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Factors that influence organizational commitment in nurse manager / subordinate dyads

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FACTORS THAT INFLUENCE ORGANIZATIONAL COMMITMENT

IN NURSE MANAGER/SUBORDINATE DYADS

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the Degree of Master of Science in Nursing

by

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FACTORS THAT INFLUENCE ORGANIZATIONAL COMMITMENT

IN NURSE MANAGER/SUBORDINATE DYADS

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Fort Hays State University, 2010

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ABSTRACT

According to Buerhaus, Auerbach and Staiger (2009), despite the current easing of the nursing shortage due to the recent recession and many nurses putting off retirement, the nursing shortage is projected to grow to approximately 260,000 registered nurses by the year 2025. Creating a work environment within nursing practice that is healthy and productive is essential to maintaining an adequate nursing workforce (Shirey, 2006). Nurse leaders play a vital role in creating work environments that are healthy, positive and productive.

The problems associated with decreasing levels of organizational commitment (OC) among staff nurses ultimately resulting in losing dedicated, skilled nursing staff are as follows: fiscal decline for the facility; decreased organizational skills and knowledge; and lower quality patient care. Without effective nurse managers contributing to maintaining and increasing OC among staff nurses, hospital budgets, skilled nursing care and, ultimately, quality patient care may be compromised (Naude & McCabe, 2005; Wilson, 2005). In a study by Upenieks (2003), highly effective leaders from prestigious magnet hospitals were found to possess people skills, such as "being visible" to their

staff, and being amiable and open in their communication. These skills are closely linked to the definition of emotional intelligence (EI).

The purpose of this investigation was to examine factors that influence OC in nurse manager/subordinate dyad. First, the EI and OC of nurse managers and staff nurses were measured. Next, the differences in the levels of EI and OC between nurse managers and their staff nurses were analyzed. Finally, the possible influence of various demographic variables (e.g., age, tenure in current position, and educational levels) on the EI/OC of nurse managers and staff nurses were examined.

The tools used in this study included two surveys and a demographic questionnaire. The tools included the Revised Emotional Intelligence Scale (EIS-41) originally by Schutte et al. (1998) and revised by Austin, Saklofske, Huang and McKenney in 2004 (Appendix B) and Meyer and Allen's (1991) Organizational Commitment Questionnaire (OCQ) (Appendix C). A short demographic questionnaire was also used (Appendix A). Completed surveys used for the investigation totaled 123 with 105 deemed useable for analysis ($N = 105$). This investigation looked at OC of nursing in relation to demographic factors and EI of nurses. Significant results of this study stated that there is a correlation between EI and OC of nurses, as has been seen in other recent studies (Carmel, 2003; Nikolaou & Tsaousis, 2002; Rozell, Pettijohn, & Parker, 2004). Tenure of nurses in their current position was also found to be a predictor for OC among nurses. No significant results were found between NMs level of EI and the OC of their SNs. Without effective nurse managers helping to maintain and increasing OC among nursing staff, quality patient care outcomes may be compromised (Naude &

McCabe, 2005; Wilson, 2005). More research is needed in the area of EI and OC to

strengthen the importance of the concept of EI in nursing and its connection to OC.

Within EI research, more valid tools are needed to accurately measure the construct of EI.

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CHAPTER 1 - INTRODUCTION

According to Buerhaus et al. (2009), despite the current easing of the nursing

shortage due to the recent recession and many nurses putting off retirement, the nursing

shortage is projected to grow to approximately 260,000 registered nurses by the year

2025. Creating a work environment within nursing practice that is healthy and productive

is essential in maintaining an adequate nursing workforce (Shirey, 2006). Nurse leaders

play a vital role in creating work environments that are healthy, positive and productive.

At the unit level, nurse leaders must work within a very stressful work environment,

dealing with subordinate staff as well as upper management simultaneously. According to

Naude & McCabe, (2005), without the commitment from subordinate nursing staff at the

unit level, quality nursing care and ultimately, nursing outcomes will suffer. In order to

retain quality, committed nursing staff, effective nurse leaders at the unit level are

imperative.

In a study by Upenieks (2003), highly effective leaders from prestigious magnet

hospitals were found to possess people skills, such as "being visible" to their staff, and

being amiable and open in their communication. These skills are closely linked to the

definition of emotional intelligence (EI). A simplistic definition of EI addresses,

according to Goleman, Boyatziz, and McKee (2002) is "how people handle themselves

and their relationships" (p.6). The concept of EI has received growing interest in nursing

management literature as being a key attribute of outstanding leaders. Many good leaders

possess high intellectual and technical skills, but exceptional leaders also possess skills in

personal and social competence (Goleman et al., 2002).

It is well documented that EI in nurse leaders affects the (OC) of their subordinates (Cho, Laschinger, & Wong, 2006; Humphreys, Weyant, & Sprague, 2003; Young-Ritchie, Laschinger, & Wong, 2009). A key challenge for nursing management is to maximize the productivity and tenure of employees by cultivating their commitment to the organization (Leach, 2005).

Organizational commitment involves three viewpoints: a sense of identification with the goals of the organization; a feeling of connection to the duties of the organization; and a feeling of loyalty to the facility (Morrow, 1993; Mowday, Steers, & Porter, 1982). Research on organizational commitment (OC) in nursing suggests that changes in acute care settings may pose a set of challenges for nurse managers who strive to maintain a committed and experienced staff within their facilities (Kleinman, 2004; Leach, 2005; Young-Ritchie, et al., 2009). The specific challenges found within the acute care setting are numerous and include workplace factors, such as high stress levels, various personal/demographic elements, inadequate compensation, and supervisor and co-worker support (Zeytinoglu et al., 2006). These are the very factors that are found to be *predictors* of whether nurses will remain with or leave their places of employment (Zeytinoglu et al., 2006). Therefore, these factors should be addressed by nurse managers to help maintain a quality nursing workforce.

One approach to addressing these issues that help maintain quality in nursing, is to put nurses who possess high EI skills at the top of the list for qualified nurse management positions. Managers with high EI could then recognize and address areas of stress in the work environment and help maintain and increase support among staff.

Historically, emotions or feelings have been considered too personal or unquantifiable to discuss in studies in a useful way within a rational leadership paradigm (Kets de Vries, 2006). Thus, research on emotional intelligence is scarce and still in its developmental stages (Akerjordet & Severinsson, 2007), and there is even less research that specifically addresses EI in nurse managers and its affect on OC. Examining the EI of nurse managers may help reveal the significance of understanding emotional and complex situations and their connection to retaining staff. More specifically, examining EI among nurse managers and discovering a relationship between EI and OC may lead to possible improvements in the area of middle management, thus helping to maintain a quality nursing workforce.

Statement of the Problem

Retaining experienced nursing staff in their place of employment is paramount to maintaining quality patient care. Several by-products of losing nurses in their areas of expertise include fiscal decline of the facility, and possible increase in litigation in facilities where greater numbers of less-experienced nursing staff work.

According to Wilson (2005), an important by-product of retaining nursing staff within a facility is enormous cost savings for the hospital. Kleinman (2004) agrees, and argues that nursing turnover is associated with increased patient care costs. An estimation of the turnover cost of a nurse ranges between 0.75 and 2.0 times the amount of the nurse's current salary (McConnell, 1999). In a study examining, in part, the same issues, Jones (2005) cited the turnover cost to be as high as 1.3 times the current salary.

Although monetary loss is of utmost importance in the current declining economy, it is also important to note that when a nurse leaves an organization, the knowledge, skill, and expertise the nurse brought to and gained within the organization is now gone (Naude & McCabe, 2005). This type of skill and experience takes at least six months, if not more, for a new employee to become fully functional at the level of the previously experienced employee (Naude & McCabe, 2005). Thus, one can understand that organizational commitment is critical in maintaining optimal quality in patient care outcomes (Wilson, 2005). In a worst-case scenario, poor patient care outcomes could lead to the possible demise of a patient, increased litigation for the hospital, and also contribute to an overall decline in the facility's reputation and moral of the staff.

In summary, the problems with decreasing levels of commitment among staff nurses ultimately resulting in losing dedicated, skilled nursing staff are as follows: fiscal decline for the facility; decreased organizational skills and knowledge; and lower quality patient care. Effective nurse managers can help ward off the problems associated with declining OC. Without effective nurse managers contributing to maintaining and increasing OC among staff nurses, hospital budgets, skilled nursing care and, ultimately, quality patient care may be compromised (Naude & McCabe, 2005; Wilson, 2005). Examining EI and OC in nurse managers may provide critical evidence to guide nurses in middle management positions toward the use of emotional intelligent behaviors that contribute to maintaining experienced subordinate nursing staff.

Purpose of the Investigation

The purpose of this investigation was to examine factors that influence OC in nurse manager/subordinate dyads. First, the EI and OC of nurse managers and staff nurses were measured. Next, the differences in the levels of EI and OC between nurse managers and their staff nurses were analyzed. Finally, the possible influence of various demographic variables (e.g., age, years of experience, and education) on the EI/OC of nurse managers and staff nurses were examined.

Significance of the Investigation

The National League for Nursing (2006) estimated that over 84,000 graduates in 2005 will become newly licensed Registered Nurses (RN). It is also thought that many of those newly licensed nurses will leave their places of employment within one year (Squires, 2002). Learning about the relationships between the EI and OC of nurse managers may help deter that type of turnover, as well as compel the discipline of nursing to focus more on EI as a factor found in effective nurse managers.

The importance of hiring effective, competent, and qualified nursing managers is sometimes taken for granted. In the past, nurse managers were not hired for their leadership or interpersonal skills, but because they had longevity within the unit and, thus, were automatically placed in these positions. Today, it is imperative that nurse leaders manage nursing units effectively and be able to develop and maintain strong, positive relationships with subordinates in order to maintain experienced staff. The EI of nurse managers may be a key to finding exceptional nurse managers who can accomplish these tasks.

Goleman et al. (2002) state that EI is the ability of an individual to understand the emotions and feelings of others, as well as their own. Four specific traits found within EI include the ability to manage groups, negotiate solutions, make personal links, and engage in social examination. According to Goleman et al., these skills demonstrate interpersonal polish, and assist in social achievement. People who possess such skills can easily form connecting relationships with others, accurately read other people's feelings and responses, successfully lead and organize other people and handle disputes. It seems fitting, therefore, to promote EI in the field of nursing, specifically nurse management. In nursing, it is obviously advantageous to form good rapport and positive relationships with subordinates. Social and interpersonal skills are undoubtedly part of nursing management, whereby nurse managers interpret and understand how subordinates are feeling, ascertain their motives and concerns, and demonstrate empathy and caring in times of stress. Furthermore, organizational and negotiating skills are required in collaboration both within the discipline of nursing and with other healthcare professionals.

Another implication of this investigation in the area of nurse management was to develop recommendations for specific testing of EI in perspective nurse managers. Specific tests for EI could be developed to measure EI abilities among nurse manager applicants to help determine their qualifications during an interview process. Thus, higher EI levels among the applicants would help administrators choose the best candidates for nurse manager positions. This may not stop at the level of the nurse manager or just in the discipline of nursing. With further research, EI testing could be completed on physicians,

nurses, nurse administrators, nurse educators, nurse practitioners, and physician assistants.

Another significant factor in this investigation concerns affective commitment on the part of the nurse manager. This is defined as the nurse manager wanting to stay within the organization and is considered to be an emotional commitment. This is, in large part, due to the immediate supervisor working with the nurse manager or a similar example in relation to this investigation would be the nurse manager working with the staff nurse. Being able to read others and tune in to the needs and wants of subordinates is one factor that causes a good manager to become a very effective and exceptional nurse manager. Exceptional nurse managers may cause staff nurses to want to stay, thus increasing OC and decreasing turnover. Retaining experienced, committed employees may then lead to better care for patients and higher satisfactions rates among patients. Thus, one significant result of this investigation, in the area of nurse management, may help to lead nurse administrators to look at EI when hiring nurse managers.

Theoretical Framework

The Caring Theory by Kristen M. Swanson was chosen as the theoretical framework for this investigation. Swanson's original middle range theory was developed from phenomenological studies in the area of perinatal nursing (Swanson, 1991). From these studies, five caring processes were established. These processes include *knowing, being with, doing for, enabling, and maintaining belief*. Each caring process has been defined and includes a subdimension that describes specific interventions for the nurse (see Table 1).

Table 1

Subdimensions of Swanson's Five Caring Processes

Knowing	- Avoiding assumptions - Centering on the one cared-for - Assessing thoroughly - Seeking cues
Being With	- Being there - Conveying ability - Sharing feelings - Not-burdening
Doing for	- Comforting - Anticipating - Performing competently/skillfully - Protecting
Enabling	- Preserving dignity - Informing/explaining - Supporting/allowing - Focusing - Generating alternatives/thinking it through - Validating/giving feedback
Maintaining Belief	- Believing in/holding in esteem - Maintaining a hope-filled attitude - Offering realistic optimism "Going the distance"

These specific directives for caring help in guiding the nurse to establish an effective caring relationship with the patient. In the nurse managers' position, this would include a caring relationship with the staff nurses of his or her unit.

Leininger (1986) stated that "caring is the essence of nursing" (p. 2). Unfortunately, the concepts of caring and managerial practice are found to be on opposite

ends of a spectrum (Watson, 2006). When staff nurses become nurse managers, their

focus changes from being patient-focused to department-focused (Mowday, Porter, &

Steers, 1979). The actual caring acts of nurse managers are frequently hidden, not valued,

looked down upon, and virtually ignored in the clinical setting (Watson, 2006). By using

Swanson's framework, the essence of nursing practice, namely caring, can be maintained

within a management setting.

