their understanding of empowerment, respondents' concerns related primarily to education, "saying no", being informed about change, team communication, patient/client advocacy and having the necessary skills for practice. Indeed almost all of the statements offered, that were drawn from the focus groups discussion and the literature, were affirmed by respondents as being part of empowerment. A notable exception to this related to the statement on "performing tasks that were previously performed by doctors or other professionals". This highlights an interesting issue around role definition and extension that also featured in the focus group discussions. It appears that most respondents felt that they did understand what empowerment means, perhaps reflecting their satisfaction that the statements (with which they also mostly agreed) did describe what they understood by empowerment. The additional comments relating to respondents' understanding of empowerment also fell within the same broad areas as the statements listed in the questionnaire. Factor analysis was carried out on these responses and the results are shown in Table C5. This assisted in the selection of items for inclusion in the main survey.

Using Laschinger's scales to measure empowerment, respondents were found to be a moderately empowered group with a mean empowerment score lying exactly between low and high empowerment. Just over half felt that their current working environment was empowering. On

the Job Activities Scale that measures formal power again respondents had moderate amounts of formal power. Respondents also scored moderately on the Organisational Relationships Scale that measures informal power. Respondents' mean scores on these two scales were 2.8 and 3.27 respectively from a range of 1 (low power) to 5 (high power).

Meyer and Allen's Affective Commitment sub-scale measures the desire to stay in their current job. Respondents had fairly high affective commitment with a mean score of 2.94 from a range of 1 (high commitment) to 7 (low commitment). This commitment was clear throughout the individual items in the sub-scale with, for example, working at their workplace having a great deal of personal meaning for 72.1% of respondents.

Regarding job satisfaction, as measured by Warr, Cook and Wall's Job Satisfaction sub-scale, respondents were found to be "a little satisfied" (the fifth point in a 7-point scale which ranges from "extremely dissatisfied" to "extremely satisfied") overall with their current jobs. The mean scores for the extrinsic and intrinsic factors were similar, again showing "a little satisfaction" with these items. There were notably high levels of satisfaction with certain extrinsic factors including fellow workers (83.5%) and job security (85.1%), with lower levels of satisfaction with their immediate boss (62.4%) and the way their organisation is managed (45.2%). Regarding intrinsic factors there were fairly high levels of satisfaction with the amount of responsibility (77.2%) and the amount of variety in the job (76.7%), with lower levels of satisfaction for other factors including chance of promotion (48.5%) and recognition for good work (43.7%). These findings mirror the concerns raised in the focus group discussions particularly relating to organisational issues, management and recognition.

Low levels of emotional exhaustion and depersonalisation and a high level of personal accomplishment were found, using Maslach's Burnout Inventory. This does not reflect the quite emotional contributions of some of the focus group discussion participants but relates well to the other aspects of the findings of this pilot, in terms of a fairly empowered, committed sample.

Using Levenson's scales, replies conveyed a moderate sense of control over one's life (Internality) and fairly weak beliefs that others control one's life (Powerful Others) and that chance affects one's outcomes. This again corresponds to the profile of this small group of respondents.

More than half of the respondents chose to suggest factors that both enhance and inhibit empowerment. These can be related to the categories of management, organisational issues, interpersonal factors, individual characteristics and professional issues.

The major enhancing factors identified by pilot survey respondents included strong leadership and management, improved staffing levels, effective communication and teamwork, knowledge, confidence, autonomy and taking responsibility. Conversely factors that inhibit empowerment included lack of support from management and hierarchical management, inadequate staffing levels, poor facilities and lack of access to education, lack of communication, bullying, lack of confidence, fear of change, low self-esteem, lack of autonomy and carrying out non-nursing duties.

All of these concerns were also articulated in the focus group discussions.

Table C5: Factor analysis on "understanding of empowerment" pilot survey results

7-FACTOR SOLUTION – BASED ON DICHOTOMISING ALL REPONSES (STRONGLY AGREE VS OTHERS)							
Rotated Component Matrix	FACTORS						
	1.00	2.00	3.00	4.00	5.00	6.00	7.00
Being involved in decision-making about patient care			0.40	0.42			
Having a supportive manager	0.42			0.67			
Having effective communication with members of the multidisciplinary team				0.71			
Having support from my colleagues				0.64			
Having access to resources for patients				0.71			
Having a Scope of Practice document					0.45		-0.40
Being accountable for my practice					0.66		
Being an advocate for my patients/clients					0.76		
Being listened to by members of the multidisciplinary team	0.62						0.43
Being involved in nurse/midwife-led clinics			0.63				
Having the authority required to practice effectively		0.48	0.48				
Being confident when dealing with members of the multidisciplinary team							0.52
Having a nurse manager who gets things done	0.54			0.57			
Being respected by members of the multidisciplinary team	0.47						
Having autonomy in my practice			0.75				
Having high self-esteem			0.58				
Being consulted about patient care by members of the multidisciplinary team	0.53						
Getting constructive feedback from my manager on my performance	0.59			0.45			
Being valued by my manager	0.75						
Being adequately educated to perform my role					0.48		
Empowering my patients/clients			0.48		0.44		
Being recognised as a professional by the medical profession	0.60						
Having control over my practice			0.64				

Being assertive		0.43					
Having access to continuing education		0.50					
Having responsibility for patient care		0.56	0.49				
Standing by my professional decisions		0.56					
Having freedom to practice within my scope of practice		0.60	0.41				
Having effective communication with management	0.65						
Being respected by my immediate manager	0.82						
Performing tasks that were previously performed by doctors and other professionals					0.62		
Having the skills to carry out my role		0.70					
Having access to resources for staff education and training		0.60					
Being informed about changes in my organisation that will affect my practice	0.62	0.41					
Being recognised for my contribution to patient care by the medical profession	0.70						
Delegating non-nursing tasks to auxiliary staff						0.59	
Knowing who my patients/clients are						0.46	
Being recognised for my contribution to patient care by my manager	0.74						
Having the back-up of my manager	0.61						
Having a clearly defined role		0.50	0.50				
Being self-directed in my practice			0.55				
Being able to say no when I judge it to be necessary		0.53					
Having adequate staffing levels in my unit	0.59						
Practising patient/client-centred care	0.43	0.55					
Knowing what my scope of practice is		0.73					
I don't understand what empowerment means** this item has its values reversed						0.49	

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization. Rotation converged in 17 iterations.

Revisions to questionnaire for main survey

On the basis of the pilot study's findings the entire set of questionnaires was reviewed.

Demographics

Some slight changes to wording were made and some extra categories were added as indicated by the pilot. It was decided to ask two questions about grade and role rather than an open question about job title.

Understanding of the meaning of empowerment

In an attempt to address the skewed nature of the pilot data, a further pilot survey using the items selected for inclusion in the main survey using factor analysis was carried out with a convenience sample of 54 nurses/midwives in practice.

The wording of the introduction and Likert scale options was changed to degrees of importance to empowerment, with a further option to indicate respondents' opinion that this item is not related to empowerment. With the aim of further discriminating between items, respondents were also asked to rank from 1 to 10 the ten items that they considered to be most important to the meaning of empowerment.

Two comments from the second pilot survey described difficulty with the ranking. There were two negative comments about the item "performing tasks that were previously performed by doctors and other professionals" itself. Factor analysis was carried out on the new data and no item had a loading <.40 on the seven factors. Analysis of skew statistics showed that the new scale was less skewed than previously. This information was deemed to be more useful because at least some of the values are spread across responses. It was also decided to include the ranking exercise. This second pilot revealed the items relating to education, skills, scope of practice and autonomy to be most frequently highly ranked. The wording of the scale was again altered and simplified.

Final selection of scales for main survey

The following components were included in the final survey (see Appendix K for a full set of questionnaires used in the main survey).

- Demographics section
- Revised "Understanding" section, including ranking exercise
- Laschinger's scales
- Meyer and Allen's Affective Commitment sub-scale
- Warr Cook and Wall's Job satisfaction sub-scale
- Levenson's Internality, Powerful Others and Chance Scale

The only negative comments about any part of the questionnaire were related to Levenson's scale. However it was deemed necessary to include this to balance the organisational perspective of Laschinger's scales and to address the importance factor of the individual's perceptions of control and power.

The relationships between burnout and both job satisfaction and empowerment were shown in this pilot. Therefore Maslach's Burnout Inventory was removed for the practical purpose of reducing the length of the overall questionnaire and therefore increasing the likely response rate.

Distribution of the questionnaires for the main survey
Given the low response rate of the pilot survey (34.6%, with 106 completed questionnaires received), considerable thought was given to the best way to collect data for the main survey. The potentially problematic issues raised before the pilot survey (numbers not in practice, inability to identify area of practice and generally low response rate to postal questionnaires) were shown to be somewhat borne out. Therefore the relative merits of using the Live Register and a Stratified Clustered Sample were considered and are shown in Tables C6 and C7.

An Bord Altranais Live Register

Table C6: Advantages and disadvantages of using Live Register for main survey

Advantages	Disadvantages
• Randomisation assured • Geographical spread (but of home addresses) Logistically straightforward and less human resource intensive • Can follow up non-responders (ID number while assuring anonymity because researchers do not have access to names/addresses)	• Low response rate by postal questionnaire • Cannot target grades (non-managerial, non-specialists etc) • Significant number (22.6% in pilot) on the Live Register are not in practice • Cannot target areas of practice – can only select by division of register

An alternative means of distributing the questionnaire, namely a Stratified Clustered Sampling technique, was considered. This would involve physical distribution of questionnaires by research staff to nurses and midwives from a sample of services within a sample of health board areas across the country.

Table C7: Advantages and disadvantages of using stratified clustered sample for main survey

Advantages	Disadvantages
Probable higher response rate	• Less rigorous randomisation • Need ethical approval in some institutions – may take up to 6 weeks • Lack of reliable personnel information on staff • Resource intensive

Given the joint concerns regarding the sensitivity of the topic and the time constraints, it was agreed that An Bord Altranais register would again be used for the main survey, with a follow-up mailing planned to improve the response rate.

