Perceived Levels of Empowerment in Parish Nursing

Jean C. Bokinskie

Follow this and additional works at: https://commons.und.edu/theses

Part of the Psychology Commons

Recommended Citation
https://commons.und.edu/theses/877
PERCEIVED LEVELS OF EMPOWERMENT
IN PARISH NURSING

by

Jean C. Bokinskie
Bachelor of Arts, Jamestown College, 1981
Master of Science, University of North Dakota, 1988

A Dissertation
Submitted to the Graduate Faculty
of the
University of North Dakota
in partial fulfillment of the requirements

for the degree of
Doctor of Philosophy

Grand Forks, North Dakota
August, 2010
This dissertation, submitted by Jean C. Bokinskie in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

Chairperson

Helen Meier

Bill O'De

Elizabeth Turek

Thomas Hildt

This dissertation meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota, and is hereby approved.

Dean of the Graduate School

August 2, 2010

Date
PERMISSION

Title Perceived Levels of Empowerment in Parish Nursing

Department Nursing

Degree Doctor of Philosophy

In presenting this dissertation in partial fulfillment of the requirements for a graduate degree from the University of North Dakota, I agree that the library of this University shall make it freely available for inspection. I further agree that permission for extensive copying for scholarly purposes may be granted by the professor who supervised my dissertation work or, in her absence, by the chairperson of the department or the dean of the Graduate School. It is understood that any copying or publication or other use of this dissertation or part thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and to the University of North Dakota in an scholarly use which may be made of any material in my dissertation.

Signature  

Date  

June 14, 2010
TABLE OF CONTENTS

LIST OF FIGURES ................................................................................................................................. xii

LIST OF TABLES ....................................................................................................................................... xiii

ACKNOWLEDGMENTS ............................................................................................................................... xv

ABSTRACT .................................................................................................................................................... xvi

CHAPTER

I. INTRODUCTION ................................................................................................................................... 2

Problem Overview ................................................................................................................................. 3

Purpose of the Study ............................................................................................................................... 7

Significance of the Study ......................................................................................................................... 7

Research Questions and Hypotheses ...................................................................................................... 10

Research Question 1 .............................................................................................................................. 10

Plan ......................................................................................................................................................... 10

Research Question 2 .............................................................................................................................. 10

Plan ......................................................................................................................................................... 10

iv
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research Question 3</td>
<td>11</td>
</tr>
<tr>
<td>Plan</td>
<td>11</td>
</tr>
<tr>
<td>Hypotheses</td>
<td>11</td>
</tr>
<tr>
<td>Plan</td>
<td>12</td>
</tr>
<tr>
<td>Delimitations and Assumptions</td>
<td>12</td>
</tr>
<tr>
<td>Limitations</td>
<td>13</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>14</td>
</tr>
<tr>
<td>Empowerment</td>
<td>14</td>
</tr>
<tr>
<td>Parish Nurse</td>
<td>15</td>
</tr>
<tr>
<td>Clergy</td>
<td>16</td>
</tr>
<tr>
<td>Faith Community</td>
<td>16</td>
</tr>
<tr>
<td>Manager</td>
<td>16</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>17</td>
</tr>
<tr>
<td>Summary</td>
<td>24</td>
</tr>
<tr>
<td>II. REVIEW OF LITERATURE</td>
<td>26</td>
</tr>
<tr>
<td>Literature Search Sources</td>
<td>26</td>
</tr>
<tr>
<td>Expansion of Previous Work</td>
<td>26</td>
</tr>
</tbody>
</table>

Produced with permission of the copyright owner. Further reproduction prohibited without permission.
Parish Nursing ..................................................................................27

Historical Perspective of Parish Nursing .................................27

Parish Nursing Practice ...............................................................28

Role of the Parish Nurse .............................................................30

Structures for Parish Nursing Practice ........................................31

Employment, Salary, Nursing Experience, and Basic Nursing Educational Preparation Characteristics of PNs ..........................................................33

Perceptions of the PN Role ..........................................................37

Summary of Parish Nursing .........................................................39

Empowerment .............................................................................40

Empowerment and Non-Nursing Literature ...............................41

Summary of Empowerment and Non-Nursing Literature .............45

Empowerment and Nursing Literature ..........................................45

Perceptions of Structural Empowerment ......................................45

Basic Nursing Educational Preparation, Years of Nursing Experience, Type of Experience, and Characteristics of Nurses ..................................................48

Relationship Between Structural Aspects of the Workplace and Perceptions of Empowerment ...............................57
Empowerment, Parish Nursing, and Faith Communities ..........83

Perceptions of Empowerment ...........................................83

Structures of Empowerment within Faith Communities .. 84

Gender Differences in Faith Community Leadership ......85

Summary of Empowerment within Faith Communities ..86

Summary .........................................................................................86

III. RESEARCH DESIGN AND METHODS ...............................................90

Research Design ............................................................................90

Population and Sample .................................................................91