Caring within nursing management has also been gaining support in nursing

research. Several studies have shown that when staff nurses feel listened to and valued,

and consideration is present between the nurse manager and staff nurse, retention is

maintained (Kleinman, 2004; Naude & McCabe, 2005; Scott, Sochalski & Aiken, 1999;

Shobbrook & Fenton, 2002; Tauton, Boyle, Woods, Hansen, & Bott, 1997). Thus, nurse

managers who show a caring attitude may also help to retain staff.

EI involves identification, processing, and managing emotions that enable the

nurse manager to cope with daily demands in a knowledgeable and supportive manner

(Matthews, Zeidner, & Roberts, 2007; Watson, 2006). Naude and McCabe (2005) stated

that one of the four main factors that has a positive effect on nurse retention is supportive

and effective management. While caring takes on many forms, factors such as valued,

supportive, and open communication would definitely be included in the caring process,

and are directly linked to the definition of EI. Swanson's (1991, 2000) five stated caring

processes convey a sense of being valued and considered. Thus, using Swanson as a

theoretical framework and applying her five caring processes, EI in nurse managers may

be identified as a contributing factor in maintaining or increasing OC (See *Figure 1*).
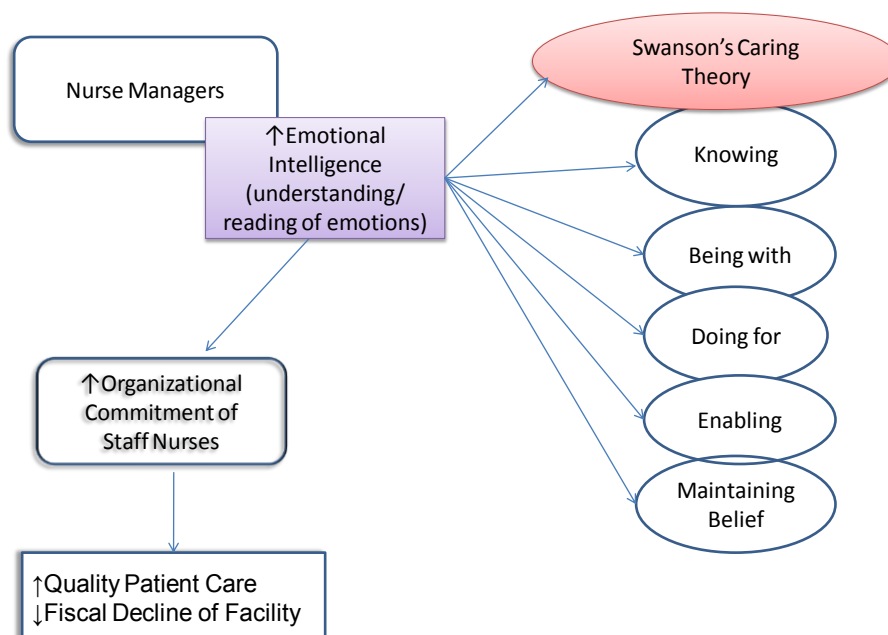
Figure 1. Model of the Association of NMs' EI to OC with Possible Outcomes

Definition of Variables

The theoretical definition of EI from Mayer, Salovey, and Caruso (2000, p. 267) is as follows: "an ability to recognize the meanings of emotions and their relationships, and to reason and problem-solve on the basis of them. EI is involved in the capacity to perceive emotions, assimilate emotion-related feelings, understand the information of those emotions, and manage them." In other words, a simple definition addresses "how people handle themselves and their relationships" (Goleman, et al., 2002, p. 6).

The operational definition of EI consists of four distinct dimensions from Wong and Law (2002). These dimensions include: (a) Appraisal and expression of emotion in the self-emotional appraisal (SEA). This relates to the individual's ability to comprehend her or his own deep emotions and to express emotions on a natural level. These

individuals are able to acknowledge and remain aware of their emotions better than most people. (b) Others' emotional appraisal (OEA). This is the ability to comprehend and perceive other people's emotions (e.g., I can tell my friends' emotions from their behavior). (c) Regulation of emotions in self (ROE). This is the ability to control one's own emotions and recover from psychological distress (e.g., I can handle, in a rational way, my anger and other difficulties that arise). (d) Use of emotions to facilitate performance, or use of emotion (UOE). This is the ability of the person to make use of her or his emotions by productive and useful activities.

The tool that was used to measure EI is *The Self-Report Emotional Intelligence Test* (SREIT) (Schutte et al., 1998). The SREIT is a 33-item self-report measure of emotional intelligence based on Mayer and Salovey's (1997) conceptualization of the construct. It was stated to have "good" reliability but no statistics were reported (Schutte et al., 1998).

The theoretical definition of organizational commitment (OC) is as follows: "an attitude bound by time and space and sustained through interactive processes that arises from the individual's acceptance of the organization's goals and values, a willingness to contribute to that organization's affairs, and strong desire to maintain a good relationship with the organization*"* (Liou, 2008, p. 120).

The operational definition of OC will be the three-component model developed by Meyer and Allen (1991). They concluded that three distinct ideas characterize an employee's commitment to her or his place of employment. The following includes their ideas:

Affective Commitment: This is the employee's emotional attachment to the workplace. The employee remains in the organization because she or he "wants to." The idea for this emotional commitment concept was drawn from earlier work by Mowday et al. (1979) and Kanter (1968).

Continuance Commitment: The employee is committed to the organization for two specific reasons: economic loss if she or he left and social costs of losing friends. More specifically, employees remain in the organization because they "have to."

Normative Commitment: The employee commits to and does not leave the organization because of "feelings of obligation." These feelings are derived from loyalty to the organization (i.e., people stay in their place of employment because they "ought to").

Organizational commitment was measured using Meyer and Allen's (1991) Organizational Commitment Questionnaire (OCQ). This tool uses a self-report format for the three previously defined categories including affective, continuance, and normative commitment. This self-report consists of 18 items; 6 items for each of the three subscales. Questions are aimed at determining commitment levels for each of the above categories. This tool uses an 5-point Likert-type scale connected to each dimension. Its acceptance as an instrument to measure the construct is supported by its worldwide use. Morrow (1993) reported Cronbach's alpha for the affective dimension was between .74 and .88; between .60 and .83 for the continuance dimension; and between .52 and .70 for the normative dimension.

Nurse managers was defined as unit coordinators and nurses in supervisory positions who oversee staff nurses, who possess a nursing license in their state of practice.

Research Questions

1. What is the contribution of EI of nurse managers to the OC of staff nurses?

2. Are there differences in levels of EI in nurse managers based on levels of education (i.e., diploma, LPN, ADN, BSN, MSN, and PhD)?

3. What is the relationship between nurses' years of experience in current position, age, and EI and their levels of OC?

4. What is the relationship between nurses' years of experience in current position and age and their levels of EI?

Assumptions

1. Organizational commitment of nurses is valued in the hospital setting.

2. The respondents responded honestly to the questionnaire(s).

3. The respondents who filled out the questionnaire(s) are who they claim to be.

4. Emotional intelligence is valued as a positive asset applied to nurse managers.

5. All hospitals want to retain experienced, well-qualified nurses

Delimitations

1. The use of a cross-sectional design may not fully capture the operational definition of OC, since OC is developed over time (Leach, 2005).

2. The convenience sample used in the investigation may cause selection bias and hinder the ability to generalize the results of the investigation.

Limitations

1. Self-assessment questionnaires were used as tools to measure EI and OC, thus bias and/or dishonesty concerning participants filling out the forms may be present.

2. Questionnaires completed on SurveyMonkey.com was the method of data collection and participants filling out questionnaires through this method may not be who they claim to be, thus results may be skewed.

3. A convenience sample was used and selection bias may be a possible result.

Summary

Organizational commitment among experienced nurses and nurse managers in hospitals is imperative. By retaining quality and experienced nurses quality patient care is maintained, hospital costs are decreased, and even litigation is diminished (Naude & McCabe, 2005; Wilson, 2005). Emotional intelligence among nurse managers is not emphasized within the hospital environment in relation to hiring mid-level managers, although it seems intuitively vital in obtaining maximally effective nurse managers. This investigation examined the association between nurse managers' EI and OC in the hospital setting. Thus, this investigation may contribute to research findings concerning EI of nurse managers and lead to more research in the area of EI in nursing leadership and management.

CHAPTER II – REVIEW OF LITERATURE

The theoretical and research literature related to emotional intelligence (EI) and organization commitment (OC) of nurse managers and staff nurses respectively, was organized into the following sections: (a) a brief history of EI; (b) the importance of emotional intelligence in nursing; (c) current research concerning EI in nursing; (d) current research concerning OC in nursing; and (e) current research that includes both EI and OC in nursing.

History of Emotional Intelligence

Since the beginning of time, humans have been trying to figure out how to "feel better" and get along with others (Freshman & Rubino, 2004). With the creation of the field of psychology, the area of interpersonal skills was addressed in a more formal way. The history of EI began with Thorndike (1920) and Gardner (1983), who stressed the importance of emotional awareness and understanding as vital components of social intelligence (Landy, 2006). Thorndike (1920) described the concept of "social intelligence" as the ability to get along with people, which is closely linked to today's definition of EI.

In the 1940s, David Wechsler began to write about the IQ of individuals and skill sets connected to this concept. Wechsler (1940) also described "non-intellective" intelligence skills as psychological skills that had to do with attitude, behavior, and change. Wechsler's premise suggested that affective components of intelligence might be essential to a successful life. In 1950, humanistic psychologist Abraham Maslow, known for "Maslow's Hierarchy of Needs," which is used in nursing school curriculums

throughout the country, described how people can build emotional strength. Other

personal and management competencies were described by Hemphill (1959) who

discussed issues such as trust, warmth, and respect, and Shostrum (1965), discussed self-

actualization as an important management trait to possess.   In 1983, the idea of "multiple

intelligences" was introduced by Gardner in his book, *The Shattered Mind,* and added

interpersonal and intrapersonal components to this idea (Freshman & Rubino, 2004). The

term "emotional intelligence" was non-existent until Payne (1986) introduced the term in

his unpublished doctoral dissertation entitled "A study of emotion: Developing emotional

intelligence; self-integration; relating to fear, pain and desire (theory, structure of reality,

problem-solving, contraction/expansion, tuning in/coming out/letting go)."

Finally, in 1990, as a result of their landmark article entitled "Emotional

Intelligence," psychologists Salovey and Mayer were credited for first defining EI. Their

definition states, "Emotional intelligence reflects not a single trait or ability but rather, a

composite of distinct emotional reasoning abilities: perceiving, understanding, and

regulating emotions" (Salovey & Mayer, 1990, p. 189). Their concept of EI was not

popularized until Daniel Goleman's (1995) book "Emotional Intelligence: Why It Can

Matter More Than IQ." Goleman made EI a popular term and connected it to leadership.

While controversies exist within the area of EI and several models and measures

have been developed, this study focused on the ability-based model by Goleman (1995),

which includes five major components: self-awareness, self-regulation, motivation,

empathy, and social skills. Freshman and Rubino (2004) point out that many of the daily

duties performed by healthcare managers or leaders can be placed within these five EI

skill categories (See Table 2). How a manager completes these tasks is directly connected

to the manager's EI abilities.

Table 2

EI Skill Sets and Relationship to Healthcare Administration (Freshman & Rubino, 2004)

EI skills set	Definition	Administration Application
Self-awareness	A deep understanding of emotions and drives	- decisiveness - issues about control - personal assessment - burnout/workaholism - personal value/self-worth
Self-regulation	Adaptability to changes and control over impulses	- ethical behavior - temper/patience - favoritism/nepotism - multi-tasking/time management - objectiveness
Motivation	Ability to enjoy challenges and to be passionate toward work	- being positive - counter downsizing/ cutbacks - organizational culture concerns - emphasizing cost controls - employee/physician meetings
Empathy	Social awareness skill: the ability to put oneself in another's shoes	- bioethical issues - patient centeredness - patient/family interventions - employee problems - employee assistance programs
Social Skills	Supportive communication skills: abilities to influence and inspire	- negotiation techniques - being attentive - personal evaluation - figurehead role - governing board/committee relations

Emotional Intelligence in Nursing

In traditional nursing programs, student nurses were instructed to hide their

emotions and thus, maintain a professional boundary with their clients (McQueen, 2004).

Focusing on the "tasks at hand" helped nurses maintain this boundary. Over the last

decade, there has been a movement away from nurses keeping their distance and hiding

their emotions from their clients (Williams, 2000). Benner (1994) stated that the

significance of the holistic approach used by nurses has been recognized, and a closer

relationship is necessary for this type of care to be accomplished. In holistic care, nurses

experience professional intimacy and emotional responses to the suffering of their

debilitated patients (McQueen, 2004). Thus, nurses are more exposed to both the physical

and emotional distress of patients on a day-to-day basis. McQueen conclusively states

that expressed emotions of the caregiver are more acceptable in nursing care today.

Clearly, there is a need for nurses to be able to manage their emotions, as well as read the

emotions of others, in order to offer emotionally intelligent help and support (Staden,

1998). Understanding the emotions of others, as well as managing one's own emotions, is

one definition of EI (Goleman, 1995).

Another factor concerning the importance of EI is related to caring. It is

interesting to note that in Swanson's Theory of Caring (1991), the five categories

(including subcategories) or "processes" from this theory include: (a) knowing, (b) being

with, (c) doing for, (d) enabling, and (e) maintaining belief. EI is a concept that falls

under the category of the art of nursing and includes factors closely related to the caring

process. EI fits well into the "processes" outlined by Swanson's theory. Discussing the background of EI and its connection to caring in nursing will help to clarify the importance of this concept in nursing (See Table 2).

If caring for the whole person includes both the art and science of nursing, EI would conclusively be an important construct to take into consideration within the discipline. Taking the idea one step further would include emphasizing the importance of front-line leaders or nurse managers caring for "the caregivers." This *caring* on the part of the nurse manager would include EI. A manager with a high level of EI may cause the staff to feel cared for and want to stay in their place of employment.