Appendix D

Demographic profile of respondents to main survey

The demographic profile of respondents to the main survey is presented in full in this Appendix. Where appropriate, comparative data from the Register of An Bord Altranais is shown. Data from the Dublin Academic Teaching Hospitals (DATHs) report "Nursing Recruitment and Retention Report 2000" is also presented, where relevant. This DATHs report presents the findings of a job satisfaction survey of 411 nurses staff currently working in the DATHs and St Luke's Hospital which was carried out 1999. It must be borne in mind however that data from respondents working in these large Dublin teaching hospitals are not strictly comparable with national data. Where no comparative data is shown, it is because none is available.

Sex

1,241 respondents (93.3%) were female while 89 (6.7%) were male, as shown in **Table D1** below. This corresponds to the overall register figures of 93% female and 7% male (DOHC, 2001). Data on the sex of respondents was missing for 10 cases.

Table D1: Sex of respondents

	Number	%	% on Register*	% DATHs study (2000)
Female	1,241	93.3	93	97.4
Male	89	6.7	7	2.6
Total	1,330	100.0	100	100.0

* Source DOHC 2001

In terms of sex of respondents and area of practice, results are shown in **Table D2** below. This shows that 55.7% of the males were in psychiatry and 22.7% in mental handicap nursing, with only 17% in general nursing. 40.3% of female respondents were in general nursing.

Table D2: Sex of respondents by area of practice

	Female	%	Male	%	Total
General	498	40.3	15	17.0	513
Psychiatry	92	7.4	49	55.7	141
Sick Children's Nursing	141	11.4	0	0.0	141
Midwifery	92	7.4	3	3.4	95
Public Health	210	17.0	1	1.1	211
Mental Handicap	203	16.4	20	22.7	223
Total	1236	100.0	88	100.0	1,324

Nationality

52 (4%) of the respondents were non-Irish. Data was missing for 31 cases.

Age

The age breakdown is given in **Table D3** below. Data on age was missing for 11 cases. It can be seen that a lower percentage of those who responded to the survey are in the younger (20-29) age group (10%) compared to 17% on the Register and that a higher proportion of the sample are in the 40-49 and 50-59 age groups than on the register. This in part is due to the weighted sampling to obtain sufficient numbers in each area of practice. The age distribution of the DATHs respondents reflects the younger workforce of these larger acute hospitals.

Table D3: Age breakdown of respondents

Age group	Number	%	% on Register*	% DATHs study 2000
20-29	133	10.0	17	47.1
30-39	373	28.1	30	29.8
40-49	516	38.8	27	14.7
50-59	277	20.8	17	2.5
60 and over	30	2.3	8	0.0
Unknown			1	5.9
Total	1,329	100.0	100	100.0

*Derived from DOHC 2001

Registration

The majority of respondents (60.6%) were firstly registered on the General Nurse division of the Register. Those with midwifery and public health qualifications necessarily registered firstly on that division. 14.4% firstly registered on the Mental Handicap Nurses division and 11.9% firstly registered on the Psychiatric Nurse division. The number of qualifications held by respondents is given in **Table D4** below. As is shown in that Table, the number of qualifications held by respondents is higher than the total number on the Register, for example 19.8% of respondents held three or more qualifications while 5% on the Register do so. This was also influenced by the weighted sampling requirement of the survey. For example, PHNs (who have at least three qualifications) were targeted, thereby raising this number. Data on the number of qualifications held was missing for 9 cases.

Table D4: Number of qualifications of respondents

	Number	%	% on Register*
One	438	32.9	63
Two	596	44.8	31
Three	264	19.8	5
Four or more	33	2.5	<1
Total	1,331	100.0	100

* Source DOHC 2001

The qualifications held included a full range across the seven divisions, shown in **Table D5** below. Data was missing for 8 cases.

Table D5: Qualifications held by respondents

	Number	%
RGN/RM	279	20.9
RGN/RSCN	197	14.8
RGN/RM/RPHN	180	13.5
RGN	177	13.3
RMHN	144	10.8
RPN	100	7.5
RGN/RPN	65	4.9
RGN/RSCN/RM	47	3.5
RGN/RMHN	28	2.1
RPN/RMHN	24	1.8
RGN/RM/RPN	20	1.5
RSCN	17	1.3
Others	62	4.1
Total	1,332	100.0

It is interesting to note that while 562 (42.3%) respondents have a midwifery qualification, only 95 are in midwifery practice. The 204 PHNs in the sample also have a midwifery qualification and 234 respondents who have a midwifery qualification are working in general nursing.

Decade of qualification

The decade in which respondents first qualified is shown in **Table D6** below. This clearly relates to the age of respondents as described above. Data was missing for 176 cases. It is not clear why such a large number chose not to answer this question.

Table D6: Decade of first qualification

	Number	Valid %
1950s	3	0.3
1960s	89	7.6
1970s	364	31.3
1980s	378	32.5
1990s	293	25.2
2000 onwards	37	3.2
Total	1,164	100.0

Further educational qualifications

The post-registration qualifications of respondents are shown in **Table D7**. Data is missing for 14 cases.

Table D7: Post-registration qualification

	Number	Valid %
No post-registration qualification	420	31.7
Certificate	278	21.0
Diploma	272	20.5
Higher Diploma	136	10.3
Degree	116	8.7
Masters degree	36	2.7
Pre-registration Diploma	8	0.6
Other	60	4.5
Total	1326	100.0

Years of nursing/midwifery experience (including training)
The number of years of experience (including training) of respondents is shown in **Table D8** below. The largest number of respondents (480) have 20-29 years of experience. This is clearly related to the age profile of respondents and is also reflected in the decade of qualification data presented above, again a function of the weighting sampling used in the survey. Data is missing for 84 cases.

Table D8: Years of nursing/midwifery experience

	Number	Valid %
3-9 years	155	12.1
10-19 years	415	32.5
20-29 years	480	37.6
30-39 years	198	15.5
more than 40 years	30	2.3
Total	**1256**	**100.0**

Place of work
52.3% of respondents work in hospitals, and 24.4% in the community, with 11.3% working in residential homes, 3.9% working in nursing homes, 3.2% working in both hospital and the community and 4.8% working in other settings. Of those who work in hospitals, 36% work in hospitals that have more than 300 beds and 64% work in hospitals that have less than 300 beds.

Geographical area of current practice

The geographical area in which respondents practice is shown in **Table D9**, with data missing for 18 cases.

Table D9: Geographical area of current practice

Area	Number	Valid %
North-east	107	8.1
East	422	31.9
South-east	168	12.7
South	177	13.4
West	153	11.6
North-west	92	7.0
Midlands	84	6.4
Mid-west	119	9.0
Total	1322	100.0

The Department of Health and Children collects data annually on the number of staff employed by the Health Boards, voluntary hospitals and voluntary services within each Health Board area. The data on number of nurses employed at 31 December 2000 are presented in **Table D10** (2001 data not yet available).

Table D10: Numbers of nurses employed in public sector

Health Board area	Number	%
North-east	2,183	7.0
East	12,896	39.0
South-east	3,471	10.0
South	4,666	14.0
West	3,686	11.0
North-west	2,113	6.0
Midlands	1,722	5.0
Mid-west	2,737	8.0
Total	33,474	100.0

Source: Annual census of health service personnel at 31.12. 2000, DoHC

Current grade

Current grade is shown in **Table D11** below. Data was missing for 8 cases.

Table D11: Current grade

	Number	Valid %
Staff nurse/midwife	579	43.5
Senior staff nurse/midwife	231	17.3
Public health nurse	200	15.0
CNM1	62	4.7
CNM2	170	12.8
CNM3	22	1.7
Assistant Director of Nursing	18	1.4
Director of Nursing	12	0.9
Other	38	2.9
Total	1,332	100.0

Grade and sex of respondents is shown in **Table D12**. It is interesting to note that 48% (n=43 of total 89) of male respondents are CNM1 or higher grade, while 19% (n=240 of 1239) of female are CNM1 or higher. There is no national data that can be used for comparative purposes.

Table D12: Sex and grade of respondents

	Female	%	Male	%	Total	%
Staff nurse/midwife	552	44.6	27	30.3	579	43.6
Senior staff nurse/midwife	213	17.2	16	18	229	17.2
PHN	199	16.1	0	0	199	15
CNM1	52	4.2	10	11.2	62	4.7
CNM2	145	11.7	24	27	169	12.7
CNM3	17	1.4	5	5.6	22	1.7
Assistant Director of Nursing	16	1.3	2	2.2	18	1.4
Director of Nursing	10	0.8	2	2.2	12	0.9
Other	35	2.8	3	3.4	34	2.9
Total	1,239	100.0	89	100.0	1,328	100.0

Current role

Current role is shown in **Table D13** below, with missing data for 19 cases.

Table D13: Current role

	Number	Valid %
Staff nurse/midwife	582	44.1
Senior staff nurse/midwife	237	17.9
Public health nurse	203	15.4
Clinical Nurse Specialist	65	4.9
Advanced Nurse practitioner	4	0.3
Manager	216	16.4
Other	14	1.1
Total	1,321	100.0

Specialties

51.5% reported that they worked in a specialist area. 82 specialties were specified. They are presented in **Table D14** below, grouped by area of practice. It is interesting to note the wide range of specialist areas within which nurses and midwives work.