Population and Setting .................................................................91

Sample ...............................................................................92

Sampling Procedure ...........................................................92

Recruitment and Retention ............................................................93

Power Analysis ............................................................................94

Instrumentation ..............................................................................95

Variables and Measures ....................................................95

Empowerment...........................................................................95

Demographic Variables .............................................................97

Data Collection Procedure ......................................................98

Data Analysis Procedure ...........................................................99

Hypotheses and Research Design ...................................100

Hypothesis 1..........................................................100

Research design ...........................................................100
<table>
<thead>
<tr>
<th>Figure</th>
<th>Description of Study Sample and Response Rates</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Description of Study Sample and Response Rates</td>
<td>108</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Reasons for Lack of Current Activity as a PN by Frequency and</td>
<td>107</td>
</tr>
<tr>
<td></td>
<td>Percentage</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Personal Religious Affiliation of the PN by Frequency and</td>
<td>110</td>
</tr>
<tr>
<td></td>
<td>Percentage</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Religious Affiliation of the Faith Community Served by the PN by</td>
<td>111</td>
</tr>
<tr>
<td></td>
<td>Frequency and Percentage</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Geographic Location of Faith Community by Frequency and</td>
<td>111</td>
</tr>
<tr>
<td></td>
<td>Percentage</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Size of Faith Community Served by PNs by Frequency and</td>
<td>112</td>
</tr>
<tr>
<td></td>
<td>Percentage</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Years of Service as a RN and as a PN by Frequency and</td>
<td>113</td>
</tr>
<tr>
<td></td>
<td>Percentage</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Highest Level of Nursing Education Attained by PNs by Frequency and</td>
<td>114</td>
</tr>
<tr>
<td></td>
<td>Percentage</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Highest Level of Non-nursing Education Attained by PNs by</td>
<td>114</td>
</tr>
<tr>
<td></td>
<td>Frequency and Percentage</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Previous and Current Nursing Practice of PNs by Frequency and</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td>Percentage</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Model of PN Practice by Frequency and Percentage</td>
<td>116</td>
</tr>
<tr>
<td>11.</td>
<td>Number of PNs that Serve with the PN by Frequency and</td>
<td>117</td>
</tr>
<tr>
<td></td>
<td>Percentage</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Hours Worked as a PN per Week by Frequency and Percentage</td>
<td>118</td>
</tr>
<tr>
<td>13.</td>
<td>Annual Gross Salary as a PN by Frequency and Percentage</td>
<td>119</td>
</tr>
<tr>
<td>14.</td>
<td>Faith Community Manager/Supervisor for the PN by Frequency</td>
<td>120</td>
</tr>
<tr>
<td></td>
<td>and Percentage</td>
<td></td>
</tr>
<tr>
<td>Table</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>15.</td>
<td>PN Position Description Usage in the Faith Community by Frequency and Percentage</td>
<td>121</td>
</tr>
<tr>
<td>16.</td>
<td>Summary of the CWEQ-II Overall and Subscale Mean Scores and Alpha Coefficients as Reported by PNs</td>
<td>123</td>
</tr>
<tr>
<td>17.</td>
<td>Univariate Results of Relationships Between Presence/Absence of a PN Position Description and CWEQ-II Subscale Scores as Reported by PNs</td>
<td>126</td>
</tr>
<tr>
<td>18.</td>
<td>Univariate Results of Relationships Between Salaried/Unpaid Status and CWEQ-II Subscale Scores as Reported by PNs</td>
<td>127</td>
</tr>
<tr>
<td>19.</td>
<td>Summary of Means and Standard Deviations for Salary and Hours Worked for PNs</td>
<td>128</td>
</tr>
<tr>
<td>20.</td>
<td>Salary Status and Religious Affiliation of the Faith Community Served by the PN by Frequency</td>
<td>128</td>
</tr>
<tr>
<td>21.</td>
<td>Salary Status and Geographic Location of Faith Community Served by the PN by Frequency</td>
<td>129</td>
</tr>
<tr>
<td>22.</td>
<td>Salary Status and Size of Faith Community Served by the PN by Frequency</td>
<td>130</td>
</tr>
<tr>
<td>23.</td>
<td>Salary Status and Nature of PN Position by Frequency</td>
<td>130</td>
</tr>
<tr>
<td>24.</td>
<td>Salary Status and PN Position Description Usage in the Faith Community by Frequency</td>
<td>131</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