Research in Emotional Intelligence in Nursing

Discussion concerning EI can be found in the literature in the areas of nursing leadership, nursing practice, and nursing education (Smith, Profetto-McGrath, & Cummings, 2009). The following are research studies including EI and the previously-mentioned categories. Examining each area of research concerning EI will help clarify its importance in nursing.

Nursing Leadership

A study by Humphreys, Weyant, and Sprague (2003) that included staff nurses examined the relationship between leader behavior and follower commitment, and the emotional and practical intelligence of both the leader and the follower. Surveys were distributed to the employees of a regional medical center located in the Southwestern United States. A total of 213 surveys were used for analysis. These employees were not specified as *nursing* employees.

Organizational commitment was measured using the 15-question Organizational Commitment Questionnaire (OCQ) developed by Mowday et al.(1982). The alpha coefficient for this sample was .88. The OCQ has demonstrated reliability and validity across numerous studies (Beck & Wilson, 2000; Cooke, 1997). Leadership behaviors were measured with Bass and Avolio's Multifactor Leadership Questionnaire (MLQ5X short form). The alpha coefficient was .96. Emotional intelligence was measured using a survey by Carson, Carson, and Birkenmeier (2000). An overall internal reliability coefficient of .72 was obtained. Finally, practical intelligence was measured using the Global scale of Epstein's Constructive Thinking Inventory (CTI). A five-point scale was used to provide a general measure of individual practical intellect. The internal reliability coefficient was .84.

Ten hypotheses were tested using Pearson's Product Moment Correlations. Significant findings from the study included Laissez-faire leadership had a negative correlation with organizational commitment $r(213) = -.401, p < .05$. Practical and emotional intelligence was positively correlated with organizational commitment, $r(213) = .183, p < .01; r(213) = .184, p < .01$, respectively. Organizational commitment was positively correlated with transformational and contingent reward leadership, $r(213) = .283, p < .01; r(213) = .342, p < .01$, respectively. Finally, highly committed followers rated their leaders as more transformational than followers who did not exhibit the same degree of OC. Strengths included detailed definitions of each variable used in the study.

Limitations of this study included inconclusive reporting of reliability and validity on the four tools used in the study. Sample size seemed adequate but was not defined specifically by the authors. The term *employees working in the hospital* was not well defined and could be applied to anything from housekeeping staff to physicians. The importance of this study for this investigation is that the study exhibited a positive relationship between employees' emotional intelligence abilities and their levels of commitment to their organization. This relationship is one that was examined in the investigation using nurse managers as the specific population.

Nursing Practice

The purpose of this quantitative, correlational study by Kooker, Shoultz, and Codier (2008) was to measure EI as related to performance levels of clinical staff nurses and also to collect data on career/organizational variables. These variables included demographic and career oriented variables such as clinical ladder participation and current area of nursing practice. A website provided the survey to be completed by participants. Data were also collected on 36 nurses from three urban hospitals in Honolulu, Hawaii. The tool used to measure EI was the MSCEIT V2 (version 2), which is the Mayer Salovey Caruso Emotional Intelligence Test (Mayer, Salovey, & Caruso, 2002). Internal consistency was reported to be .91 and test-retest reliability was .86. Content and construct validity for this instrument was considered strong.

Results for this study included evidence that staff nurses' performance levels were positively related to EI ($p < .05$). The significance value was the only statistic provided throughout the study. No tables or correlational statistical results were provided by the

authors. It is important to note that a majority of nurses in this study scored below average on the total and subscores of EI. Limitations for this study included a very small sample size, and the nurses were younger than average for nurses in Hawaii. This study does warrant further investigation using a larger sample size. The study was important to this investigation since it points to the fact that EI is associated with effectiveness in clinical nurse performance. This current investigation looked specifically at the EI of nurse managers.

A study by Prati, Yongmei, Perrewe, and Ferris (2009), examined the role of EI in the surface acting strain relationship. Prati et al. connected surface acting strain closely with emotional labor. Emotional labor was defined by Hochschild (1983) as the physical and psychological management of feelings in order to express organizationally accepted or required emotions. Surface acting was described as an employee's ability or inability to hide her or his true emotions. This is not seen as a *choice* by the employee (Trougakos, Beal, Green, & Weiss, 2006). For example, if an employee was depressed or had somatic complaints, the organization would not find it acceptable to portray a continually depressed state or have constant complaints of physical ailments while at work.

This correlational study specifically asked if higher levels of EI were related to a weaker relationship between surface acting and strain (i.e., depression at work, somatic complaints). A total of 220 employees and managers from a retail bookstore chain located in the southeastern part of the United States completed surveys concerning EI, surface acting, depressed mood at work, and somatic complaints. Emotional intelligence was measured using the Self-Report Emotional Intelligence Test (SREIT; Schutte et al.,

1998). Surface acting was measured using Grandey's (2003) five-item scale. Depressed

mood at work was measured by a 10-item depressed mood scale by Quinn and Shepard

(1974). Somatic complaints were measured by House and Rizzo's (1972) somatic anxiety

scale. A control variable, negative affectivity was also measured using the 10-item

Positive and Negative Affect Schedule (PANAS). Most scales reported good internal

consistency ratings. Results indicated that higher EI levels were associated with lower

levels of depressed mood and somatic complaints (β = -0.13, p < .05).

The strengths of the study were that it contributes to the area of emotional

intelligence and its importance in regard to stress coping. Even though this study did not

specifically use nurses in the sample, surface acting is evident in nursing practice and

should be considered as a possible topic for future nursing research. Limitations were the

cross-sectional design and self-report measures. One reason this study applied to this

investigation is that the tool used to measure EI was found to be valid and reliable and

was used in this current investigation.

Nursing Education

Benson, Ploeg, and Brown (2009) conducted a study describing the EI scores of

baccalaureate nursing students to determine if there were differences in EI scores over a

four-year nursing program. This descriptive study used a cross-sectional design with 100

female nursing students (25 students every year for four years). Emotional intelligence

was measured using the Bar-On Emotional Quotient Inventory: Short (EQ:iS) (Bar-On,

2002). This tool is a self-report measure of emotional intelligence. Validity and reliability

were stated to be "robust and sound," but no statistics were provided. Since there are

known differences in how males and females respond to EI surveys, only females were used in the study. Female students were randomly chosen each new school year. A $100 gift certificate to the university's bookstore was provided for those students who agreed to participate in the study.

Results indicated EI scores of the baccalaureate students to be within appropriate emotional and social function. Thus, these students were identified as being able to establish fulfilling interpersonal relationships, and work well under pressure. The difference in total EQ scores between students in the first year and the fourth year was statistically significant $p < .05$, as were the scores in the interpersonal and the stress management subscales $p < .05$, with students in the fourth year scoring above those in the first year. Limitations for this study included the small and gender-specific sample size and the cross-sectional design. The authors did mention that this study was a precursor for a future longitudinal study where males and all age groups would be included. This study reiterates that with age or over time, EI may increase in the nursing student population.

<p style="text-align:center">Research in Organizational Commitment in Nursing</p>

Discussion concerning OC can be found in the literature in the areas of nursing leadership, nursing practice, and nursing education (Humphreys et al., 2003; Kovner & Brewer, 2009). The following are research studies including OC and the previously-mentioned categories. Examining each area of research concerning OC will help clarify its importance in nursing.

Nursing Leadership

A descriptive, correlational study by Leach (2005) was completed to investigate the relationship between nurse executive leadership style, including nurse executives (NEs) and nurse managers (NMs), and organizational commitment among registered nurses in an acute care hospital setting.

Two self-report survey instruments, as well as a demographic survey were mailed to the subjects (i.e., NEs, NMs, and RNs). A total of 102 NEs, 148 NMs, and 651 RNs completed and returned the surveys. The instruments used were the Transformational Leadership Profile (TLP), which measures transformational and transactional leadership, and the Organizational Commitment Scale, which had Cronbach's alpha ratings of $\alpha = .63 - .88$ and $\alpha = .79 - .82$, respectively. These statistics were stated within the text of the study, but in examining the table for the TLP instrument, it appeared the lowest Cronbach's alpha rating was actually .42. Cronbach's alpha rating for the TLP in one subscale of the instrument was less than adequate, thus, internal validity may have been weak for the study. Description of the TLP included a 50-item, 5-point Likert-type scale with responses from 1 (strongly disagree) to 5 (strongly agree). Transformational leadership was measured using questions addressing *credible leadership*, and *caring*, *creative*, and *confident leadership* (Marshall, Rosenbach, Deal, & Peterson, 1992). Transactional leadership was measured addressing *capable management* and *reward equity* (Sashkin, Rosenbach, Deal, & Peterson (1992).

Results included a statistically significant, inverse correlation between nurse executive transformational and transactional leadership and organizational commitment

$r(101) = -.24$; $r(101) = -.31$, $p < .05$, respectively. (Note: Leach (2005) used "alienative

commitment" as her measure of OC; which is the negative end of a continuum and is

labeled as being "highly intense and negative involvement" in the organization. Thus, an

inverse relationship would be the expected outcome in this instance.) A positive

association was demonstrated between NE and NM leadership $r(247) = .23$, $p < .05$.

Finally, a statistically significant negative relationship was demonstrated between NM

transformational leadership and RN commitment $r(146) = -.22$; $p < .05$. The use of a

cross-sectional design within the study was considered to be a limitation since it is

believed that commitment develops over time, thus a longitudinal study would be more

appropriate.

The results of this study demonstrate that NE leadership does have an effect on

the type and degree of commitment experienced by RNs. This study would lead into this

current investigation by focusing specifically on the NM's role concerning a specific facet

of leadership style (i.e., EI) and its relationship to organizational commitment.

Laschinger (2009) used a cross-sectional, non-experimental design to test an

expanded model of Kanter's (1977) theory connecting unit level leader-member

exchange (LMX) quality and structural empowerment to psychological empowerment

and OC at the individual level. A stratified cluster sampling design was used with 3,156

staff nurses surveyed. The variables measured in the study included LMX quality,

structural and psychological empowerment, core self-evaluation (CSE), and OC.

Cronbach's alphas for all tools were reported as appropriate.

The results of the study provided support for a multilevel model of OC in nursing that demonstrates both unit-level and individual level predictors of staff nurse OC. At the individual level, CSE had a significant positive effect on psychological empowerment ($\beta = .333$) and this in turn had a significant positive influence on OC ($\beta = .386$). At the unit level, LMX quality had a significant direct effect on structural empowerment ($\beta = .202$), which in turn had a significant direct effect on individual-level nurses' psychological empowerment ($\beta = .672$) and job commitment ($\beta = .392$). The results of this study showed that the quality of the relationship between the unit managers and their staff nurses is vital in creating empowering work environments that promote OC.

Limitations include a cross-sectional design. Strength included well-designed, multi-item, validated scales that were used with a large sample. One limitation was that the researchers did not report the internal consistency reliabilities of the four instruments for their sample. A reason this study was important for this investigation on was that OC was one of the variables being measured and this was done at the unit manager level.

Nursing Practice

DeCicco, Laschinger, and Kerr (2006) used a non-experimental descriptive study with a correlational and directional component. The hypotheses developed for this study were stated as follows: (a) "Long-term care staff nurses' perceptions of structural and psychological empowerment will be positively related to feelings of respect." (b) "Long-term care staff nurses' who perceive their workplace to have high levels of structural and psychological empowerment and respect for employees will have high levels of affective commitment to the organization." By using Kanter's (1977) theory of structural

empowerment as their theoretical framework, a sample of nurses from Canada examined the relationships between nurses' perceptions of structural and psychological empowerment, respect, and organizational commitment.

A random sample of long-term care staff nurses (N =154) was taken. The tools used within the study were the following: (a) Work Effectiveness Questionnaire-II (CWEQ-II), used to measure staff nurses' perceptions of empowerment. The Cronbach's alpha levels ranged from .78 to .93. (b) Spreitzer's (1995) 12-item Psychological Empowerment Questionnaire that measures four components of psychological empowerment. Cronbach's alpha was reported to be .93 for this study. (c) Three questions from the Esteem Subscale of the Effort Reward Imbalance Questionnaire were used to measure respect. Cronbach's alpha ranged from .70 to .91. (d) The affective commitment subscale from Meyer, Allen, and Smith's (1993) Organizational Commitment Questionnaire was also used to measure affective organizational commitment. This questionnaire as a whole has well-established reliability and validity coefficients. The reported reliability coefficient from this study was .82.

Using the Statistical Package for Social Sciences (SPSS) software, results were analyzed using descriptive and inferential statistical methods. Results of the study indicated a significant relationship between structural empowerment and respect, which corresponds to the first stated hypothesis β = .42, t = 4.05, p =.0001; β = .33, t = 3.15, p = .0001. The second hypothesis of the study was also supported. Structural and psychological empowerment as well as respect were all significantly related to organizational commitment (p = .0001).

While reliable and valid instruments were used in this study, the authors only used "parts" of two of the instruments, which may alter their reliability and validity. The sample of staff nurses in nursing homes would also be difficult to generalize to the population, thus decreasing the external validity of the study.

While the hypotheses used in this study included one variable that matched the current investigation, the study would be important in that it did show a strong relationship between empowerment of employees and organizational commitment. Nursing leaders, especially in management positions, have the ability to promote empowerment among their staff.

Nursing Education

Gould and Fontenla (2006) conducted a qualitative study to explore the areas of job satisfaction, opportunities to attend continuing professional education activities, family-friendly policies in the workplace, and how they are related to nurses' organizational commitment. This exploratory study used an in-depth approach to interview 27 nurses. All nurses who were asked to be interviewed agreed. The nurses interviewed were from two different areas. One area was a small non-teaching hospital in an inner city. The second group was from a large teaching hospital in the United Kingdom with an international reputation. A purposive sample was completed in the second group to even out the standard hospital nursing unit and the highly innovative nursing unit.