Table D14: Specialist areas in which respondents work

GEN	PSY	MID	PH	SC	MH
Medicine: Endocrinology Ophthalmology Oncology Haematology Renal Respiratory Breast care Neurology Rheumatology Cardiology Rehabilitation Dermatology Physical disability	Alzheimer's/ Dementia	Post-natal-breast-feeding	Community mothers' programme	Medicine: including Dermatology Haematology Oncology Ophthalmology Renal Cerebral palsy Cystic fibrosis Physical disability	Profound Learning Disability
Surgery: Orthopaedics Urology ENT Wound clinic Phlebotomy	Acute care	Ultrasound	Immunisation programme	Surgery: including Orthopaedics ENT Urology Burns	Community care
Geriatrics	Addiction counselling	Neonatal unit	Pre-school services	ICU	Challenging behaviour
A&E	Community mental health Gynaecology	Family development Education	Day services		
Radiology Endoscopy	Long-stay care	Community midwifery/ DOMINO care	Carers' services	Neonatal Unit	High dependency
Infection control	Secure unit	Labour ward	Schools	A&E	Respite care
ICU	Eating disorders	Antenatal care	Child health	Theatre	Music therapy
Education	Child and adolescent psychiatry	Postnatal care	Liaison		Early intervention

GEN	PSY	MID	PH	SC	MH
Palliative care	Counselling	Women's health	Child sexual abuse		Education
Addiction counselling RGN in community care	ECT Autism	Lactation consultant Education	Refugee screening Travellers' health		Sports and leisure Palliative care ECT
Screening/ health education	Group work	Theatre	Services for homeless people		
Prison services	Day services		Genito-urinary medicine		
Research	Geriatrics				
Theatre	Prison services				
Practice nurse	Clinical placement coordination				
Occupational health	Education				
Clinical placement coordination					

Table D15 below presents the most frequently reported specialties.

Table D15: Main specialist areas in which respondents work

Specialty	Number
Geriatrics	141
Theatre	41
ICU	40
Neonatal unit	32
A&E	27
Challenging behaviour	26
Practice nurse	24

Work status

65.3% of respondents were in full-time employment, 34.7% in part-time employment. 29% (n=390) of respondents did not answer the question on whether they were in permanent or temporary employment. Of those who did answer this question, 85.2% were in permanent employment and 14.8% in temporary employment.

In the DATHs study 81.1% worked full-time, 18.9% part-time. 81.2% were permanent and 18.5% temporary [sic].

Location

57.4% work in urban areas, 22.2% in rural and 20.3% in both urban and rural areas.

Employer

The employer of respondents is shown in **Table D16**. Data was missing for 32 cases. Comparative data for public sector employers is shown in **Table D17.**

Table D16: Employer

Employer	Number	Valid %
Health Board/Area Health Board	910	69.6
Voluntary Hospital	174	13.3
Voluntary Services	75	5.7
Private sector institution (including GPs)	122	9.3
University	4	0.3
Other	23 1	0.8
Total	1,308	100.0

Table D17: Number of nurses in public sector employment by employer

Employer	Number	%
Health Boards	19,282	66.0
Voluntary hospitals	7,696	26.0
“Mental handicap homes”	2,199	8.0
Total	29,177	100.0

Source: Annual Health Personnel Census at 31.12. 2000

Overseas Practice

48.6% of respondents had practised outside Ireland, 40.4% of whom had practised overseas for two years or less, 44.2% for 3-9 years and 12.9% for 10-19 years, 2.5% for 30 years or more.

Appendix E

Responses to "understanding of empowerment" questionnaire in main survey

Table E1: "Understanding of empowerment": valid percentage per item

Item	Crucially important to empowerment	Quite important	Important	Somewhat important	A little important	I don't think that this item is related to empowerment
1 Being valued by my manager	44.5	28.7	19.2	3.9	1.3	2.3
2 Being an advocate for my patients/clients	57.7	27.4	10.6	2.2	1.0	1.2
3 Knowing what my scope of practice is	65.6	22.9	9.6	1.3	0.4	0.2
4 Having the skills to carry out my role	80.8	14.2	3.8	0.5	0.4	0.3
5 Being recognised for my contribution to patient care by my manager	36.2	32.5	22.6	5.5	2	1.2
6 Having access to resources for patients	47.3	30.5	17.3	2.8	1 1	
7 Delegating non-nursing tasks to auxiliary staff	22.4	26.5	27.1	10.7	4.4	8.9
8 Having a supportive manager	55.1	28.5	13 2	0.8	0.5	
9 Having support from my colleagues	50.1	33.7	13.1	1.9	0.8	0.4
10 Having effective communication with management	60.0	8.9	8.9	1.2	0.6	0.5
11 Being listened to by members of the multidisciplinary team	52.3	33.4	11.5	1.4	0.8	0.7
12 Being informed about changes in my organisation that will affect my practice	58.7	27.8	10.9	1.7	0.4	0.5
13 Having control over my practice	54.2	31.2	10.6	2.1	0.9	1.2
14 Being adequately educated to perform my role	71.8	20.3	5.6	1.1	0.9	0.2
15 Performing tasks that were previously performed by doctors and other professionals	9.3	19.0	21.5	15.4	6.5	28.3
16 Being able to say no when I judge it to be necessary	57.6	27.3	12.5	1.3	0.7	0.5
17 Being accountable for my practice	72.6	19.8	5.9	0.8	0.5	0.5
18 Being recognised as a professional by the medical profession	56	24.4	11.8	3.1	1.6	3.1
19 Being involved in nurse/midwife-led practice	39.9	31.5	16.7	4.6	1.4	6
20 Empowering my patients/clients	42.7	31.9	16.2	3.7	1.7	3.8
21 Having access to resources for staff education and training	49.0	34.2	12.9	1.9	0.6	1.4
22 Having autonomy in my practice	48.0	30.5	14.9	3.0	1.3	2.3
23 Having the back-up of my manager	57.2	29.4	10.6	1.4	0.5	0.9
24 Being recognised for my contribution to patient care by the medical profession	35.4	30.2	20.4	6.2	2.8	5.0

Table E2: Ranking of items relating to the understanding of empowerment: % ranked	Not Ranked	Ranked 1	Ranked 2	Ranked 3	Ranked 4	Ranked 5	Ranked 6	Ranked 7	Ranked 8	Ranked 9	Ranked 10
1 Being valued by my manager	64.0	9.1	5.2	4.3	2.7	2	2.2	2.2	2.3	2.7	3.4
2 Being an advocate for my patients/clients	49.0	12.6	6.6	5.6	5.4	4.3	3.0	3.1	3.8	3.5	3.0
3 Knowing what my scope of practice is	40.8	14.3	11	7.9	5.9	2.6	3.4	3.3	3.6	3.1	4.1
4 Having the skills to carry out my role	22.3	21	19.6	10.1	5.9	4.8	2.7	4.5	2.4	3.3	3.6
5 Being recognised for my contribution to patient care by my manager	78.8	1.7	2.5	3.0	2.6	1.7	2.0	1.5	2.4	1.4	2.3
6 Having access to resources for patients	59.8	1.6	4.2	7.3	4.0	4.4	3.7	3.5	3.5	3.5	4.6
7 Delegating non-nursing tasks to auxiliary staff	86	0.4	0.6	1.0	0.8	1.3	1.7	1.7	1.9	2.5	2.2
8 Having a supportive manager	51.3 4.5		5.5	5.4	6.7	5.4	5.4	3.6	5.2	3.2	3.7
9 Having support from my colleagues	54.2	1.6	3.8	4.7	5.4	6.8	4.8	5.7	3.2	4.9	4.9
10 Having effective communication with management	40.5	4.3	3.7	4.8	6.6	8.3	6.9 5	.7	7.0	6.2	6.0
11 Being listened to by members of the multidisciplinary team	52.6	1.8	2.6	3.7	5.0	5.6	5.3	6.1	5.9	6.0	5.3
12 Being informed about changes in my organisation that will affect my practice	52.3	0.8	1.8	3.1	5.4	6.1	7.0	4.8	5.8	6.9	6
13 Having control over my practice	55.7	4.3	3.7	4.4	4.5	5.0	5.4	5.0	4.0	3.5	4.5
14 Being adequately educated to perform my role	31.3	9.7	8.8	9.1	7	9.7	6.8	6.4	4.3	4.2	2.8
15 Performing tasks that were previously performed by doctors and other professionals	93	0.7	0.3	0.6	0.8	0.5	1.1	1.0	0.6	0.6	0.7
16 Being able to say no when I judge it to be necessary	47.5	2.9	3.4	4.1	4.9	6.4	7	6.0	7.3	6.6	4.0
17 Being accountable for my practice	35.5	5.7	6.3	7.3	7.4	6.5	6.8	6.9	7.1	5.6	4.9
18 Being recognised as a professional by the medical profession	68.8	2.3	2.0	2.3	3.7	2.6	2.7	4.5	3.6	3.1	4.4
19 Being involved in nurse/midwife-led practice	76.5	1.3	1.3	1.8	1.5	2.1	3.1	2.4	4.1	3.1	2.9
20 Empowering my patients/clients	63.4	2.6	2.5	2.3	2.9	3.8	3.1	5.2	4.8	4.6	4.8
21 Having access to resources for staff education and training	56.1	1.3	2.2	2.5	4.6	3.4	4.8	5.6	6.3	7.0	6.3
22 Having autonomy in my practice	61.5	4.4	3.0	3.5	4.3	3.3	4.6	4.5	4.0	4.0	3.0
23 Having the back-up of my manager	61.3	1.8	2.4	2.7	2.8	3.0	3.6	4.8	5.0	6.0	6.6
24 Being recognised for my contribution to patient care by the medical profession	75.7	1.8	1.5	1.6	1.4	1.2	2.6	1.5	2.9	3.5	6.3

Table E3: Rank order of items by sum of scores

		Sum of scores
1	Having the skills to carry out my role	6,752
2	Being adequately educated to perform my role	5,062
3	Knowing what my scope of practice is	4,766
4	Being accountable for my practice	4,155
5	Being an advocate for my patients/clients	3,935
6	Having effective communication with management	3,541
7	Having a supportive manager	3,269
8	Being able to say no when I judge it to be necessary.	3,019
9	Having control over my practice	2,794
10	Having support from colleagues	2,731
11	Being valued by my manager	2,731
12	Being listened to by members of the multidisciplinary team	2,602
13	Having access to resources for patients	2,535
14	Being informed about changes in my organisation that will affect my practice	2,461
15	Having autonomy in my practice	2,444
16	Having access to resources for staff education and training	2,192
17	Empowering my patients/clients	2,005
18	Having the back-up of my manager	1,951
19	Being recognised as a professional by the medical profession	1,764
20	Being recognised for my contribution to patient care by my manager	1,389
21	Being involved in nurse/midwife-led practice	1,248
22	Being recognised for my contribution to patient care by the medical profession	1,172
23	Delegating non-nursing tasks to auxiliary staff	674
24	Performing tasks that were previously performed by doctors and other professionals	418