Open-ended questions were used and respondents were to identify factors that contributed to their commitment to nursing and to their place of employment. If

continuing education was not suggested, it was introduced by the interview guide. All interviews were completed by the same individual in a quiet room away from clinical traffic areas. Tape-recorded interviews were completed with permission and transcribed data were analyzed to discover recurrent themes.

Results included topics that were found to be specific to securing OC and job satisfaction. The most important topic was family-friendly policies that were connected to increasing commitment in nurses. Higher levels of job satisfaction were seen in those nurses who had jobs that had professional autonomy and entailed social hours. Professional continuing education had less influence on OC. A limitation of this study was its small sample size. Strengths were found in the detailed quotes found within the study and careful attention to detail was apparent.

Emotional Intelligence and Organization Commitment in Nursing

To date, few studies have captured a clear picture of the relationship between EI and OC. The following are current research studies that have used EI and OC specifically within their study.

Research Studies

Young-Ritchie et al. (2009), used a predictive, non-experimental design to examine the relationship between emergency nurses' perceptions of supervisors' emotionally intelligent leadership behavior, structural empowerment, and affective organizational commitment. A random sample of 300 emergency staff nurses working in acute care hospitals in Ontario, Canada, was obtained from the provincial registry. A total of 206 nurses completed three surveys including the Emotional Competency Inventory,

the Conditions for Work Effectiveness Questionnaire-II, and the Affective Subscale of the Organizational Commitment Questionnaire (OCQ). The OCQ was reported to have adequate reliability and validity ratings. Other tools mentioned in this study did not have reliability or validity coefficients reported.

Using path analysis, the statistical results of this study supported the authors' hypothesis that perceived emotionally intelligent leadership behaviors had a strong direct effect on affective commitment ($\beta = .61$). Thus, this study was found to support the theoretical framework of Kanter's (1977) theory of structural power which asserts that having access to strong interpersonal relationships, information, support, resources, and opportunities empower employees to accomplish meaningful work. This study also emphasized the importance of leadership behavior on working conditions for nurses as well as organizational effectiveness.

Affective commitment is the employee's emotional attachment to her or his place of employment. The employee remains in the organization because he/she "wants to" (Meyer & Allen, 1991). Since this study supported emotional leadership behaviors and affective commitment, a subscale of organizational commitment, it was important in this current study to be aware of how leadership *style* may also be linked to OC. Since the emotional aspect of leadership style was mentioned, this could be closely related to the EI component of this investigation. Specifically, looking at staff nurses' emotional connection to their place of employment, and how leadership style may play a role in this connection, is very closely related to this investigation.

A descriptive correlational study by Kleinman (2004) took place in a 465-bed community hospital located in the Northeastern part of the US. All nurse managers and staff nurses from the ambulatory and acute care settings were invited to participate. The first purpose of this study was to describe the relationship between perceptions of nurse managers' leadership behaviors (independent variable) and staff nurse turnover rates (dependent variable). The second purpose was to compare leadership behaviors (dependent variable) exhibited by nurse managers, as perceived by the nurse managers (independent variable), and nursing staff (independent variable).

After obtaining approval from the hospital's Institutional Review Board, packets containing a letter of purpose, demographics, and the Multifactor Leadership Questionnaires (MLQ), which was the instrument used to measure leadership behaviors, were placed in each potential participant's mailbox. A total of 79 staff nurses and 10 nurse managers, all working on the day shift (7:00 am – 3:00 pm) responded to the survey ($N = 89$). Thus, the small and specific sample sizes were a weaknesses found in the study; internal validity was weakened and generizabilty was not feasible.

Results included a single significant correlation between *active management by exception* as perceived by staff nurses with nurse staff turnover rate $r(87) = .26, p = < .01$. The attribute of *visibility* had a significant negative correlation with perception of staff nurses' whose managers had a laissez-faire type leadership style $r(272) = −.40, p = \leq .01$. Thus, findings stated that staff nurses who have limited interaction with their nurse managers' have a less favorable perception of their managers' leadership style.

The leadership style that would cause them to remain in their current place of employment, and possibly develop organizational commitment to the facility, was active management by exception. Thus, importance of findings included educating nurse managers' to remain *visible* to staff nurses on *all* shifts on their units as well as remain active in management behaviors with nursing staff.

With minimal significant correlational findings, more research was found to be needed in the area of nursing management and nursing turnover. Since nursing turnover may be related to organizational commitment, this study was important in that it addresses variables related to this current investigation of nursing management and organizational commitment.

A study by Güleruz, Güney, Aydin, and Asan (2008) examined the relationships between EI, job satisfaction, and OC of nurses, as well as the mediating effects of job satisfaction between EI and OC. Questionnaires were distributed to 550 nurses working at different departments of a hospital in Ankara, Turkey, with a total of 267 questionnaires accepted for analysis. A three-part questionnaire was completed by the nurses in Hacettepe University Hospital. Emotional intelligence was assessed by using the Emotional Intelligence Questionnaire (EIO; Wong and Law, 2002). Job satisfaction was assessed by using the Job Diagnostic Survey by Hackman and Oldham (1975). The organizational commitment questionnaire by Mowday et al. (1979) was used to assess OC. There was no report on reliability or validity for these instruments. Results included a significant and positive correlation between EI and both job satisfaction $r(267) = .236$, $p < .01$ and OC $r(267) = .229$, $p < .01$. A significant positive relationship was found

between job satisfaction and OC $r(267) = .667$, $p < .01$. Job satisfaction was also found to be significantly related to subcategories of EI, including both "regulation of emotion" (ROE) and "use of emotion" (UOE). Thus, job satisfaction was found to be a mediator between EI and OC.

Limitations to this study were the use of self-reports for all three variables in the study. There was no report on the validity or reliability of the instruments used. This study applies to this investigation because it measured both EI and OC, which are the specific variables used in the current investigation.

Nikolaou and Tsaousis (2002) conducted a correlational study in mental health institutions to explore the relationship between EI and sources of job stress and outcomes. A total of 212 professionals from mental health institutions participated in the study. These professionals filled out the Emotional Intelligence Questionnaire (EIQ); (Tsaousis, 2003) which measures four dimensions of EI: perception and appraisal of emotions, control of emotions, understanding and reasoning of emotions, and use of emotions for problem solving. Another tool used in this study was the Organizational Stress Screening Tool (Cartwright & Cooper, 2002). Results showed a negative association between EI and occupational stress, which indicated that those who had high EI experience less workplace stress. A positive association was found between EI and OC, which indicates that EI is a possible indicator of employee OC or loyalty to the organization. No reliability or validity was reported.

Limitations for this study included the use of a mental health facility, thus generalizations would be difficult. In addition, a cross-sectional correlational design was

used; therefore, causal explanations were not possible. This study was important for my current in that it used the same variables within the study (i.e., EI and OC); however, sampling was vastly different.

The next correlational study by Yang and Chang (2008) investigated how nursing staff affected job satisfaction and OC when emotional labor was performed. Thus, from the perspective of the nursing staff, the association between emotional labor, job satisfaction, and OC was examined. In this study, emotional labor was defined by using Hochschild's (1983) definition and was stated by the authors as the expression or suppression of feelings in order to produce an appropriate state of mind in others; it is a sense of being cared for in a safe place (Yang & Chang, 2008).

The sample consisted of 295 nursing staff in a teaching hospital in Taiwan. Emotional labor was assessed by a 24-item scale that measured five dimensions of emotional labor (Lin, 2000). Internal consistency reliability was .75 to .86. Job satisfaction was measured using the short form of the Minnesota Satisfaction Questionnaire (Weiss, Davis, England, & Lofguist, 1967). This was a 20-item scale measuring both intrinsic and extrinsic satisfaction. Internal consistency measured at $\alpha =$ .83 to .92. Finally, OC was measured using the Organization Commitment Questionnaire developed by Mowday et al. (1982). Internal consistency for this tool was $\alpha = .83$ to .92.

Results included the emotional display rule, which is a subdimension of emotional labor. The Emotional Display Rule (EDR) was significantly and negatively related to job satisfaction, meaning that when EDR increased job satisfaction decreased $r(295) = -.29$, $p < .01$. Surface acting also had a negative relationship with OC, meaning when surface

acting increased OC decreased $r(295) = -.23$, $p < .01$. Deep acting (DA) significantly and positively correlated with job satisfaction $r(295) = .30$, $p < .01$. Finally, job satisfaction was found to be significantly and positively correlated with organizational commitment $r(295) = .76$, $p < .01$.

Strengths for this study included an adequate sample size and the instruments used had adequate internal consistency. Limitations for this study included its cross-sectional design, thus causality cannot be tested. Also, since a teaching hospital was used, this study could not be generalized to all hospitals. The importance of this study included the fact that the variables used in the study were closely related (one exact match) to this current investigation. In addition, a positive correlation was found between emotional labor and OC and, since emotional labor has been described as a subdimension of emotional intelligence, that also helps to connect this study to the current investigation (Yang & Chang, 2008).

A correlational study by Humphreys, Brunsen, and Davis (2005) was conducted to determine if the emotional structure of those who worked directly with patients was related to their commitment to the organization. Self-report surveys were distributed to 105 direct healthcare workers (i.e., nurses, respiratory therapists, radiology technicians, etc.), employed by a small regional medical center. Self-report surveys measured EI, emotional coping ability, and affective OC. The tool used to measure EI was Carson, Carson, and Berkenmeier's (2000) Emotional Intelligence Survey. This tool measures the subdimensions of empathetic response, mood regulation, interpersonal skills, internal motivation, and self-awareness. The sample produced an internal consistency reliability

coefficient of .72. Emotional coping ability was measured using the Constructive

Thinking Inventory (CTI) (Epstein, 1993). This 108 item self-report scale measures

automatic and destructive thinking. Affective OC was measured using a 15-question

OCQ by Mowday et al. (1979). The alpha coefficient for this sample was .88.

Results included a significant association between EI, emotional coping ability,

and OC. Another finding stated that emotional intellect was a moderating variable

between coping ability and commitment, meaning direct healthcare workers who

displayed higher emotional coping abilities were more committed when EI was high

rather than low. Limitations to this study included a cross-sectional design and a small

sample size. This study was the first of its kind to use the constructs of emotional

intellect, coping ability, and OC using a sample that included direct healthcare workers.

This study was important to this current investigation because the variables of EI and OC

were used in this investigation. It did not explicitly use nurses in the example, but the

sample did contain some nurses.

Summary of Research

The literature review included literature from 2002 to 2009, with most of the

articles from 2008 and 2009. This supports the notion that EI is a recent topic of interest

in nursing. Each research article concerning EI contained a different tool to measure EI.

Most studies stated adequate reliability and validity for the tools used, but not all

included statistical analysis to defend their statements. The tool used most often to

measure OC was the Organizational Commitment Questionnaire (OCQ), in which

reliability and validity has been found to be adequate and is the tool of choice for this investigation (Mowday et al., 1979).   .

The variables included in the literature were mainly EI and OC. Other variables included leader behavior or style, job satisfaction, job stress, surface-acting strain relationship, empowerment, and nursing turnover rates. Emotional labor was also a variable in one study and is a subdimension of EI (Yang & Chang, 2008). Leadership was a common variable associated with EI and OC. This was important for this investigation since nurse managers' levels of EI were measured. Transformational leadership was the specific type of leadership most often positively correlated with OC (McGuire & Kennerly, 2006). This is important to note since transformational leadership is the type of leadership more closely linked to EI than the other types of leadership (e.g., transactional or Lassez-Faire); (Daus & Ashkanasy, 2003). Empowerment was another variable found within both the EI and OC literature, thus this could also be linked to the type of leadership subordinates would be connected to and would affect the level of empowerment these subordinates would be able to possess.

Research articles concerning EI and education were difficult to find and was considered a major gap found in nursing research. One descriptive study concerning baccalaureate nursing students and level of EI was located. This is significant in the fact that many scholars believe EI can be learned and improves over time (Goleman et al., 2002). Adding EI to the nursing curriculum may help increase awareness of an important construct at the student level and may improve nursing in the area of leadership and management.

Several of the studies had a positive correlation between EI (or a subdimension of EI) and OC (Güleruz et al., 2008; Humphreys et al., 2003; Nikolauo & Tsaousis, 2002; Yang & Chang, 2008; Young-Ritchie et al., 2009). Finally, most of the above literature used correlational studies with the independent variable being leadership, leadership styles, or administrative leadership. While OC was used as a dependent variable in most of these studies, nurse retention was also used since it is closely related to OC.

Based on the literature review, it was conclusively determined that nursing literature supported an association between EI and OC (Güleruz et al., 2008; Humphreys, et al., 2003; Kleinman, 2004; Nikolauo & Tsaousis, 2002; Yang & Chang, 2008; Young-Ritchie et al., 2009).

While the above literature review appears to support this investigation, no research was found that specifically addressed *nurse managers'* EI and OC. This investigation will be non-experimental and comparative in nature, and it is specifically designed to fill the gap on this topic in nursing research. Hopefully, this investigation will identify significant relationships among these variables but, if not, it will certainly add to nursing's body of knowledge in the area of EI and OC.

CHAPTER III – METHODOLOGY

This chapter addressed the research design, sample characteristics, sample size, data collection method, instruments, and data analysis used for this investigation.

Research Design

This investigation used a cross-sectional, quantitative, non-experimental design. Because the investigation compared the variables EI and OC and no intervention was used, it is a non-experimental design. The investigation was placed at a Level IV design (Polit & Beck, 2008). Data collection took place at one point in time and was considered cross-sectional. Participant responses were submitted via SurveyMonkey, an online survey administration website. Thus, online questionnaire administration was the method of data collection. By allowing participants to respond via the Internet, the convenience and, hopefully, perceptions of anonymity using this method helped increase the response rate.