Appendix F

Factor analysis on responses to main survey, re "understanding of empowerment"

Rotated Component Matrix – dichotimised data (removing 'not related to empowerment')

	COMPONENT			
	Factor 1	Factor 2	Factor 3	Factor 4
Being valued by my manager	0.65			
Being an advocate for my patients/clients				0.72
Knowing what my scope of practice is		0.50		0.42
Having the skills to carry out my role		0.65		
Being recognised for my contribution to patient care by my manager	0.57			
Having access to resources for patients				0.44
Delegating non-nursing tasks to auxiliary staff			0.52	
Having a supportive manager	0.77			
Having support from my colleagues	0.59			
Having effective communication with management	0.56	0.45		
Being listened to by members of the multidisciplinary team		0.47		
Being informed about changes in my organisation that will affect my practice		0.51		
Having control over my practice				
Being adequately educated to perform my role		0.67		
Performing tasks that were previously performed by doctors and other professionals			0.64	
Being able to say no when I judge it to be necessary				
Being accountable for my practice		0.49		
Being recognised as a professional by the medical profession			0.41	
Being involved in nurse/midwife-led practice			0.60	
Empowering my patients/clients	0.45	0.51		
Having access to resources for staff education and training		0.40	0.48	
Having autonomy in my practice			0.59	
Having the back-up of my manager	0.72			
Being recognised for my contribution to patient care by the medical profession	0.53		0.45	

Extraction Method: Principal Component Analysis. % variance explained 45.45%

Appendix G

Responses on scales of main survey

Table G1: Laschinger's Scales: valid percentage per item

How much of the following do you have in your present job?	None	None -some	Some	Some – a lot	A Lot
1. Challenging work	2.7	4.6	29.7	22.0	41.0
2. The chance to gain new skills and knowledge on the job	6.3	15.4	40.4	21.9	16.0
3. Tasks that use all of your own skills and knowledge	3.3	11.3	35.6	23.5	26.2
4. Information about the current state of your organisation-service	6.2	19.8	41.1	20.9	12.0
5. Information about the goals of top management	27.6	23.6	31.5	12.4	4.8
6. Information about the values of top management	29.9	25.8	30.1	9.9	4.3
7. Specific information about things you do well	30.6	22.6	28.7	13.1	5.1
8. Specific comments about things you could improve	27.3	24.2	33.8	10.9	3.7
9. Helpful hints or problem solving advice	20.5	22.8	37.2	14.6	4.8
10. Time available to do necessary paperwork	15.6	28.9	38.8	13.3	3.5
11. Time available to accomplish job requirements	8.2	24.7	42.4	20.8	3.9
12. Acquiring temporary help when needed	26.4	27.0	32.8	10.0	3.8
In your work setting	**None**	**None -some**	**Some**	**Some – a lot**	**A Lot**
1. The rewards for innovation on the job are	35.7	22.3	28.2	8.4	5.3
2. The amount of flexibility in your job is	12.6	17.5	40.3	18.6	11.0
3. The amount of visibility of your work-related activities within your organisation/service is	12.1	25.8	42.2	13.6	6.3
In your present job, how much opportunity do you have for these activities?	**None**	**None -some**	**Some**	**Some - a lot**	**A Lot**
1. Collaborating on patient care with doctors	8.8	15.4	37	18.5	20.3
2. Being sought out by peers for information	5.7	12.1	34.7	26.1	21.4
3. Seeking out ideas from professionals other than doctors, e.g., Physiotherapists, Occupational Therapists, Dieticians	10.7	13.5	33.8	22.8	19.2
	Strongly Agree	**Agree**	**Neither agree nor Disagree**	**Disagree**	**Strongly Disagree**
1. Overall, my current work environment empowers me to accomplish my work in an effective manner	8	43.6	25.3	18.2	4.9
2. Overall, I consider my workplace to be an empowering environment	6.1	32.1	28.9	26.3	6.6

Table G2: Meyer and Allen's Affective Commitment sub-scale: valid percentage per item

	Strongly Agree	Agree	Neither agree nor Disagree	Disagree	Strongly Disagree
1. I do not feel like part of a family at my workplace	7.6	15.0	22.5	40.3	14.6
2. I feel emotionally attached to my workplace	8.2	32.0	24.6	25.2	10.0
3. Working at my workplace has a great deal of personal meaning for me	12.4	46.4	23.3	13.9	4.0
4. I feel a strong sense of belonging to my workplace	11.7	44.8	25.2	13.6	4.7
5. My workplace does not deserve my loyalty	4.4	8.9	17.5	43.8	25.4
6. I am proud to tell others that I work at my workplace	22.0	47.9	21.1	5.8	3.2
7. I would be happy to work at my workplace until I retire	15.4	30.8	23.8	17.2	12.7
8. I really feel that any problems faced by my workplace are also my problems	7.4	31.6	26.3	26.2	8.6
9. I enjoy discussing my workplace with people outside of it	4.3	20.2	26.2	31.9	17.5

Table G3: Warr, Cook and Wall's Job Satisfaction sub-scale: valid percentage per item

		Extremely Dissatisfied	Very Dissatisfied	A Little Dissatisfied	Not Sure	A Little Satisfied	Very Satisfied	Extremely Satisfied
1	The physical work conditions	7.6	14.6	24	2.5	23.2	23.4	4.7
2	The freedom to choose your own method of working	1.8	6.6	16.6	7.6	25.4	35.2	6.8
3	Your fellow workers	0.8	2	9	5.7	18.3	49.1	15.1
4	The recognition you get for good work	8.9	14.8	17.8	12.1	24	17.9	4.4
5	Your immediate boss	6.8	8.4	12.3	9.3	20.1	30.7	12.4
6	The amount of responsibility you are given	2.6	5.9	8.9	5.6	19.4	45.6	12
7	Your rate of pay	11.6	14.4	18.3	4.4	28.1	20	3.1
8	The opportunity to use your abilities	3.7	8.5	15.9	6.1	26.1	32.3	7.4
9	Industrial relations between management and workers	9.5	13.2	18	17.7	19.9	18.5	3.1
10	Your chance of promotion	14.2	12.7	13.8	23.5	17.2	15.2	3.4
11	The way your organisation is managed	11.7	16.3	24.4	11.3	19.6 14		2.8
12	The attention paid to suggestions you make	7.3	13.1	18.7	11.4	28.2	17.7	3.6
13	Your hours of work	4.6	7.1	14.8	2.5	22.4	35.8	12.8
14	The amount of variety in your job	3.5	5.5	13.6	4	23.8	37.5	12
15	Your job security	3.8	3.5	3	6.4	11.9	44.5	27
16	The amount of challenge in your job	2.7	5.7	12.7	6	22.8	37	13.2
17	Taking everything into consideration, how do you feel about your job as a whole	2.3	5.5	12.5	5.7	27.4	36.8	9.8

Table G4: Levenson's Internality, Powerful Others and Chance Scale: valid percentage per item

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1. Whether or not I get to be a leader depends mostly on my ability.	15.2	38.5	13.6	23.5	9.4
2. To a great extent my life is controlled by accidental happenings.	2.0	13.1	19.6	48.2	17.1
3. I feel like what happens in my life is mostly determined by powerful people.	4.3	10.7	19.4	49.4	16.2
4. Whether or not I get into a car accident depends mostly on how good a driver I am.	3.0	16.9	18.6	42.3	19.2
5. When I make plans, I am almost certain to make them work.	12.6	60.4	18.3	7.8	0.9
6. Often there is no chance of protecting my personal interests from bad luck happenings.	4.0	22.3	29.2	36.8	7.6
7. When I get what I want, it's usually because I'm lucky.	1.2	6.8	18.4	61.1	12.6
8. Although I might have good ability, I will not be given leadership responsibility without appealing to those in positions of power.	10.0	30.6	17.0	34.2	8.1
9. How many friends I have depends on how nice a person I am.	5.6	29.9	22.8	32.2	9.5
10. I have often found that what is going to happen, will happen.	6.2	39.0	30.2	21.0	3.6
11. My life is chiefly controlled by powerful others.	1.2	5.8	15.1	55.9	22.0
12. Whether or not I get into a car accident is mostly a matter of luck.	2.6	20.4	23.8	41.3	11.9
13. People like myself have very little chance of protecting our personal interests when they conflict with those of strong pressure groups.	4.1	19.3	21.3	45.2	10.1
14. It's not always wise for me to plan too far ahead because many things turn out to be a matter of good or bad fortune.	1.8	16.3	20.8	49.5	11.5
15. Getting what I want requires pleasing those people above me.	2.6	16.7	19.9	46.7	14.0
16. Whether or not I get to be a leader depends on whether I'm lucky enough to be in the right place at the right time.	3.2	17.9	21.7	45.2	11.9
17. If important people were to decide they didn't like me, I probably wouldn't make many friends	1.1	5.5	11.9	53.2	28.2
18. I can pretty much determine what will happen in my life.	6.3	42.9	22.9	21.5	6.3
19. I am usually able to protect my personal interests.	10.5	75.4	9.8	3.4	0.9
20. Whether or not I get into a car accident depends mostly on the other driver.	2.4	17.7	34.4	37.3	8.2
21. When I get what I want, it's usually because I worked hard for it.	25.3	62.6	7.8	3.4	0.9
22. In order to have my plans work, I make sure that they fit in with the desires of people who have power over me.	2.5	20.6	27.1	41.0	8.9
23. My life is determined by my own actions.	22.0	56.6	14.7	5.9	0.8
24. It's chiefly a matter of fate whether or not I have a few friends or many friends.	2.3	6.2	17.6	56.4	17.5

Table G5: Mean scores on scales used in national survey

Scale	Number of items in scale	Mean	Number of missing cases	Number of values required for case to be included	New mean	New number of missing cases
CWEQ	12	11.29	144	8/12 *	11.30	28
IJS	7	4.51	138	6/7		35
EJS	8	4.55	156	7/8	4.48	37
JS	15	4.53	233	13/15**	4.49	36
Lev PO	8	3.52	94	7/8	3.52	35
Lev I	8	2.57	98	7/8	2.56	29
Lev Ch	8	3.45	89	7/8	3.45	25
Commitment	9	2.95	101	8/9	2.69	34
JAS	3	2.67	69			
ORS	3	3.32	28			
GE1	1	5.04	16			
GE2	1	5.00	17			
G JS1	1	2.68	32			
G JS2	1	2.95	56			

*1 missing from each of 4 sub-scales

** sum of IJS and EJS

Appendix H

Significant correlations between survey tools using Pearson's r correlation coefficient

	LEV-I	LEV-C	JS	CWEQ	JAS	ORS	M&A	GE1	GE2	JS1	JS2
LEV-PO	.076*	.558**	.277**	.203**	.181**	.159**	.133**	-.135**	-.163**	.166**	.207**
LEV-I			-.161**	-.154**	-.139**	-.096**	.181**	.142**	.144**	-.146**	-.116**
LEV-C			.103**	.070*		.092**				.089**	.080**
JS				.633**	.619**	.378**	-.558**	-.608**	-.627**	.594**	.710**
CWEQ					.629**	.420**	-.427**	-.517**	-.588**	.491**	.497**
JAS						.344**	-.368**	-.489**	-.515**	.364**	.452**
ORS							-.293**	-.311**	-.322**	.361**	.326**
M&A								.457**	.479**	-.423**	-.584**
GE1									.761**	-.386**	-.572**
GE2										-.408**	-.527**
JS1											.590**
JS2											

2-tailed significance: * 0.05; ** 0.01

Key:
LEV-PO: Levenson's Powerful Others sub-scale
LEV-I: Levenson's Internality sub-scale
LEV-C: Levenson's Chance sub-scale
JS: Overall Job Satisfaction score
CWEQ: Laschinger's Conditions for Work Effectiveness Scale
JAS: Laschinger's Job Activities Scale
ORS: Laschinger's Organisational Relationships Scale
M&A: Overall score for Meyer and Allen Affective Commitment sub-scale
GE1: Global Empowerment item 1 (Laschinger)
GE2: Global Empowerment item 2 (Laschinger)
JS1: Global Job satisfaction item (item 16, Job Satisfaction Scale)
JS2: Global Job satisfaction item (item 17, Job Satisfaction Scale)

Appendix I

Results of univariate analysis of variance

Table I1: UNIVARIATE ANALYSIS OF VARIANCE

	Area of practice	Further ed.	No. of qual	Geog. Region of practice	Grade	Overseas practice	Employer	Sex	Time in current job	Age
Opportunity sub-scale	**.000**	**.000**	.001	.002	**.000**	.208	**.000**	.335	.190	.638
Information sub-scale	.150	.087	.098	.423	**.000**	.003	.002	.788	.057	.018
Support sub-scale	.278	.697	.664	.145	**.000**	.002	**.000**	.687	.034	.030
Resources sub-scale	.003	.911	.047	**.000**	.005	.160	.010	**.000**	.181	.604
Cond. Work Effective	.835	.366	.811	.021	**.000**	.001	.001	.339	.006	.706
Job Activities Scale	.507	.434	.701	**.000**	**.000**	.085	**.000**	.423	.007	.736
Org. Relationships Sc.	**.000**	.002	.500	.030	**.000**	.422	.049	.601	.210	.012
Global emp. item 1	.043	.972	.231	.051	.001	.003	**.000**	.458	.765	.035
Global emp. item 2	.339	.720	.305	.235	**.000**	.001	**.000**	.272	.194	.026
Intrinsic job satis.	.002	.122	.021	.033	**.000**	.041	**.000**	.293	.105	.101
Extrinsic job satis.	.017	.240	.041	.073	**.000**	.081	**.000**	.704	.090	.027
Job satisfaction	.007	.123	.047	.037	**.000**	.061	**.000**	.451	.084	.045
Challenge in job	**.000**	.001	.001	.006	**.000**	.033	.240	.439	.232	.837
Global job satis.	.018	.124	.407	.178	**.000**	.003	.092	.177	.191	.022
Commitment	.006	.001	.136	.115	**.000**	**.000**	.005	.152	.014	**.000**
Levenson – Pow. Others	.222	.081	.401	.438	.036	.568	.002	.412	.048	.236
Levenson – Chance	.496	**.000**	.100	.199	**.000**	.231	.644	.240	.125	.054
Levenson – internality	.421	.230	.696	.080	.582	.465	.143	.709	.294	.628

Significant (<.001) variances shown in bold

The factors which showed significant variance for the dependent variables tested are shown below:

Table 12: Factors with significant variance for each scale

Scale/dependent variable	Factors with significant variance
Opportunity sub-scale	Area of practice Further educational qualifications Grade Employer
Information sub-scale	Grade
Support sub-scale	Grade Employer
Resources sub-scale	Geographical region Sex
Conditions for Work Effectiveness	Grade
Job Activities Scale	Geographical region Grade Employer
Org. Relationships Scale	Area of practice Grade
Global empowerment item 1	Employer
Global empowerment item 2	Grade Employer
Intrinsic job satisfaction sub-scale	Grade Employer
Extrinsic job satisfaction sub-scale	Grade Employer
Job satisfaction total score	Grade Employer
Item re. Challenge in job	Area of practice Grade
Global job satisfaction item- overall satisfaction with job	Grade
Meyer and Allen's Affective Commitment sub-scale	Grade Overseas practice Age
Powerful Others sub-scale	-
Chance sub-scale	Further education grade
Internality sub-scale	-

Area of practice

The scores for which significant variance in relation to area of practice of respondents were found were

- Laschinger's opportunity sub-scale
- Laschinger's Organisational Relationships sub-scale
- Warr Cook and Wall's global item on challenge in job

Table 13: Results for scales showing significant variance for area of practice

	Laschinger's opportunity sub-scale	Organisational Relationships sub-scale	Global item on challenge in job
RANGE	1-5 low to high access to opportunities	1-5 low to high informal power	1-7 Low to high challenge in job
General	3.49	3.30	4.95
Psychiatry	3.38	3.22	4.76
Sick children's	3.92	3.66	5.43
Midwifery	3.74	3.18	5.19
Public health	3.83	3.32	5.43
Mental handicap	3.46	3.29	4.75
Total mean	3.59	3.32	5.04

Laschinger's opportunity sub-scale
As can be seen from Table 4 the means across area of practice ranged from 3.38 for psychiatry to 3.92 for those in sick children's nursing. Post hoc tests (Scheffe and Least Small Differences (LSD)) were performed and showed the following significant variance (<0.05) between the following pairs:

- Sick children's and each of the following: general, psychiatry and mental handicap
- Public health and each of the following groups: general, psychiatry and mental handicap

The LSD test also showed significant variance between:

Midwifery and both general and psychiatry

Organisational Relationships scale
As can be seen in Table 4 the score for Laschinger's ORS ranged from 3.18 for midwifery to 3.66 for sick children's nursing, with a total mean of 3.32. Post hoc tests showed the following significant variances using both the Scheffe and LSD tests:

- Sick children's and each of the other groups: general, psychiatry, midwifery, public health and mental handicap

Warr, Cook and Wall's global item on challenge in current job
Regarding the amount of challenge in your current job, scores according to area of practice ranged from 4.75 for mental handicap to 5.43 for both sick children's and public health nursing. Post hoc tests showed significant variance between:

- Sick children's and each of the following: general, psychiatry and mental handicap
- Public health and each of the following: general, psychiatry and mental handicap

LSD test also showed significant variance between:

midwifery and both psychiatry and mental handicap

Educational qualification
The scores for which significant variance in relation to further educational qualification of respondents were found were:

- Laschinger's opportunity sub-scale
- Levenson's Chance sub-scale

Table 14: Results for scales showing significant variance for educational qualification

	Laschinger's opportunity sub-scale	Levenson's Chance sub-scale
RANGE	1-5 low to high access to opportunities	1-5 strong to weak belief in chance
No further educational qualification	3.43	3.34
Certificate	3.66	3.48
Diploma	3.67	3.50
Higher diploma	3.75	3.44
Degree	3.70	3.52
Master's degree	3.54 3	.60
Other	3.55	3.63
Total mean	3.59	3.45

Laschinger's opportunity sub-scale
Mean scores for Laschinger's Opportunity sub-scale ranged from 3.43 for those with no further educational qualification to 3.75 for those with a higher diploma. Scores appeared to increase with increasing educational level until Higher Diploma level but then fell for Degree and master's degree level. Post hoc tests identified significant variances between the following groups:

- No qualification and higher diploma level

LSD tests also revealed:

- No qualification with each of the following levels: certificate, diploma and degree

Levenson's Chance sub-scale
Mean scores for Levenson's Chance sub-scale ranged from 3.34 for those with no further educational qualification to 3.60 for those with a Master's degree (with 3.63 for those with "other" qualifications). In this case scores rose with increased educational level, except a slight fall for higher diploma. Post hoc tests showed the following significant variances:

- No qualification with both diploma and "other"

LSD test also showed:

- None with: certificate, degree and master's degree
- Other with: certificate and higher diploma

Geographical region of practice

The scores for which significant variance in relation to geographical region of practice of respondents were found were:

- Laschinger's resources sub-scale
- Laschinger's Job Activities scale

Table I5: Results for scales showing significant variance for geographical region of practice

	Laschinger's resources sub-scale	Laschinger's Job Activities scale
RANGE	1-5 (low to high access to resources)	1-5 (low to high formal power)
North-east	2.66	2.75
East	2.75	2.83
South-east	2.51	2.67
South	2.75	2.51
West	2.45	2.52
North-west	2.49	2.63
Midlands	2.49	2.45
Mid-west	2.51	2.60
Total mean	2.62	2.66

Laschinger's resources sub-scale
Mean scores for Laschinger's resources sub-scale range from 2.45 in the West to 2.75 in both the South and East. Using Post Hoc (Scheffe and LSD) tests significant variances are found between:

- West and east

LSD also found significant variances between:

- West and north-east

- East and each of the following: north-west, midlands, mid-west, south-east
- South and each of the following: south-east, west, north-west, midlands and mid-west

Laschinger's Job Activities scale

Mean scores for Laschinger's Job Activities Scale range from 2.45 in the Midlands to 2.83 in the east. Significant variance was found between:

- East and south

LSD:
- South and both north-east and midlands,
- East and each of the following: west, midlands and mid-west
- Midlands and north-east

Grade

The scores for which significant variance in relation to grade of respondents were found were:
- Laschinger's opportunity sub-scale
- Laschinger's information sub-scale
- Laschinger's support sub-scale
- Laschinger's CWEQ total score
- Laschinger's Job Activities scale
- Laschinger's Organisational Relationships sub-scale
- Laschinger's global empowerment item 2
- Intrinsic job satisfaction sub-scale
- Extrinsic job satisfaction sub-scale
- Job satisfaction total score
- Item re. Challenge in job
- Global job satisfaction item – overall satisfaction with job
- Meyer and Allen's Affective Commitment sub-scale
- Levenson's Chance sub-scale

Table 16: Results for empowerment scales showing significant variance for grade

	Opportunity sub-scale	Information sub-scale	Support sub-scale	CWEQ total	JAS	ORS	Global emp. Item 2
RANGE	1-5 low-high	1-5 low-high	1-5 low-high	4-20 low-high	1-5 low-high	1-5 low-high	1-5 high-low
S.N/Midwife	3.34	2.50	2.37	10.87	2.59	3.16	3.08
Senior SN/M	3.46	2.42	2.45	10.96	2.53	3.25	3.01
PHN	3.85	2.57	2.39	11.19	2.63	3.34	3.02
CNM1	3.81	2.78	2.58	11.81	2.75	3.75	2.84
CNM2	4.03	2.95	2.69	12.24	2.85	3.69	2.59
CNM3	3.97	3.12	2.65	12.42	2.63	3.5	2.91
Ass. DoN	3.78	3.59	2.87	13.15	3.04	3.39	2.67
Director Nurs.	3.97	4.25	2.69	13.72	3.50	3.78	2.25
Other	4.13	3.17	2.89	13.05	3.36	3.56	2.57
Total	3.59	2.63	2.47	11.30	2.67	3.32	2.95

Discussion of Laschinger's Scales' results

- On the Opportunity sub-scale, scores rise with increasing grade as far as CNM2 level when they fall. PHNs scores lie between CNM1 and CNM2 grades.
- On the Information sub-scale scores fall slightly from staff nurse/midwife (2.50) to senior staff nurse/midwife (2.42) and then increase with increasingly higher grades up to Director of Nursing level. PHNs scores lie between senior staff nurse/midwife and CNM1 grades.
- On the Support sub-scale scores increase from staff nurse/midwife (2.37) to CNM2 grade (2.69), falling for CNM3 (2.65) grade, rising for Assistant Director of Nursing (2.87) and then again falling for Director of Nursing grade (2.69). PHNs scores lie between staff nurse/midwife and senior staff nurse/midwife grades.
- On the overall CWEQ scale scores increase with grade, from 10.87 for staff nurse/midwife to 13.72 for Director of Nursing with no exception. PHNs scores lie between senior staff nurse/midwife and CNM1 grades.
- On the Job Activities Scale, scores fall from staff nurse/midwife (2.59) to senior staff nurse/midwife (2.53) and then rise from senior staff nurse/midwife up to CNM2 level, fall for CNM3 and then rise again for the remaining higher grades. PHNs scores lie between senior staff nurse/midwife and CNM1 grades.
- On the Organisational Relationships Scale, scores rise from staff nurse/midwife to CNM1, and then fall until Director of Nursing grade. PHNs scores lie between senior staff nurse/midwife and CNM1 grades.
- On the global empowerment item a higher score indicates lower empowerment. The staff nurse/midwife grade has the highest score and the Director of Nursing grade the lowest.

It is interesting to note that for all of Laschinger's scales except for the Resources sub-scale of CWEQ there was significant (<0.001) variance by grade. In fact the significance level for the resources sub-scale was 0.005, itself a fairly significant level. The mean score range for this sub-scale is from 2.42 for PHNs to 2.91 for Assistant Director of Nursing grade, with scores persistently falling between staff nurse/midwife (2.67) and CNM2 (2.57) grades then rising to

Assistant Director of Nursing grade (2.91), falling again for Director of Nursing grade (2.81). This is the only scale on which PHNs have the lowest score.

Table 17: Results for job satisfaction and other scales showing significant variance for grade

	Intrinsic Job satis	Extrinsic job satis	Job satis	Challenge	Global job satis	Commitment	Chance
RANGE	1-7 low-high	1-7 low-high	1-7 low-high	1-7 low-high	1-7 low-high	1-5 high-low	1-5 high-low
S.N/Midwife	4.27	4.35	4.31	4.68	4.81	2.79	3.39
Senior SN/M	4.35	4.43	4.39	5.00	4.95	2.63	3.45
PHN	4.74	4.61	4.68	5.46	5.26	2.74	3.52
CNM1	4.69	4.53	4.60	5.36	5.22	2.56	3.36
CNM2	4.90	4.64	4.76	5.49	5.37	2.56	3.52
CNM3	4.76	4.59	4.67	5.38	4.86	2.71	3.46
Ass. DoN	4.61	4.64	4.63	5.35	4.61	2.61	3.68
Director Nurs.	5.17	5.13	5.10	5.36	5.17	2.28	3.95
Other	5.23	5.15	5.19	5.81	5.11	2.40	3.61
Total	4.50	4.48	4.49	5.05	5.00	2.70	3.45

Discussion: Job satisfaction

- In all of the job satisfaction scales and items, CNM2s show high levels of job satisfaction. For the two global items their satisfaction score is higher than that of the Director of Nursing grade. For the intrinsic and overall satisfaction scales it is higher than for the Assistant Directors of Nursing and for extrinsic it is equal to that score of that grade.
- Director of Nursing grade scores are highest on intrinsic, extrinsic and overall job satisfaction scales.
- On intrinsic job satisfaction, scores initially rise with grade level, although dropping between CNM2 and CNM3, again dropping for Assistant of Nursing and rising for Director of Nursing. PHNs' mean score lies between CNM1 and CNM2 levels.
- On extrinsic job satisfaction, scores also initially rise with grade level, although drop between CNM2 and CNM3, rising for Assistant of Nursing and again rising for Director of Nursing. PHNs' mean score lies between CNM1 and CNM2 levels.
- On overall job satisfaction scores also initially rise with grade level until CNM3 level where they drop, again falling for Assistant Director of Nursing and rising for Director of Nursing. PHNs' mean score lies between CNM1 and CNM2 levels.
- On the global satisfaction item relating to challenge scores rise until CNM2 level, fall for CNM3 grade, falling again for Assistant Director of Nursing and rising slightly for Director level. PHNs' mean score lies between those CNM1 and CNM2 grades.
- On the global satisfaction item relating to overall job satisfaction scores rise until CNM2 grade (5.37), drop for CNM3 level (4.86), fall again for Assistant Director of Nursing (4.61) and rise substantially for Director level (5.17). PHNs' mean score lies between those CNM1 and CNM2 grades.

- On the affective commitment scale, a low score indicates higher commitment. The highest commitment is therefore found for Director of Nursing grade (2.28) and the lowest for Staff Nurse/midwife (2.79). In order of highest to lowest commitment the grades are located as follows: Directors (2.28), CNM1 and CNM2 (2.56), Assistant Director (2.61), Senior Staff nurse/midwife (2.63), CNM3 (2.71), PHN (2.74) and Staff Nurse/midwife (2.79).
- On Levenson's Chance sub-scale Directors of Nursing have the highest belief in chance affecting outcomes (3.95), while CNM1s have the lowest belief in chance (3.36). Between these groups lie (in order of high to low belief in chance) Assistant Director (3.68), PHNs and CNM2s (3.52), CNM3s (3.46), Senior staff nurse/midwife (3.45) and staff nurse/midwife (3.39).

Employer

The scores for which significant variance in relation to employer of respondents were found were:

- Laschinger's opportunity sub-scale
- Laschinger's support sub-scale
- Laschinger's job activities scale
- Laschinger's global empowerment item 1
- Laschinger's global empowerment item 2
- Intrinsic job satisfaction sub-scale
- Extrinsic job satisfaction sub-scale
- Job satisfaction total score

Table I8: Results for scales showing significant variance for employer

	Oppor-tunity	Support Activities	Job Scale	Global emp. 1	Global emp. 2	Intrinsic job satis.	Extrinsic job satis.	Job satis.
RANGE	1-5 low-high	1-5 low-high	1-5 low-high	1-5 high- low	1-5 high- low	1-7 low-high	1-7 low-high	1-7 low-high
Health Board	3.59	2.39	2.57	2.77	3.03	4.40	4.39	4.40
Vol. Hosp.	3.82	2.55	2.77	2.62	2.90	4.62	4.59	4.60
Vol. Service	3.60	2.59	2.95	2.59	2.89	4.64	4.68	4.66
Private sector	3.34	2.75	2.98	2.32	2.58	4.85	4.81	4.83
Other (n= 25)	3.60	3.04	3.25	2.23	2.27	5.28	4.99	4.08
Total mean	3.60	2.47	2.67	2.69	2.95	4.5	4.48	4.5

Discussion

- Respondents working for a Health Board/Area Health Board scored lowest on the support sub-scale of the CWEQ, the Job Activities Scale and the Intrinsic, Extrinsic and Overall Job satisfaction scales.
- Those working in the private sector scored lowest on the opportunity sub-scale, while those working in voluntary hospitals scored highest on this scale.
- Omitting the "other" group, those working in the private sector scored highest on the support sub-scale, the Job Activities Scale and the Intrinsic, Extrinsic and overall job satisfaction scales.
- Those working for a Health Board/Area Health Board scored highest on the global empowerment items – indicating lower empowerment. Again omitting the "other" group those employed in the private sector had the highest empowerment levels.