The intent of the investigation was to collect data concerning nurse managers' self-ratings of EI, staff nurses' ratings of their managers' EI, and staff nurses' self-ratings of OC. Demographic data including age, education, and years of experience from both nurse managers and staff nurses was examined in terms of their relationships to EI and OC to address the research questions for this investigation and to provide insights for possible future studies.

Type of Participants and Sample Selection Process

The first sample for this investigation was nurse managers from hospitals in the Midwest. This was a probability sample. Three hospitals known to this researcher and

who agreed to participate were used for this investigation, due to convenience and this researcher's connection to these facilities. Letters containing information about the investigation, researcher, major professor, and contact information were hand delivered and sent via email by this investigator to the nurse administrators and health administrators of these hospitals. After permission was granted by the hospitals, meetings were set up with nursing staff explaining the investigation and access to SurveyMonkey was presented. One hospital did not allow meeting with the nursing staff in person and only placed the surveys on the email list server. If computer access was not available, hard copies of each tool was provided to the nursing staff.

The second sample consisted of staff nurses working on the same units as the nurse managers noted above. Matching staff nurses to nurse managers (nurse manager/subordinate dyads) was completed through a coding technique through SurveyMonkey within the demographic survey. Education levels of the staff nurses and nurse managers participating in the study included the following: Doctoral Degree (PhD), Master of Science in Nursing (MSN), Bachelor of Science in Nursing (BSN), Associate Degree Nurses (ADN), Diploma, and Licensed Practical Nurses (LPN) and Certified Nurse Aide (CNA).

<div align="center">Sample Size</div>

The purpose of an effect size (ES) was to provide the reader with the magnitude of effects within the research sample, which is an important issue connected to evidence-based practice (Polit & Beck, 2008). Power analysis uses effect size and three other factors to determine the sample size for an investigation to reduce the risk of making a

Type II error (i.e., failing to reject the null hypothesis when the null hypothesis is false).

The four components involved in power analysis included: significance criterion (α),

sample size (*N)*, ES, and power (1 − β), (Polit & Beck, 2008).

For this investigation the probability of rejecting a false null hypothesis was .80 or

80% power. The risk for a Type I error (α) was .05. The effect size (ES) was based on

the inferential statistics used to analyze the data. Since no pilot study was located, Polit

and Beck (2008) state that when there are no relevant earlier findings, researchers use

conventions based on expectations of a small, medium, or large effect, with most nursing

studies being modes. Thus, relevant information obtained from comparable studies

having the same independent and dependent variables as this investigation were used and

the estimated population correlation was found to be approximately .35. Thus, our sample

size was 140 for staff nurses. Projected nurse manager sample size was 63, using the

same power analysis as with staff nurses, with .50 being the ES for nurse managers'

calculations.

Finally, in an attempt to prevent a Type II error, data collection continued until

completed questionnaires from at least 140 staff nurses and 63 nurse managers were

received or for 3 weeks, whichever came first. To help increase the response rate, follow-

up reminders in an email format were sent to all possible participants after a 2-week

waiting period. This principle investigator also visited 2 of the participating hospitals to

remind them in person during this time.

It is important to keep in mind that power analysis only provides an estimate

based on a single test using a single inferential statistic (e.g., a *t*-test). With the use of

multiple statistical tests, as was used in this investigation, the results of a single power

analysis will become erroneous.

<div align="center">Protection of Human Subjects</div>

Human rights were protected for this investigation by the following:

1. Approval was obtained from Fort Hays State University's Nursing Research

    Ethics Committee (NREC) and an exemption status was obtained. Recommended

    changes were completed prior to this approval.

2. Implied consent was understood if surveys were completed by the participant.

    This was explained in the informed consent-survey cover letter provided for this

    investigation (Appendix A). Information contained in the informed consent

    included: (a) an overview including details to inform the potential participants of

    the requirements of the investigation but not so much information that it might

    introduce experimenter bias, (b) contact information for this researcher and major

    professor including; name, address, phone number, and credentials; (c)

    participation was voluntary and any questions or concerns were referred to this

    researcher; (d) the investigation results will be shared for educational and research

    purposes only; (e) confidentiality was maintained throughout the investigation, (f)

    risks to participants was minimal; (g) data obtained was via a self-report method;

    (h) to ensure confidentiality all statistical results were presented in aggregate

    form; and (i) the investigation performed was a course requirement for the

    purpose of obtaining a Master's in Nursing Administration degree at Fort Hays

    State University, as well as further development in the area of nursing research.

3. The website used for questionnaires pertaining to the investigation were set up with the NM and staff nurses having the opportunity to gain access to SurveyMonkey.com and connected to their respective surveys via a hyperlink. The hyperlink was provided in person, with a short presentation and through email to each nurse manager and staff nurse of each facility.

4. All returned survey forms were secured through the SurveyMonkey.com website. No names were included on the survey forms to ensure anonymity. Statistical analyses were completed using only aggregated data in the Statistical Package for Social Sciences (SPSS) program. To ensure confidentiality, a password entry flash drive device specified for the investigation was used to back-up the research investigation information. It was kept in a locked drawer in the researcher's desk. SurveyMonkey results were kept secured through the websites security feature.

Data Collection Procedure

After NREC approval was obtained and a status of "exempt" was given, hospitals within close proximity and known to this researcher were contacted. Directions via a cover letter (Appendix A) were emailed directly to the nurse administrators, nurse managers and health administrator of each participating hospital explaining the investigation. Informed consent containing a brief summary of this investigation was provided. If the nurse managers agreed to participate a formal presentation was offered and provided to the staff briefly explaining the investigation and surveys to be completed via an on-line format, if computer access was available. Hard copies of the surveys were

also provided along with a secure collection device if computer access was not available or participants choose not to fill out via computer format.

Each nurse manager and staff nurse who agreed to the survey was asked to go to SurveyMonkey.com via a hyperlink provided by the principle researcher. This hyperlink directed each nurse to the specific surveys included in this investigation, to be filled out online at their convenience. Specific instructions were provided to each participant concerning procedural details including this researcher's email address, address, and phone number. Providing an online venue for filling out surveys helped to increase compliance, due to the fact they were able to fill out the surveys at their work facility or at home. All surveys filled out via the online format were automatically collected through SurveyMonkey.com and used for data analysis. This probability sampling helped to ensure external validity, but generalizability was limited to nurses and nurse managers in the Midwest.

This researcher kept in close contact with the nurse administrators and nurse managers of each hospital during the time of data collection. All questions were addressed via email format concerning the surveys as well as in person when this principle investigator was on site. All nurse managers and staff nurses from these same hospitals who complete the surveys were included in the investigation. Collection of data was stopped after a 3-week time period. Data from the surveys included matching of nurse managers and staff nurses from the same facilities, to help aid in analyses.

Instruments

With permission obtained from the authors, two tools were chosen for this

investigation. The first tool was the Revised Emotional Intelligence Scale (EIS-41)

originally by Schutte et al. (1998) and revised by Austin et al. in 2004 (Appendix B).

The second tool was Meyer and Allen's (1991) Organizational Commitment

Questionnaire (OCQ) (Appendix C). Permission for the EIS-41 was stated within the tool

itself. Permission to use the OCQ was requested and granted (Appendix D).

Emotional intelligence was measured by Schutte's Revised Emotional

Intelligence Scale (EIS-41). The EIS-41, revised by Austin et al. (2004), is a 33-item

emotional intelligence scale and it has subsequently been used in a number of studies

(Ciarrochi, Chan, & Bajgar, 2001; Petrides & Furnham, 2000; Saklofske, Austin, &

Minski, 2003; Schutte et al., 2001). A three-factor structure including Optimism/Mood

Regulation, Utilization of Emotions, and Appraisal of Emotions was contained within the

tool (Austin et al., 2004). Optimism/Mood Regulation measures the extent to which

people report being able to regulate emotions in oneself and others; Utilization of

Emotions measures the extent to which people report being able to utilize emotions in

solving problems; and Appraisal of Emotions measures the extent to which people report

being able to identify emotions in oneself and others. Three of the items (5, 28, & 33)

were reversed scored. Questions were based on the emotional intelligence model from

Salovey and Mayer (1990). A 5-point Likert-type scale ranging from 1 = Strongly

Disagree to 5 = Strongly Agree was used for each dimension of the self-report measure.

Adequate psychometric properties of the scale have been reported. Cronbach's alpha was

reportedly .90 for the 33-point scale. Test-retest reliability was reportedly .78. The authors of this instrument permit free use of the scale for research (Schutte et al., 1998).

Organizational commitment was measured by Meyer and Allen's (1991) Organizational Commitment Questionnaire (OCQ). This tool is a self-report format using the three previously defined categories including affective, continuance, and normative commitment. Questions are aimed at assessing levels of occupational commitment in each of the above categories. It uses a 5-point Likert-type scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree for each dimension. Four items were reversed scored (affective: Items 3, 4, & 5; normative: Item 1) Morrow reported Cronbach alphas for the affective dimension were between .74 and 0.88; between .69 and .83 for the continuous dimension; and between .52 and .79 for the normative dimension.

A demographic questionnaire (Appendix E) contained items to provide information on both staff nurses and nurse managers. It included the following: name of hospital, name of specific unit on which the participant works; total years of practice; total years working at facility; total years working on unit; type of nursing degree; and age. The information from the demographics questionnaire provided the required information related to practice sites and other information to be taken into account when the data was analyzed. The demographic questionnaire was the last page of the questionnaire placed on the website SurveyMonkey.com, which was placed strategically to enhance response rate.

Data Analysis

For the demographic data obtained from respondents, descriptive statistics were calculated and the results provided. In addition, the demographic variables were used as independent variables in some analyses using inferential statistics. All data analysis was carried out using SPSS. Data was analyzed for each research question using inferential statistics. An alpha of .05 was set as the level of significance for this investigation. Statistical analyses were completed using data only in its aggregate form. No personal identifiers or single participant analyses were completed to ensure anonymity. For this investigation, the following research questions were analyzed:

1. What is the contribution of EI of NMs to the OC of staff nurses?

2. Are there differences in levels of EI in nurse managers based on levels of education (i.e. ADN, BSN, MSN)?

3. What is the relationship between nurses' tenure in current position, age, and EI and their levels of OC?

4. What is the relationship between nurses' tenure in current position, age and their levels of EI?

Data analysis for each question was completed as follows:

The first research question was addressed using regression analysis and examined the single dependent variable (OC of staff nurses) and the extent to which changes in levels of EI of nurse managers (independent variable) affect this dependent variable. The second research question was addressed using a one-way ANOVA and, given a significant obtained value of F, a post hoc Tukey HSD analysis. The independent

variable (i.e., education) has seven levels (CNA, diploma, LPN, ADN, BSN, MSN or PhD), and the dependent variable is EI levels of Nurse Managers. Finally, Questions 3 and 4 were addressed using regression analysis. This method will be used to analyze how a single dependent variable, nurses' [which includes both NMs and staff nurses] OC is affected by three independent variables (i.e., age, EI, and years of experience in current position). Any changes found in levels of R^2 were used to determine significant predictors of levels of OC in staff nurses.

Summary

A quantitative, cross-sectional, non-experimental design was used for this investigation. NREC approval was sought from Fort Hays State University; revisions were completed after their review and exemption status obtained for this investigation. Subjects included staff nurses and nurse managers with varying educational backgrounds from Midwestern hospitals. Hospitals were selected based on location in the Midwest region as well as this researcher's connection to the facilities through student involvement and prior employment. Surveys were distributed via a hyperlink to the SurveyMonkey.com website provided by this researcher after a confirmation email was received from the facilities' administrators. The surveys included were Emotional Intelligence Scale by Schutte et al. (1998) and revised by Austin et al. (2004) and the Revised Organization Commitment Questionnaire by Meyer and Allen (1991). Psychometric testing of both surveys was found to have acceptable reliability and validity.

CHAPTER IV- FINDINGS

This investigation examined factors that influence OC of staff nurses. The variables used as possible factors included: (a) EI of nurses, (b) EI of nurse managers [NMs], (c) education level, (d) nurses' tenure in current position, and (e) age. Types of statistical analysis included linear regression and analysis of variance (ANOVA). This chapter presents findings of analyses of aggregate data from three hospitals located in the Midwest. The data were collected from surveys compiled on the SurveyMonkey website, as well as eight paper and pencil surveys. Data collected online were directly distributed into an Excel file from SurveyMonkey and uploaded into SPSS for analysis. This method helped decrease the possibility of data entry error. Data from hard copies of the survey were carefully entered by hand into an Excel file and also uploaded into SPSS. The level of significance for this investigation was set at $p = .05$.

Sample Characteristics

The samples used in this investigation and percent of total sample for each included nurse managers ($n = 29, 27.6\%$) and their staff nurses ($n = 74; 70.5\%$) from three Midwest hospitals. A total of 123 surveys were completed, with eight of these being completed via paper and pencil. After eliminating incomplete surveys, 105 surveys were deemed usable for analysis ($N = 105$), which is an overall usable response rate of 85.37%. Demographic information was obtained by a brief questionnaire (Appendix E). The demographic data analyzed included: (a) gender, (b) ethnicity (c) educational level, (d) current position, and (e) age (see Table 3).

Table 3

Demographic Characteristics of Sample (*N*=105)

Variable	Response Option	*n*	%
Gender	Male	17	16.30
	Female	87	83.70
Ethnicity	Caucasian	95	90.50
	African American	3	2.90
	Hispanic	2	1.90
	Asian	2	1.90
	Other	3	2.90
Educational Level	CNA	2	2.00
	Diploma	3	2.90
	LPN	15	14.70
	ADN	32	31.40
	BSN	40	39.20
	MSN	8	7.80
	Doctorate	2	2.00
Current Position	Nurse Manager	29	27.60
	Staff Nurse	74	70.50

Percentages may not sum to 100% due to rounding.