Sex

The scores for which significant variance in relation to sex of respondents were found were:

- Laschinger's resources sub-scale

Table I9: Results for scales showing significant variance for sex

	Laschinger's resources sub-scale
RANGE	1-5 (low to high access to resources)
Female	2.60
Male	2.96
Total	mean 2.62

The mean score for females (N= 1225) was 2.60 while that for males (N= 89) was 2.96. (Post hoc tests not relevant where only two groups)

Practised overseas or not

The scores for which significant variance in relation to overseas practice of respondents were found were:

- Meyer and Allen's Affective Commitment sub-scale

Table I10: Results for scales showing significant variance for overseas practice

	Meyer and Allen's Affective Commitment sub-scale
RANGE	1-5 high to low affective commitment
Practised outside Ireland	2.77
Did not practice outside Ireland	2.62
Total mean	2.69

Those who practiced outside Ireland had a significantly higher mean score of 2.77 than those who did not (2.62), indicating higher affective commitment of the latter group.

Age

The scores for which significant variance in relation to age of respondents were found were: Meyer and Allen's Affective Commitment sub-scale

Table I11: Results for scales showing significant variance for age

	Meyer and Allen's Affective Commitment sub-scale
RANGE	1-5 high to low affective commitment
20-29 years	2.87
30-39 years	2.81
40-49 years	2.66
50-59 years	2.54
60 years or over	2.40
Total mean	2.70

Affective commitment is shown to rise (i.e. scores fall) persistently with age, with a range of 2.87 for 20-29 year age-group to 2.40 for the 60 year or more age-group. Post hoc tests show significant variance between:

- 20-29 year olds and 40-49, 50-59 and 60 or over age-groups
- 30-39 year olds and 40-49, 50-59, 60 or over age-groups

LSD:

- 40-49 and 50-59 and 60 or over age groups

As can be seen from Table I1 there were no significant variances (<0.001) found in relation to number of qualifications or length of time in current job.

Appendix J

Regression analysis

Regression analysis was carried out to supplement the information gained from the Univariate Analysis of Variance. Therefore only those variables showing significant variance were included in the regression analysis.

For regression analysis, variables must be categorical and binary.

The following were already linear:
- Age
- Years in current job
- Number of qualifications

The following were not linear but already binary
- Sex
- Practised overseas or not

The other relevant variables were reworked as follows in **Table J1**. Groups were collapsed as appropriate in order to have an adequate number of cases and also to reduce the number of new variables created. In these cases a reference group must be chosen, with a new variable being set up for each of these other groups, to test their variance in relation to the base group.

Table J1: Variables created in relation to reference group for regression analysis

	Reference group	Variables created in relation to reference group
Area of practice	General	Psychiatry Sick Children's Nursing Midwifery Mental handicap Public health
Grade	Staff nurse/midwife	Senior staff nurse/midwife Public Health Nurse CNM1 CNM 2 or 3 Higher management (Assistant Director and Director of Nursing)
Employer	Health Board	Voluntary hospital Voluntary service Private sector
Educational qualification	None	Certificate Diploma (including Higher Diploma) Degree (including Master's)
Geographical region	East	North-east South-east West Midlands Mid-west South North-west

Multiple regression analysis was performed for all of the scales for which there were significant variances found in Univariate analysis.

A summary of the results from multivariate regression analysis of factors significant univariately (at p<0.005) in predicting scales and sub-scales.

Table J2: Results of regression analysis showing significant demographic factors and % variance explained

Scale	Significant Factors	% variance explained
Opportunity Sub-scale	CNM23 (p<0.001) PHN (p=0.005) Paed (p<0.001) Midwife (p=0.003) CNM1 (p=0.002) Higher manager (p=0.001) Western (p=0.007) Psychiatry (P=0.009)	13.1%
Information sub-scale	Higher manager(p<0.001) CNM23 (p<0.001) Voluntary service (p=0.011) Outside Ireland (p=0.011) Private sector (p=0.009)	8.0%
Support sub-scale	CNM23 (p<0.001) Private sector (p<0.001) Outside Ireland (p=0.004) Higher manager (p=0.022)	3.3%
Resources	Sex (p=0.002) Western (p<0.001) Seast (p<0.001) Nwest (p=0.001) Mwest (p=0.001) Midland (p=0.002) PHN (p=0.003)	6.7%
New CWEQ	CNM23 (p<0.001) Higher manager (p<0.001) Outside Ireland (p=0.004) CNM1 (p=0.039)	6.1%
Jobs activities scale	Private Sector (p<0.001) Higher manager (p<0.001) CNM23 (p=0.017) Voluntary service (p=0.002) Southern HB (p<0.001) Midland (p=0.004) Western (p=0.003) Mid western (p=0.018)	5.8%

Org. Relationship scale	CNM23 (p<0.001) Paediatrics (p<0.001) CNM1 (p<0.001) Higher manager (p=0.026) Diploma (p=0.033)	6.7%
Global empowerment 1	CNM23 (p<0.001) Private sector (p<0.001) Outside Ireland (p=0.012)	3.4%
Global empowerment 2	CNM23 (p<0.001) Private sector (p<0.001) Outside Ireland (p=0.002) Higher manager (p=0.004)	4.5%
Intrinisic job satis.	CNM23 (p<0.001) Private (p<0.001) CNM1 (p=0.009) Psychiatry (p=0.013) Higher manager (p=0.023) Mental health (p=0.047) Voluntary service (p=0.045)	6.7%
Extrinsic job satis.	Private sector (p<0.001) PHN (p<0.001) CNM23 (p=0.006) Higher manager (p=0.019) Voluntary Service (p=0.016) Voluntary hosp (p=0.021)	3.4%
Job satisfaction	Private sector (p<0.001) CNM23 (p<0.001) PHN (p<0.001) Higher manager (p=0.020) Voluntary hosp (p=0.027) Voluntary service (p=0.035)	4.8%
Challenge in job	CNM23 (p<0.001) PHN (p=0.021) Paed (p=0.002) Degree (p=0.022) CNM1 (p=0.002) Higher manager (p=0.008) Mental health (p=0.012) Psychiatry (p=0.018)	7.4%
Global job satis.	CNM23 (p<0.001) PHN (p<0.001) Outside Ireland (P=0.001)	2.7%
Commitment	Age (p<0.001) Outside Ireland (p=0.002) Degree (p=0.007) CNM23 (p=0.009) Higher Manager (p=0.045)	5.7%

Levenson – Powerful Others	Private hospital (p=0.001) Voluntary service(p=0.029)	1.2%
Levenson – Chance	Higher manager (p=0.001) PHN (p=0.031) Diploma (p=0.044) Degree (p=0.017)	2.4%

Table J3: A summary of the results from multivariate analysis of factors in predicting empowerment, job satisfaction and affective commitment scores

Scale	Significant Factors	% variance explained
CWEQ (empowerment)	Total job satisfaction score (p<0.001) Job Activities Scale (formal power) score (p<0.001)	49.8%
Job satisfaction scale	CWEQ (empowerment score) (p<0.001) Affective commitment score (p<.001) Job Activities Scale (p<0.001)	55.9%
Affective commitment	Total job satisfaction score (p<0.001) Levenson's Internality Score (p<0.001) Total CWEQ score (p<0.001) Levenson's chance score (p<0.001)	31.9%

Appendix K: Main survey questionnaire

Nurses′ and Midwives′ Understanding and Experiences of Empowerment in Ireland

Questionnaire

Please complete this questionnaire and return
in the enclosed PRE-PAID envelope as soon as possible

Many thanks
School of Nursing
Dublin City University

Please answer all of the following questions

1. Sex
   - Female ☐
   - Male ☐

2. Nationality Irish ☐
   - Other (please specify) ________________
   ____

3. Age Group 20-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60+ ☐

4. On which divisions of the An Bord Altranais register are you registered and in what year did you register? *(tick and fill in the year for as many as required)*

Division	Year of Registration
RGN	________
RSCN	________
RM	________
RPN	________
RMHN	________
PHN	________
RNT	________

5. What further educational qualifications do you have?
   - None ☐
   - Certificate ☐
   - Pre-registration Nursing Diploma ☐
   - Other Diploma ☐
   - Higher Diploma ☐
   - Degree ☐
   - Master's Degree ☐
   - Other (please specify below)

   ____

6. How many years of nursing/midwifery experience (including your training) do you have?

   ________ years *(to the nearest year)*

7. Where do you work?
   - A hospital *(Please go to Q.7a)* ☐
   - The community ☐
   - A hospital and the community ☐
   - Residential home ☐
   - Nursing home ☐
   - Other (please specify) ☐

7a. Does the hospital you work in have
   - Greater than 300 Beds ☐
   - Less Than 300 Beds ☐
   - Not applicable ☐

8. In what geographical area of Ireland do you practice?
   - North-East ☐
   - East ☐
   - South-East ☐
   - South ☐
   - West ☐
   - North-West ☐
   - Midlands ☐
   - Mid-West ☐

9. Which of the following grades are you?
   - Staff Nurse/Midwife ☐
   - Senior Staff Nurse/Midwife ☐
   - Public Health Nurse ☐
   - CNM1 ☐
   - CNM2 ☐
   - CNM3 ☐
   - Assistant Director of Nursing ☐
   - Director of Nursing ☐
   - Other ________________

10. What is your current role?
- Staff nurse/midwife ☐
- Senior Staff Nurse/Midwife ☐
- Clinical Nurse Specialist ☐
- Advanced Nurse Practitioner ☐
- Manager ☐
- Public Health Nurse ☐

11. How long have you been in your current post?

_______________ years *(to the nearest year)*

12. What is your current area of practice?
- General ☐
- Psychiatry ☐
- Paediatrics ☐
- Midwifery ☐
- Public Health ☐
- Mental Handicap ☐
- Other (please specify) ______________________________

____

13. How many years of experience in your current area of practice do you have?

_______________ years *(to the nearest year)*

14. Do you work in a specialist area?

Yes ☐ If yes, please specify ____________________

No ☐ ______________________________________

15. Is your job
- Full time ☐
- Part time ☐

16. Is your job
- Permanent ☐
- Temporary ☐

17. Is your work setting?
- Urban ☐
- Rural ☐
- Both ☐

18. Are you employed by
- Health Board/Area Health Board ☐
- A Voluntary Hospital ☐
- Voluntary Services ☐
- A Private Sector Institution ☐
- A University ☐
- Other (please specify) ______________________________

____

19. Have you practised as a nurse/miswife outside Ireland?
- Yes ☐
- No ☐

If yes, please specify length of time _________ yrs. *(to the nearest year)*

Your Understanding of Empowerment

The following items have been reported to be important to the meaning of empowerment. In this part of the questionnaire we are trying to identify what you consider to be the core elements of empowerment and those elements which are not quite so important.

1. Please fill out the scale by circling the relevant number for each of the 24 items listed below to indicate how important to empowerment the following items are. If you do not think that the item is related to empowerment please circle n/a (not applicable) for that item.

PLEASE SEE BELOW: Rank order (1-10) of top 10 most important items			Crucially important to empower-ment	Quite important	Important	Somewhat important	A little important	I don't think that this item is related to empower-ment
☐	1	Being valued by my manager	1	2	3	4	5	n/a
☐	2	Being an advocate for my patients/clients	1	2	3	4	5	n/a
☐	3	Knowing what my scope of practice is	1	2	3	4	5	n/a
☐	4	Having the skills to carry out my role	1	2	3	4	5	n/a
☐	5	Being recognised for my contribution to patient care by my manager	1	2	3	4	5	n/a
☐	6	Having access to resources for patients	1	2	3	4	5	n/a
☐	7	Delegating non-nursing tasks to auxiliary staff	1	2	3	4	5	n/a
☐	8	Having a supportive manager	1	2	3	4	5	n/a
☐	9	Having support from my colleagues	1	2	3	4	5	n/a
☐	10	Having effective communication with management	1	2	3	4	5	n/a
☐	11	Being listened to by members of the multidisciplinary team	1	2	3	4	5	n/a
☐	12	Being informed about changes in my organisation that will affect my practice	1	2	3	4	5	n/a
☐	13	Having control over my practice	1	2	3	4	5	n/a
☐	14	Being adequately educated to perform my role	1	2	3	4	5	n/a
☐	15	Performing tasks that were previously performed by doctors and other professionals	1	2	3	4	5	n/a
☐	16	Being able to say no when I judge it to be necessary	1	2	3	4	5	n/a
☐	17	Being accountable for my practice	1	2	3	4	5	n/a
☐	18	Being recognised as a professional by the medical profession	1	2	3	4	5	n/a
☐	19	Being involved in nurse/midwife-led practice	1	2	3	4	5	n/a

☐	20	Empowering my patients/clients	1	2	3	4	5	n/a
☐	21	Having access to resources for staff education and training	1	2	3	4	5	n/a
☐	22	Having autonomy in my practice	1	2	3	4	5	n/a
☐	23	Having the back-up of my manager	1	2	3	4	5	n/a
☐	24	Being recognised for my contribution to patient care by the medical profession	1	2	3	4	5	n/a

2. Now please rank the 10 items that you consider to be most important to the meaning of empowerment, from 1 to 10, where 1 is the most important, 2 is the second most important etc. by placing the numbers 1 to 10 in the relevant boxes to the left of the 10 items that you have selected.

Please add anything relating to your understanding of the term empowerment that you feel has not been covered by the above:

____

____

____

____

____

____

____

____

Your Experience of Empowerment

In this section we are interested in your experience of empowerment in your current workplace.

Please circle the number which best describes your response to the following:

How much of the following do you have in your present job?

		None		Some		A Lot
1.	Challenging work	1	2	3	4	5
2.	The chance to gain new skills and knowledge on the job	1	2	3	4	5
3.	Tasks that use all of your own skills and knowledge	1	2	3	4	5
4.	Information about the current state of your organisation/service	1	2	3	4	5
5.	Information about the goals of top management	1	2	3	4	5
6.	Information about the values of top management	1	2	3	4	5
7.	Specific information about things you do well	1	2	3	4	5
8.	Specific comments about things you could improve	1	2	3	4	5
9.	Helpful hints or problem solving advice	1	2	3	4	5
10.	Time available to do necessary paperwork	1	2	3	4	5
11.	Time available to accomplish job requirements	1	2	3	4	5
12.	Acquiring temporary help when needed	1	2	3	4	5

In your work setting:

		None		Some		A Lot
1.	The rewards for innovation on the job are	1	2	3	4	5
2.	The amount of flexibility in your job is	1	2	3	4	5
3.	The amount of visibility of your work-related activities within your organisation/service is	1	2	3	4	5

In your present job, how much opportunity do you have for these activities?

		None		Some		A Lot
1.	Collaborating on patient care with doctors	1	2	3	4	5
2.	Being sought out by peers for information	1	2	3	4	5
3.	Seeking out ideas from professionals other than doctors, e.g., Physiotherapists, Occupational Therapists, Dieticians	1	2	3	4	5

Please circle the number which best describes your response to the following:

		Strongly disagree	Agree agree	Neither agree nor	Disagree Disagree	Strongly
1.	Overall, my current work environment empowers me to accomplish my work in an effective manner	1	2	3	4	5
2.	Overall, I consider my workplace to be an empowering environment	1	2	3	4	5

In this section we are interested in how satisfied you are with various aspects of your job.

Please circle the number which best describes your response to the following:

		Extremely Dissatisfied	Very Dissatisfied	A Little Dissatisfied	Not Sure	A Little Satisfied	Very Satisfied	Extremely Satisfied
1.	The physical work conditions	1	2	3	4	5	6	7
2.	The freedom to choose your own method of working	1	2	3	4	5	6	7
3.	Your fellow workers	1	2	3	4	5	6	7
4.	The recognition you get for good work	1	2	3	4	5	6	7
5.	Your immediate boss	1	2	3	4	5	6	7
6.	The amount of responsibility you are given	1	2	3	4	5	6	7
7.	Your rate of pay	1	2	3	4	5	6	7
8.	The opportunity to use your abilities	1	2	3	4	5	6	7
9.	Industrial relations between management and workers	1	2	3	4	5	6	7
10.	Your chance of promotion	1	2	3	4	5	6	7
11.	The way your organisation is managed	1	2	3	4	5	6	7
12.	The attention paid to suggestions you make	1	2	3	4	5	6	7
13.	Your hours of work	1	2	3	4	5	6	7
14.	The amount of variety in your job	1	2	3	4	5	6	7
15.	Your job security	1	2	3	4	5	6	7
16.	The amount of challenge in your job	1	2	3	4	5	6	7
17.	Taking everything into consideration, how do you feel about your job as a whole	1	2	3	4	5	6	7

Please circle the number which best describes your response to the following:

		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1.	I do not feel like part of a family at my workplace	1	2	3	4	5
2.	I feel emotionally attached to my workplace	1	2	3	4	5
3.	Working at my workplace has a great deal of personal meaning for me	1	2	3	4	5
4.	I feel a strong sense of belonging to my workplace	1	2	3	4	5
5.	My workplace does not deserve my loyalty	1	2	3	4	5
6.	I am proud to tell others that I work at my workplace	1	2	3	4	5
7.	I would be happy to work at my workplace until I retire	1	2	3	4	5
8.	I really feel that any problems faced by my workplace are also my problems	1	2	3	4	5
9.	I enjoy discussing my workplace with people outside of it	1	2	3	4	5

Please circle the number which best describes your response to the following:

		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1.	Whether or not I get to be a leader depends mostly on my ability.	1	2	3	4	5
2.	To a great extent my life is controlled by accidental happenings.	1	2	3	4	5
3.	I feel like what happens in my life is mostly determined by powerful people.	1	2	3	4	5
4.	Whether or not I get into a car accident depends mostly on how good a driver I am.	1	2	3	4	5
5.	When I make plans, I am almost certain to make them work.	1	2	3	4	5
6.	Often there is no chance of protecting my personal interests from bad luck happenings.	1	2	3	4	5
7.	When I get what I want, it's usually because I'm lucky.	1	2	3	4	5
8.	Although I might have good ability, I will not be given leadership responsibility without appealing to those in positions of power.	1	2	3	4	5
9.	How many friends I have depends on how nice a person I am.	1	2	3	4	5
10.	I have often found that what is going to happen, will happen.	1	2	3	4	5
11.	My life is chiefly controlled by powerful others.	1	2	3	4	5
12.	Whether or not I get into a car accident is mostly a matter of luck.	1	2	3	4	5
13.	People like myself have very little chance of protecting our personal interests when they conflict with those of strong pressure groups.	1	2	3	4	5
14.	It's not always wise for me to plan too far ahead because many things turn out to be a matter of good or bad fortune.	1	2	3	4	5
15.	Getting what I want requires pleasing those people above me.	1	2	3	4	5
16.	Whether or not I get to be a leader depends on whether I'm lucky enough to be in the right place at the right time.	1	2	3	4	5
17.	If important people were to decide they didn't like me, I probably wouldn't make many friends.	1	2	3	4	5
18.	I can pretty much determine what will happen in my life.	1	2	3	4	5
19.	I am usually able to protect my personal interests.	1	2	3	4	5
20.	Whether or not I get into a car accident depends mostly on the other driver.	1	2	3	4	5
21.	When I get what I want, it's usually because I worked hard for it.	1	2	3	4	5
22.	In order to have my plans work, I make sure that they fit in with the desires of people who have power over me.	1	2	3	4	5
23.	My life is determined by my own actions.	1	2	3	4	5
24.	It's chiefly a matter of fate, whether or not I have a few friends or many friends.	1	2	3	4	5

There may be factors that you feel enhance and inhibit empowerment in the workplace. Please describe these below in your own words.

What factors do you think enhance empowerment?

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What factors do you think inhibit empowerment?

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If you have any other comments about this questionnairee, please add these below:

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Thank you very much for taking the time to complete this questionnaire – we really appreciate it.

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