Data for age were collected as scale data ($M = 44.90$, $SD = 12.07$). Nurse Managers ($n = 29$) averaged 50.89 years ($SD = 10.15$), while staff nurses ($n = 74$) averaged 42.77 years of age ($SD = 12.05$). Total years of experience in their current position was also collected as scale data ($M = 17.98$, $SD = 11.85$). Nurse Managers averaged 23.90 years ($SD = 11.56$) years in their current position, while staff nurses averaged 15.66 years ($SD = 11.21$). Demographic reporting of education level for the nurse managers revealed that the majority of the nurse managers held a BSN degree ($n = 13$, 46.4%) and, in decreasing order of frequency, ADN ($n = 6$, 21.4%), MSN ($n = 5$, 17.9%) Doctorate ($n = 2$, 7.1%), Diploma ($n = 1$, 3.6%) and LPN, ($n = 1$, 3.6%).

Research Question Findings

Four research questions guided this investigation. The following contains discussion of each question.

Research Question 1

Research Question 1 asked, "What is the contribution of EI of NMs to the OC of staff nurses?" Data analysis for the first research question was addressed using regression analysis and examined the single dependent variable (OC of staff nurses) and the extent to which changes in levels of EI of nurse managers (independent variable) affected this dependent variable. To pair NMs with their SNs, each hospital was coded ($1 - 3$) and subgroups of NMs and SNs for both EI and OC were completed. Total EI of NMs was examined as a predictor variable for OC of SNs for all three hospitals combined and for each hospital individually. The results were not significant for any of the four analyses (see Table 4).

Table 4

Correlations between EI of Nurse Managers and OC of Staff Nurses.

Correlations EI × OC

Sample	N	r	p
All	86	.13	.12
Hospital 1	32	.22	.12
Hospital 2	50	.05	.37

The original EI scale consisted of 33 items. In order to determine the number of latent variables represented by the scale, a Principle Component Analysis was conducted. (Note: details of this analysis are addressed in "Other Findings" section within this chapter.) The 23 items with the highest loading on Factor 1 were combined into a modified EI Scale score. That was then used as a predictor in the same analyses as noted above; however, significant results were still not obtained.

Research Question 2

The second research question asked, "Are there differences in levels of EI in NMs based on levels of education (e.g., ADN, BSN, and MSN)?" This question was addressed using a one-way ANOVA and, given a significant obtained value of *F*, a post hoc Tukey HSD analysis. The independent variable (i.e., education level) had seven levels (CNA, Diploma, LPN, ADN, BSN, MSN or Doctorate in Nursing). The means for each level included the following: BSN degree (*n* = 13, 46.4%), ADN (*n* = 6, 21.4%), MSN (*n* = 5, 17.9%) Doctorate (*n* = 2, 7.1%), Diploma (*n* = 1, 3.6%) and LPN, (*n* = 1, 3.6%). In this

analysis only three levels were used (i.e., ADN, BSN, MSN) because only these three

education levels had large enough sample sizes to meet the assumptions of ANOVA. The

three education level groups did not differ significantly with regard to level of EI of NMs

(F (2, 20) = .138, p = .834). Therefore, post hoc analysis was not completed.

Research Questions 3 and 4

The third research question asked, "What is the relationship between nurses'

tenure in current position, age, and EI and their levels of OC?" Regression analysis was

also used for Question 3. This method was used to analyze how a single dependent

variable, nurses' OC, which includes both NMs and staff nurses, was affected by three

independent variables (i.e., age, tenure in current position, and EI). Any significant

changes in levels of R^2 were used to determine the significant predictors of levels of OC

in nurses. Findings included total EI levels of nurses and tenure in current position as

significant predictors of nurses' OC (see Table 5).

Table 5

Predictors for OC of Nurses (N = 105)

Predictor	b	SE	B	t	R^2	$\triangle R^2$	p
EI	.301	.090	.306	3.34	.0978	.0978	.001
Tenure	.030	.011	.251	2.74	.1607	.0629	.007
EI[1]	.424	.117	.332	3.63	.1172	.1172	.000
Tenure	.030	.011	.254	2.78	.1815	.0643	.007

[1]New Subscale for EI

The fourth research question asked, "What is the relationship between nurses' tenure in current position, age, and their levels of EI?" Regression analysis was also used for this question; however, the results were non-significant.

Other Findings

Factor and reliability analyses were conducted on both the EI and OC scales, and the results can be seen in Table 5. Principal Component Analysis revealed 10 factors for the EI scale; however, 23 of the 33 items loaded at .41 or higher on the first factor. In examining those 23 items, it appears that two themes emerge; "Self-Awareness" and "Empathy/Sympathy as illustrated, for example, by the following items (see Table 6).

Table 6

Emerging Themes from Revised EI Tool

Self-Awareness	Empathy/Sympathy
#2--When I am faced with obstacles, I remember times I faced similar obstacles and overcame them	#13--I arrange events others enjoy
#3--I expect that I will do well on most things I try	#18--By looking at their facial expressions, I recognize the emotions people are experiencing
#12--When I experience a positive emotion, I know how to make it last	#25-- I am aware of the non-verbal messages other people send
#17--When I am in a positive mood, solving problems is easy for me	#26--When another person tells me about an important event in his or her life, I almost feel as though I have experienced this event myself
#19--I know why my emotions change	#29-- I know what other people are feeling just by looking at them
#21--I have control over my emotions	#30-- I help other people feel better when they are down
#22--I easily recognize my emotions as I experience them	#32-- I can tell how people are feeling by listening to the tone of their voice

Both of these themes are integral parts of EI, and both are in line with Swanson's

Caring Theory. More specifically, this factor appears to be directly aligned with the

"Being With," "Doing for," and "Enabling" sub-dimensions of Swanson's Caring

Processes.

While the reliability of the 33-items scale was good ($\alpha = .88$), the 10-factor solution suggests validity was, most likely, low. More specifically, The EI construct does not, ostensibly, encompass ten separate factors. As such, a 10-factor solution indicates the construct validity of this EI scale is in question. Reducing the number of items to the 23 that had the highest factor loadings yielded a more prudent solution, and one that was interpretable. In addition, the internal consistency reliability of the 23-item scale increased to .89.

Meyer and Allen's (1991) OC scale has a solid history of reliability and validity, with a well-established factor structure. The 18 items of the OC scale are evenly divided across three subscales: Affective Commitment (AC), Continuance Commitment (CC), and Normative Commitment (NC). The numbers of factors corresponding to each commitment scale (i.e., full scale and subscales), as well as the related reliability coefficients, can be seen in Table 7.

Table 7

Factor Structure and Reliabilities for Emotional Intelligence and Organizational

Commitment Scales

Scales	Number of Factors	Cronbach's Alpha
EI—33 Item Scale	10	.88
EI—23 Item Scale	1	.89
OC—18 Item Scale	2	.85
AC—6 Item Scale	1	.90
NC—6-Item Scale	1	.84
CC—6-Item Scale	1	.74

The factor analysis for the OC scale revealed two factors, with both the AC and NC items loading on the first factor. The CC items loaded on a separate factor. This is not unusual for a small sample ($N = 105$), especially when there are two sub-groups within the same sample. Given the well-established psychometric properties of this scale, its validity in the context of this study is not in question. In addition, the coefficients obtained for this study are in line with those established in the literature (Meyer & Allen, 1991, 1997).

Looking for between-group differences for Nurse Managers and Staff Nurses, independent group *t*-tests were conducted for EI using both the original and revised scales. The results of those analyses were not significant, and the group means can be

seen in Table 8. The virtually identical means for both groups, regardless of scale, certainly precludes any between-group analyses using either of these scales.

Table 8

Mean Scores for NMs and SNs on Original and Revised EI Scales

Scales	Nurse Managers ($n = 29$)	Staff Nurses ($n = 74$)
Original EI Scale—33 Items[1]	126.48	126.11
Revised EI Scale—23 Items[2]	88.93	88.32

[1]Scale Range: 33 – 165   [2]Scale Range: 23 – 115

Independent groups t-tests were also conducted for the Organizational Commitment Scales and the results of those analyses can be seen in Table 9. As can be seen from the results, NMs have significantly higher scores on the full OC scale, as well as on the AC and NC subscales.

Table 9

Results of Independent Groups t-tests for NMs and SNs on Full Scale and Subscales for OC

	Mean Scores			
Scales	Nurse Managers	Staff Nurses	*t*-score	*p*-value
Organizational Commitment[1]	61.93	56.00	3.04	.003
Affective Commitment[2]	23.31	19.15	4.27	.000
Normative Commitment[2]	21.24	18.66	2.44	.016
Continuance Commitment[2]	17.38	18.19	−.18	n/s

[1]Scale Range = 18 – 90   [2]Scale Range = 6 – 30

In order to examine the tenure-commitment relationship more closely, correlations between tenure and OC, AC, NC, and CC were calculated for both NMs and SNs. Those coefficients can be seen in Table 10.

Table 10

Correlation Coefficients Between Tenure and Organizational Commitment Total Scores and Subscale Scores for NMs and SNs.

	OC	AC	NC	CC
Nurse Managers[1]	.15	.07	.22	-.01
	$p = .44$	$p = .70$	$p = .26$	$p = .97$
Staff Nurses[2]	.23	.19	.12	.22
	$p = .04$	$p = .11$	$p = .06$	$p = .31$

[1]$n = 29$; [2]$n = 74$

As can be seen in Table 10, overall OC is positively and significantly related to tenure for SNs but not NMs. The remainder of the correlations were non-significant.

Summary

This chapter has presented research questions, the data collected, and the results of the statistical analyses for this investigation. Possible reasons for non-significant findings were discussed

CHAPTER V- SUMMARY AND CONCLUSIONS

This chapter provides a summary of this investigation, interpretation of the findings, and discussion of conclusions. Limitations are also discussed. Finally, this chapter concludes with recommendations for possible changes in the area of nursing management, nursing education, and future development of nursing research in the area of EI in relation to OC in nursing.

Summary of the Investigation

This investigation used a cross-sectional, quantitative, non-experimental design. The intent of the investigation was to discover factors (e.g., EI and demographic variables), that influence OC of staff nurses. Data were collected using two self-report surveys and a demographic survey from three Midwestern hospitals via an online method. The sample for this investigation included nurse managers and staff nurses ($N = 105$). The independent variable(s) for this investigation included: EI, along with other demographic variables (i.e., age, educational level, and years of experience in current position). The dependent variable for this investigation was OC.

Interpretation of Findings

Demographic results and interpretation of the findings from the investigation are included in this discussion. Results from this study are compared to current studies found in the nursing literature.

Demographic Characteristics

The demographics of the participants for age revealed the majority of nurse managers were 50 years of age or older. Staff nurses' average age was over 40, which corresponds to statistics from the Department of Health and Human Services latest

population survey, stating the average age of the RN population in the United States

is 46.8 years. According to Benson, Ploeg, and Brown (2009), higher EI levels are related

to those with more life experience. Since the majority of both NMs and SNs in this study

were 40 years of age and older, the very similar EI levels for both groups may explain the

minimal difference found in total EI scores between NMs and SNs. Another factor related

to age is the OC of the nurses. The average experience as a nurse was over 17 years.

Nurse Managers averaged 10 years in the same hospital and staff nurses averaged 6 years

($M = 10.25$; $SD = 9.52$; $M = 6.34$; $SD = 6.32$, respectively). It is important to note that

normative or continuance commitment may be found when the employee has worked for

most of their adult life in the same organization (Meyer & Allen, 1997).

First Research Question

The first research question asked, "What is the contribution of EI of NMs to the

OC of SNs?" This study specifically wanted to look at NMs' levels of EI and how that

may be related to the OC of their staff nurses. Each hospital's NMs and SNs were

analyzed in their specific units, as well as across all hospitals. Regression analysis

showed no significant results. Thus, EI of NMs was not found to be a predictor for OC of

SNs in this investigation. The use of another, more valid EI tool may help in the future to

obtain significant results in this area. A very recent study by Momeni (2009) did find that

the higher the manager's EI, the higher the manager's OC. This study was not specific to

nursing, but indicated that 55% of OC was accounted for by the EI of manager's

($p = .01$). It is important to note that the EI tool used in this study was the EI Inventory

(ECI-360) designed by Goleman et al, (2002). Their study did not report specific

reliability of validity findings, but stated it has been used worldwide with good reliability and validity ratings.

Second Research Question

The second question asked, "Are there differences in levels of EI in nurse managers based on levels of education (i.e., ADN, BSN, and MSN)?" No significant differences in levels of EI of NMs based on differences in education level were found at the $p = .05$ level. Thus, results indicate that group differences concerning level of education and EI level of nurse managers were not beyond chance expectations. The BSN group contained the majority of NMs ($n = 13$) followed by the ADN group ($n = 6$), and the MSN group ($n = 5$). It was interesting to note that all EI scores across all NM groups were virtually identical, thus making any findings with this analysis unlikely. Benson et al. (2009), cited in Chapter II, indicated that significant differences were found among BSN students and their levels of EI. More specifically, students' EI levels were assessed once each year across their four years in the program, and the results showed that EI scores significantly increased across that time span.

Third and Fourth Research Questions

The third and fourth questions examined the relationship between nurses' tenure in their current position, age, EI and their levels of OC. Interpretation of findings included that EI levels of all nurses surveyed as a group (i.e., NMs and SNs together) were found to predict the OC of nurses. Thus, nurses who are found to have high levels of EI may be more committed than those who do not have high levels of EI. This was not surprising since several other studies have already discovered that EI is positively

correlated with OC (Carmel, 2003; Nikolaou & Tsaousis, 2002; Rozell et al., (2004). This is also interesting to note since the first question examined whether the EI of NMs was a predictor of the OC of SNs. The findings indicated that the EI of NMs was not a predictor, but the EI of the individual nurse is a predictor of his or her own OC level. This may imply that nurses with higher levels of EI may be more committed to their places of employment than those who have high lower levels of EI. Chermiss and Goleman (2001) reported that emotionally intelligent people often convey cooperative attitudes, creativity, and commitment to their organization, which are key factors found to be very important to organizational effectiveness. Thus, cooperative and creative nurses may help to retain nurses in their place of employment.

Age was not found to be a predictor for OC in this study; however, Chermis and Goleman (2001) did find many demographic variables including age, work experience, and educational level that were significantly related to OC. It should be noted that the instruments used to measure EI in their study was different from the EI tool used in this investigation.

Tenure in current position was a significant predictor of OC in this investigation. It is often the case that workers who have been in their job for a long period of time may feel they cannot leave for a variety of reasons, such as financial (e.g., losing their pension) or fear of losing long-time social ties (Meyer & Allen, 1997). Another contributing factor for this finding may be a reflection of the times. Economic hardship may lead to feelings of "the need to stay" or continuance commitment, especially if the worker is getting close to retirement age (Meyer & Allen, 1997).

Finally, this investigation found no correlation between tenure, age and levels of EI. This might be an important finding when considering how and when EI is developed. For example, if levels of EI increase across the lifespan simply as a matter of fact (i.e., a linear relationship between age and EI), then that would suggest there is no reason to try and actively develop EI. However, given the non-significant relationship between age and EI (RQ-4) and the positive relationship between EI and OC (RQ-3), it would be incumbent on individuals to work to increase levels of EI so as to positively influence commitment. Therefore, emotional intelligence may be an important concept to explore as a possible competency to develop for new staff in facilities with high turnover.

Interpretation of Other Findings

Results of the independent groups t-tests for NMs and SNs for OC (see Table 8) indicate that NMs have higher positive emotional attachment to the organization than do SNs (i.e., greater AC), and they also tend to commit to and remain with the organization because of feelings of obligation (i.e., higher NC), as compared to the SNs. These findings could be due, in part, to longer average tenure on the part of NMs (23.90 years vs. 15.66 years). There might also be feelings on the part of the NMs that they owe something to the hospital because they were placed in supervisory positions.

While the difference in CC between NMs and SNs was not significant, the direction of the findings indicates SNs are more committed to the organization because they perceive higher costs of losing organizational membership (see Table 8). Those costs can include economic costs (such as pension accruals) and social costs (friendship

ties with co-workers) that would be incurred. Thus, employees remain with the organization because they feel they "have to" (Meyer & Allen, 1997).

Findings related to the correlation coefficients between tenure and OC total and subscale scores for NMs and SNs included a positively significant finding related to tenure of SNs and not NMs (see Table 9). While the remainder of the correlations were found to be non-significant, interestingly, AC (positive emotional attachment) seems to increase over time for SNs but not for NMs; however, for NC (feelings of obligation), the opposite appears to be true. When discussing the results of the t-tests above, it was suggested that tenure might be a driving force behind significantly higher AC and NC scores for NMs; however, these results suggest that is not necessarily the case. Looking again at the demographic results, the variability in tenure for both NMs and SNs was high (i.e., $SD = 11.56$ and $SD = 11.21$, respectively).

Therefore, while mean scores were significantly different, that did not fully take into account the linear nature of the relationship. Examining the remaining coefficients, for NMs there is virtually zero relationship between tenure and CC, but for SNs feeling of having to stay with the hospital increase over time. It should be noted that these non-significant relationships could be a function of sample size but, regardless, the directionality of the results are certainly informative for this sample.

Limitations

A number of limitations were found in this study. A convenience sample was used and selection bias may be a result. Sample size was small ($N = 105$) and may possibly account for the non-significant results, as well as increasing the possibility of committing

a Type II error. Since the focus was on nurses from the Midwest caution should be taken in generalizing any findings to nurses in other areas. Replication of this study with larger and more representative samples of nurse in various work settings is needed to evaluate the generalizability of findings. The potential for response bias as a result of using self-report measures must also be taken into account (Polit & Beck, 2008).

In performing a reliability analysis, another limitation was found concerning the reliability of the EI survey tool, which was already discussed in the "Other Findings" section. This limitation was not surprising given the fact that more research was found concerning the reliability and validity of the OC tool, which is a well-established instrument (Meyer and Allen, 1991, 1997; Meyer et al., 1993). The EI instrument, on the other hand, was a "free" tool with, ostensibly, sound reliability and validity ratings, but few authors had used this tool in their research, as indicated in the Chapter II literature review.

<center>Recommendations</center>

Significant findings from this investigation provided information concerning factors that contributed to OC of nurses. A statistically significant correlation related to EI levels of nurses and OC was discovered, and both tenure and total EI were found to be significant predictors for levels of OC in nurses ($p \leq .001$). Based on these findings, the following recommendations in the areas of nursing education, practice, research, and theory are discussed.

Nursing Education

This study did not show a significant relationship between EI of nurse managers and OC of staff nurses, but an overall significant relationship was found in the levels of EI and OC across all nurses. In addition, the results related to RQ-4 indicate that age and experience are not factors to consider when predicting EI of nurses. Emphasizing the importance of EI levels in only upper management may be an incorrect approach to improving the OC of nurses. Given this, exposing nursing students to the concept of EI while in nursing classes would be important and may help novice nurses become more committed to their place of employment. Whether or not nursing students become committed to the organizations for which they work will be important for overall growth of the profession itself.

Goleman et al. (2002) argues that it is possible to develop EI competencies through training and developmental programs. He goes on to state that successful organizations recognize how emotional aptitude in leaders preserves relationships, creates healthy workplaces and, thus, results in organizational success. Nurses must be leaders whether in administrative positions or at the bedside (Malloch & Porter-O'Grady, 2009). By starting out student nurses with a knowledgebase, concerning EI may help them stay committed to their organization and practice, increase their emotional aptitude, and help create a healthy work environment among their peers.

Nursing Practice

Using EI level measurements in the area of hiring may help healthcare facilities keep experienced nurses working in the same organization for many years. This may be

very important in the area of hiring administrative personnel in nursing, where EI and the

authentic leader have been highly recognized as the most effective type of leadership in

nursing (Malloch & Porter-O'Grady, 2009).

Another important factor concerning nursing practice includes nurses regulating

their own emotions in a mature and professional manner. Understanding their own

emotions and being able to read the emotions of others would be helpful to anyone just

starting out in a profession where collaboration, communication, and emotional maturity

are needed on a daily basis (Humphreys et al., 2005). Since awareness is the first step

towards change, incorporating the understanding of the concept of EI at the unit level

may also help emotionally immature nurses develop in this area.

Another significant finding in this investigation included tenure in current

position being a predictor for OC. Thus, nurses with longer tenure may remain more

committed to the organization than nurses with less tenure. Making sure these nurses are

recognized for their valuable expertise given to the organization over the years may help

maintain quality staff over a longer period of time, which may then lead to increased

quality care and more positive patient outcomes (Naude & McCabe, 2005; Wilson,

2005).

Nursing Research and Theory

On-going research concerning EI and OC is needed. This research should include

a larger cross-section from areas other than the Midwest. Using a valid tool that measures

EI more accurately may also help reveal different and more valid findings concerning EI

and OC. The main problem may lie in the fact that the EI construct has not been

adequately defined. Emotional intelligence remains in its infancy as a construct (Spector, 2005). Controversial discussions have questioned not only the measurement of EI, but also the nature of EI as a construct (Spector, 2005). This became obvious during the literature review performed for this investigation, which revealed many studies having different operational definitions for the construct, as well as different tools to measure it.

Finally, connecting EI with Swanson's Caring Theory (Swanson, 1991) may help the concept of caring become even more emphasized in the area of leadership and management. Health care leaders have the responsibility of meeting the needs of staff by helping them to develop better interpersonal skills, while at the same time becoming more humanistic themselves (Vitello-Cicciu, 2002). Wilson (2005) states that interpersonal skills are necessary management characteristics that impact nurse retention. The most successful organizations focus on enhancing self-awareness, self-management, social awareness and social skills (referred to as EI) of their leaders (Feather, 2008). It seems logical that a manager with high EI would cause workers to want to stay in their organization.

While the influences of interpersonal skills, assessed as MNs EI, were not a significant variable in this investigation, one reason may have been the use of a poor instrument for measuring EI. Thus, until EI is more established as a construct, it may be difficult to define true associations among EI, OC, and Swanson's Caring Theory.

Watson (2006) stated, "Caring and administrative practices are often considered in conflict with each other" (p. 48). Even without significant findings, this study,

hopefully, may help to bring awareness to the dichotomous concepts of administrative practice and caring on the same level in the nursing realm.

Summary

Without effective nurse leaders helping to maintain and increase OC among nursing staff, quality patient care outcomes may be compromised (Naude & McCabe, 2005; Wilson, 2005). Studies show that high OC decreases the cost of turnover; employees' resistance to change; and also improves quality, creativity, and accepting risks which all lead to the loyalty of customers (Momeni, 2009). Emotional intelligence has become an important concept in health care as it is vital for leaders in nursing to engage in relationships that will encourage successful management and OC of employees (McQueen, 2004).

This investigation looked at OC in nursing in relation to demographic factors and EI of nurses. Significant results of this study indicated there is a correlation between EI and OC of nurses, as has been seen in other recent studies (Carmel, 2003; Nikolaou & Tsaousis, 2002; Rozell et al., 2004). Understanding one's own emotions and being able to read the emotions of others may help to increase the organizational commitment of nursing. Before nurses are placed in the workforce, educational awareness of the construct of EI needs to be added to nursing curriculum, especially in leadership and management courses.

According to Buerhaus et al. (2009), despite the current easing of the nursing shortage due to the recent recession and many nurses putting off retirement, the nursing shortage is projected to grow to approximately 260,000 registered nurses by the year

2025. Nurses are not necessarily wanting to stay in the profession, but feel they cannot leave due to the economic climate, which is part of continuance commitment's definition.

The stress within the nursing profession itself has also been cited as an area that causes nurses to want to leave the profession. Comments are made in exit interviews that state the employee is leaving their position because the nurse manager did not possess good leadership skills, and not because they necessarily wanted to retire (Feather, 2008). Nurses with high EI are needed at the bedside, as well as in administration to help retain competent nursing staff (Porter-O'Grady, 2003; Snow, 2001). Once a nursing administrator understands the value of EI and how it can be developed within an organization, a training program should be started (Feather, 2008).

Presently there is a gap in knowledge in relation to research regarding EI and OC. On-going research that includes reliable and valid tools to measure the construct of EI is needed to accurately determine the connection between EI and OC in nursing. Nursing needs leaders who have an understanding of how EI can help turn good leaders into effective leaders. These successful leaders will hopefully help quality nurses to remain committed to the profession.

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Appendix A

Consent to Participate in Research Investigation

Consent to Participate in Research Investigation
Fort Hays State University
Nurse Managers and Staff Nurses

Title of Investigation: Factors that Influence Organizational Commitment
in Nurse Manager/Subordinate Dyads

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General Information

You are being asked to voluntarily take part in a research investigation. You may refuse to join, or you may withdraw your consent to be in the investigation, for any reason, and at any time *without consequences*.

This investigation is being conducted to examine factors that influence the organizational commitment (OC) of staff nurses. This researcher will need your permission to send a link to your email address that will directly take you to a website (SurveyMonkey.com). This site will direct you to two separate short surveys (maximum total time of 15 minutes). Clicking on this link will imply your consent to participate in the investigation. Hard copies of these surveys will be provided if no computer access is available or preference is for paper and pencil format. A collection device will be provided by this researcher that will be kept in a secured area if paper and pencil format is chosen by the participant.

This information could help nursing management and their staff in the future but you may not receive any specific benefit from the investigation. There are potential risks with any investigation, but it is believed these risks are minimal.

A description of the investigation is included. It is important for you to understand the information, so you can make an informed choice about participating in this research investigation.

You should ask this researcher any questions you have about this investigation at any time. Contact information concerning this researcher's faculty advisor is also provided.

Your decision whether or not to participate will have no effect on your job status or benefits to which you are otherwise entitled. Please ask questions if there is anything you do not understand.

What is the purpose?
The purpose of the investigation is to examine factors that may influence whether staff nurses stay within or leave their place of employment.

How many people will take part?
If you decide to be in this investigation, you will be one of approximately 203 people in the investigation.

How long will the investigation last?
Your involvement will require you to complete two survey instruments and a short demographic questionnaire. The total time required to complete the survey should be less than 20 minutes.

What will happen in the investigation?
Nursing management and staff will help identify factors that may influence whether nursing staff leave their place of employment. You will be emailed a link to SurveyMonkey.com, which will take you directly to two survey forms to complete, using the click of a mouse. Clicking on the link implies informed consent.

What are the possible risks?
There are no foreseeable physical or psychological risks associated with participants in this study. You should report any problems or concerns to this researcher immediately.

What are the possible benefits?
Research is designed to benefit society by gaining new knowledge. You may benefit personally by understanding specific factors that help you in retaining employees or possible factors that influence your reasons for staying or not staying in your place of employment.

How will your privacy be protected?
No personally identifying information will be asked of your during your participantion and your data will be identified through codes known only to the researcher. You will not be identified in any report or publication about this investigation. The Fort Hays State University's Department of Nursing Research Ethics Committee and Institutional Review Board (IRB) have thoroughly reviewed and approved the details of the investigation before it began.

Will you receive anything for being in this investigation?
You will not receive any monetary benefits for taking part in this research investigation.

Will it cost you anything?
There are no costs associated with being in the investigation.

What if you have questions about this investigation?
You have the right to ask, and have answered, any questions you may have about this research. If you have questions or concerns that the patient care staff cannot address, you should contact the researcher listed on the first page of this form.
All research on human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights in this investigation, you may contact, anonymously if you wish, the Institutional Review Board (IRB) at Fort Hays State University (785-628-FHSU).

Participant's Agreement:
You are under no obligation to participate in the investigation. Your online completion of the two surveys will be taken as evidence of your willingness to participate and your consent to have the information used for purposes of the investigation. You may keep this cover letter and explanation about the nature of your participation in this investigation and the handling of the information you provide.

Appendix B

The 33-item Emotional Intelligence Scale (EIS-41)

The 33-item Emotional Intelligence Scale (EIS-41)

Instructions: Listed below is a series of statements that represents feelings that individuals might have about the organization in which they work. With respect to your own feelings about the particular organization for which you are now working, please indicate the degree of your agreement or disagreement with each statement by clicking on the corresponding responses indicated using the scale below.

1 = Strongly Disagree
2 = Disagree
3 = Undecided
4 = Agree
5 = Strongly Agree

1. I know when to speak about my personal problems to others
2. When I am faced with obstacles, I remember times I faced similar obstacles and overcame them
3. I expect that I will do well on most things I try
4. Other people find it easy to confide in me
5. I find it hard to understand the non-verbal messages of other people*
6. Some of the major events of my life have led me to re-evaluate what is important and not important
7. When my mood changes, I see new possibilities
8. Emotions are one of the things that make my life worth living
9. I am aware of my emotions as I experience them
10. I expect good things to happen
11. I like to share my emotions with others
12. When I experience a positive emotion, I know how to make it last
13. I arrange events others enjoy
14. I seek out activities that make me happy
15. I am aware of the non-verbal messages I send to others
16. I present myself in a way that makes a good impression on others
17. When I am in a positive mood, solving problems is easy for me
18. By looking at their facial expressions, I recognize the emotions people are experiencing
19. I know why my emotions change
20. When I am in a positive mood, I am able to come up with new ideas
21. I have control over my emotions
22. I easily recognize my emotions as I experience them
23. I motivate myself by imagining a good outcome to tasks I take on
24. I compliment others when they have done something well
25. I am aware of the non-verbal messages other people send
26. When another person tells me about an important event in his or her life, I almost feel as though I have experienced this event myself
27. When I feel a change in emotions, I tend to come up with new ideas

28. When I am faced with a challenge, I give up because I believe I will fail*
29. I know what other people are feeling just by looking at them
30. I help other people feel better when they are down
31. I use good moods to help myself keep trying in the face of obstacles
32. I can tell how people are feeling by listening to the tone of their voice
33. It is difficult for me to understand why people feel the way they do*
    (*Note:* * Indicates a reverse-keyed item.)
    Note: The authors permit free use of the scale for research and clinical purposes.

Appendix C

Revised Organizational Commitment Questionnaire (OCQ)

Revised Organizational Commitment Questionnaire (OCQ)

Instructions: Listed below is a series of statements that represent feelings that individuals might have about the organization in which they work. With respect to your own feelings about the particular organization for which you are now working, please indicate the degree of your agreement or disagreement with each statement by clicking on the corresponding number from 1 to 5 using the scale below.

1= Strongly Disagree
2 = Disagree
3 = Undecided
4 = Agree
5 = Strongly Agree

Affective Commitment Scale

1. I would be very happy to spend the rest of my career with this organization.
2. I really feel as if this organization's problems are my own.
3. I do not feel a strong sense of "belonging" to my organization. *
4. I do not feel "emotionally attached" to this organization. *
5. I do not feel like "part of the family" at my organization. *
6. This organization has a great deal of personal meaning for me.

Continuance Commitment Scale

7. Right now, staying with my organization is a matter of necessity as much as desire.
8. It would be very hard for me to leave my organization right now, even if I wanted to.
9. Too much of my life would be disrupted if I decided I wanted to leave my organization now.
10. I feel that I have too few options to consider leaving this organization.
11. If I had not already put so much of myself into this organization, I might consider working elsewhere.
12. One of the few negative consequences of leaving this organization would be the scarcity of available alternatives.

Normative Commitment Scale

13. I do not feel any obligation to remain with my current employer. *
14. Even if it were to my advantage, I do not feel it would be right to leave my organization now.
15. I would feel guilty if I left my organization now.
16. This organization deserves my loyalty.
17. I would not leave my organization right now because I have a sense of obligation to the people in it.
18. I owe a great deal to my organization.

(*Note:* * Indicates a reverse-keyed item.)

Appendix D

Permission for Revised Organizational Commitment Questionnaire (OCQ)

Re: Graduate Student from FHSU.

John Meyer [meyer@uwo.ca]

You replied on 10/14/2009 5:15 PM.

Sent: Wednesday, October 14, 2009 5:04 PM

To :   Laurie Stegeman

Hi Laurie - Dr. Allen may have already replied to your request but, if not, you can get

permission to use the commitment scales for academic research purposes by going to the

following website and following the instructions:

www.employeecommitmentresearch.com. There is currently no charge for academic use.

I hope this helps. Good luck with your research.

Best regards,

John Meyer

Appendix E

Demographic Survey

Demographic Survey

To enable me to describe survey participants as a group, please provide the following information.

Age: _____

Female _____   Male _____

Ethnicity:_____ White _____Hispanic _____ American Indian _____ Other_____
African American _____ Asian _____ Pacific Islander

Job Title:

_____ Nurse Manager   _____ Staff Nurse
_____ Head Nurse   _____ Other

Name of Hospital where employed: _____

Unit on which you currently work (If a staff nurse-PRN or Float, name unit where you work over 50% of the time.) _____ _

Highest level of academic preparation completed:

_____Diploma in Nursing   _____ Certified Nurse Assistant
_____Licensed Practical Nurse   _____Master's degree in Nursing
_____Associate Degree in Nursing   _____Master's degree in other field
_____Bachelor of Science in Nursing   _____Doctoral degree in Nursing

Please list your total number of years of nursing experience. _____

How long have you remained in your place of employment with the same nurse manager? _____yrs. _____mo.

How long have you remained employed in your current hospital? ___yrs. __mo.

How long have you remained employed on your current unit? ___yrs. _____mo.
If you are a manager, how long have you been a nurse manager? __yrs. ____ mo.
Any comments are welcome (write in the space below).

THANK YOU FOR YOUR ASSISTANCE in PROMOTING EVIDENCE-BASED PRACTICE WITHIN THE NURSING PROFESSION.

Appendix F

Copy of SurveyMonkey Survey:

Factors that Influence Organizational Commitment

Welcome to the Survey Entitled:

Factors that Influence Organizational Commitment

This survey is being conducted by Laurie Stegeman in partial fulfillment of the requirements for her Masters in Nursing Degree

****

Welcome to the Survey Entitled: Factors that Influence Organizational Commitment

This investigation is being conducted to examine factors that may influence the organizational commitment of nurses. The possible benefits of this study include a better understanding of factors that help in retaining employees and an examination of specific factors that influence nurses' reasons for staying or not staying in their places of employment.
In order to maintain confidentiality, no personally identifying information will be asked. It is estimated that it should take no more than 15 minutes to complete the survey.

For the items below, please circle the number that indicates the extent to which you agree

or disagree with each of the statements.

		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	I would be very happy to spend the rest of my career with this organization.	1	2	3	4	5
2	I really feel as if this organization's problems are my own.	1	2	3	4	5
3	I do not feel a strong sense of "belonging" to my organization.	1	2	3	4	5
4	I do not feel "emotionally attached" to this organization.	1	2	3	4	5
5	I do not feel like "part of the family" at my organization.	1	2	3	4	5
6	This organization has a great deal of personal meaning for me.	1	2	3	4	5
7	Right now, staying with my organization is a matter of necessity as much as desire.	1	2	3	4	5
8	It would be very hard for me to leave my organization right now, even if I wanted to.	1	2	3	4	5
9	Too much of my life would be disrupted if I decided I wanted to leave my organization now.	1	2	3	4	5
10	I feel that I have too few options to consider leaving this organization.	1	2	3	4	5
11	If I had not already put so much of myself into this organization, I might consider working elsewhere.	1	2	3	4	5
12	One of the few negative consequences of leaving this organization would be the scarcity of available alternatives.	1	2	3	4	5
13	I do not feel any obligation to remain with my current employer.	1	2	3	4	5
14	Even if it were to my advantage, I do not feel it would be right to leave my organization now.	1	2	3	4	5
15	I would feel guilty if I left my organization now.	1	2	3	4	5
16	This organization deserves my loyalty.	1	2	3	4	5
17	I would not leave my organization right now because I have a sense of obligation to the people in it.	1	2	3	4	5
18	I owe a great deal to my organization.	1	2	3	4	5

Please continue on the next page…

		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	I know when to speak about my personal problems to others.	1	2	3	4	5
2	When I am faced with obstacles, I remember times I faced similar obstacles and	1	2	3	4	5
3	I expect that I will do well on most things I try.	1	2	3	4	5
4	Other people find it easy to confide in me.	1	2	3	4	5
5	I find it hard to understand the non-verbal messages of other people.	1	2	3	4	5
6	Some of the major events of my life have led me to re-evaluate what is important	1	2	3	4	5

7	When my mood changes, I see new possibilities.	1	2	3	4	5
8	Emotions are one of the things that make my life worth living.	1	2	3	4	5
9	I am aware of my emotions as I experience them.	1	2	3	4	5
10	I expect good things to happen.	1	2	3	4	5
11	I like to share my emotions with others.	1	2	3	4	5
12	When I experience a positive emotion, I know how to make it last.	1	2	3	4	5
13	I arrange events others enjoy.	1	2	3	4	5
14	I seek out activities that make me happy.	1	2	3	4	5
15	I am aware of the non-verbal messages I send to others.	1	2	3	4	5
16	I present myself in a way that makes a good impression on others.	1	2	3	4	5
17	When I am in a positive mood, solving problems is easy for me.	1	2	3	4	5
18	By looking at their facial expressions, I recognize the emotions people are	1	2	3	4	5
19	I know why my emotions change.	1	2	3	4	5
20	When I am in a positive mood, I am able to come up with new ideas.	1	2	3	4	5
21	I have control over my emotions.	1	2	3	4	5
22	I easily recognize my emotions as I experience them.	1	2	3	4	5
23	I motivate myself by imagining a good outcome to tasks I take on.	1	2	3	4	5
24	I compliment others when they have done something well.	1	2	3	4	5
25	I am aware of the non-verbal messages other people send.	1	2	3	4	5
26	When another person tells me about an important event in his or her life, I almost	1	2	3	4	5
27	When I feel a change in emotions, I tend to come up with new ideas.	1	2	3	4	5
28	When I am faced with a challenge, I give up because I believe I will fail.	1	2	3	4	5
29	I know what other people are feeling just by looking at them.	1	2	3	4	5
30	I help other people feel better when they are down.	1	2	3	4	5
31	I use good moods to help myself keep trying in the face of obstacles.	1	2	3	4	5
32	I can tell how people are feeling by listening to the tone of their voice.	1	2	3	4	5
33	It is difficult for me to understand why people feel the way they do.	1	2	3	4	5

For each of the questions on this page, please put a ✓ or ✗ in the box in front of your answer(s) or fill in the requested information.

What is your gender?

	Female
	Male

Racial/Ethnic Group?

	Caucasian
	African-American
	Hispanic
	Asian American or Asian
	Native American
	Pacific Islander
	Other

What was your age on your last birthday? _____
(Please enter 2-digit number)

Please write your responses for the next two items:

Name of Hospital where you are currently employed:	
Name of Unit on which you currently work. (If you are a staff nurse-PRN or Float, name of unit where you work over 50% of the time):	

What is the highest level of academic preparation you have completed?

	Certified Nurse Assistant (CNA)		Bachelor of Science in Nursing
	Licensed Practical Nurse		Master's Degree in Nursing
	Diploma in Nursing		Master's Degree in Other Field
	Associate Degree in Nursing		Doctoral Degree in Nursing
	Other (please list below)		

Please enter your total number of years of nursing experience: _____
(Please enter 1- or 2-digit number)

Which of the following best describes your current position in the hospital?

	Nurse Manager
	Staff Nurse

For each of the following, indicate the number of years and months for each question:

	Years	Months
How long have you been employed in your current hospital?		
How long have you been employed on your current unit?		
If you are a Nurse Manager, please also answer the following question:		
How long have you been a nurse manager?		

THANK YOU FOR YOUR ASSISTANCE in PROMOTING EVIDENCE-BASED PRACTICE WITHIN THE NURSING PROFESSION.

If you are interested in obtaining a copy of the results of this study, you may contact the principal investigator, Laurie Stegeman, after August 2010.

Appendix G

Nursing Research Ethics Committee (NREC) Approval

Date: 04/21/2010 04:15 PM
To: "Laurie Stegeman" <lstegeman1@cox.net>, "Liane Connelly" <lconnell@fhsu.edu>,
"Karen Trible" <ktrible@fhsu.edu>
From: "Leslie Paige" <no-reply@irbnet.org>
Reply To: "Leslie Paige" <lpaige@fhsu.edu>
Subject: IRBNet Board Action

Please note that Fort Hays State University IRB has taken the following action on
IRBNet:

Project Title: [164328-1] FACTORS THAT INFLUENCE ORGANIZATIONAL
COMMITMENT IN NURSE MANAGER/SUBORDINATE DYADS
Principal Investigator: Laurie Stegeman, MSNc

Submission Type: New Project
Date Submitted: April 12, 2010

Action: EXEMPT
Effective Date: April 20, 2010
Review Type: Administrative Review

Should you have any questions you may contact Leslie Paige at lpaige@fhsu.edu.

Thank you,
The IRBNet Support Team