I wish to, first and foremost, thank God for providing me with the guidance, courage, and wisdom to complete this incredible journey. Often I called to him in prayer to provide the strength to continue in the work. I am very thankful to my husband, Bruce, who juggled many of the home responsibilities and provided unconditional love so that I could pursue this goal. To my children, Katherine and Kirsten, who spent many evenings and weekends waiting for me to complete another assignment. Much thanks to my family, friends, and colleagues who served as sounding boards and cheerleaders throughout this process. I am grateful to Lu and Annette who provided the "gentle nudge" to get started in the program. Special thanks to the parish nurses who lifted this work up in prayer during this process. Next, I would like to express my gratitude to Dr. Helen Melland and Dr. Julie Anderson for serving as my academic advisors, dissertation chairs, and mentors. They both had faith in my ability to complete the doctoral program and the dissertation process. They knew my abilities and pushed me to a higher level of achievement. I would like to thank the other members of my dissertation committee (Dr. Elizabeth Tyree, Dr. Bette Ide, and Dr. Thomasine Heitkamp) who provided insights and wisdom on empowerment, faith communities, research methods, and statistical analysis. Special thanks to Dr. Albert Bartz and Dr. David Roth for their statistical wisdom and patience as they guided me in a deeper understanding of statistical analysis. And finally, I would like to thank my fellow classmates in the doctoral program for their contribution to my growth in knowledge and for their friendship.
To Bruce, Katherine and Kirsten

In Memory of Anthony
ABSTRACT

Parish nursing is a community-based subspecialty practice of nursing. The parish nurse (PN) melds spiritual care with nursing practice to wholistically address the needs of parishioners and faith communities. PNs work with other health care providers and organizations, as well as lay and professional church leaders to successfully develop, organize, and lead health promoting and spiritually healing activities. Empowerment of PNs is necessary to achieve positive outcomes of PN directed initiatives. Empowerment occurs through supportive and nurturing environments, as well as access to resources, information and power. However, multiple professional demands, interpersonal conflicts, and lack of adequate resources have created disempowering environments for PNs. These barriers may be further exacerbated by the lack of empowerment structures within faith communities for PNs.

As parish nursing is a relatively new specialty practice of nursing, little is known about the organizational structures of faith communities and the placement of parish nursing within the organization. Using a quantitative, descriptive, correlational design, the researcher explored the concept of structural empowerment with nurses in their PN roles within faith communities. The majority of respondents were well-seasoned nurses, but relatively new PN practitioners, who practiced as unpaid staff within a congregational-based model of practice. Similar to findings of staff nurses in hospital settings, school nurses and nurse clinicians, the researcher found that parish nurses expressed a moderate perception of structural empowerment in their role as PNs.
Nurses who had more years of nursing experience reported that they had greatest access to opportunities and to information within the faith community setting. PNs who received a salary for their PN work reported more access to formal and informal power, opportunity, information and support than PNs who were unpaid. In addition, salaried PNs worked significantly more hours per week and reported using a position description more often than unpaid PNs.

The outcomes of this research will aid in the understanding of empowerment within this unique setting, and will assist with the development and improvement of policies and structures related to empowerment within faith communities.
CHAPTER ONE
INTRODUCTION

Parish nursing is a community-based health promotion, disease prevention specialty practice of nursing with a focus on spiritual care (Solari-Twadell, 1999a). Parish nursing focuses on caring for the whole person - body, mind, and spirit - in the context of service within a faith community. From an ontological perspective, "to be is to be a part of - to find identity within a community of significant others..." (Shelly & Fish, 1988). Parish nurses provide wholistic care by addressing the biological, psychological, sociological needs of the client with special attention to the spiritual needs of the client in the context of the rites and rituals of a faith community. Dossey, Keegan and Guzzetta (2000) would add that spirituality goes beyond religiosity to include one's "values, meaning, and purpose in life" (p. 8). Working within faith communities, the parish nurse (PN) melds spiritual care with nursing practice to wholistically address the needs of parishioners and faith communities. As community-based care providers, PNs work with other health care providers and organizations, as well as lay and professional church leaders to successfully develop, organize, and lead health promoting and spiritually healing activities. Empowerment of PNs is necessary to achieve positive outcomes of PN directed initiatives. Empowerment occurs through supportive and nurturing environments, and through access to resources, information and power (Kanter, 1977). However, multiple professional demands, interpersonal conflicts, and lack of adequate resources have created disempowering environments for PNs (Bokinskie & Kloster,
This chapter outlines the problem, the purpose, significance, specific aims, research questions, hypotheses, assumptions, limitations, definition of terms and theoretical framework of this study. A discussion of the need for the study concludes this chapter.

Problem Overview

As community-based care providers, PNs work with other health care providers and organizations, as well as lay and professional church leaders to successfully organize, lead, and develop health promoting and spiritually healing activities. The PN serves the faith community by focusing on the needs of the individual parishioner, the entire faith community, and the surrounding geographic area with attention to spiritual needs. The PN role includes seven functions within health and healing ministry (a) health educator, (b) personal health counselor, (c) volunteer coordinator, (d) community liaison/referral agent, (e) developer of support groups, (f) health advocate, and (g) integrator of faith and health (Solari-Twadell, 1999a). Furthermore, activities within the PN role include (a) organizing health screenings and health fairs, (b) referring parishioners to health care providers and services, (c) actively listening to parishioners' life stories, (d) advocating for access to health care and healthy lifestyles, and (e) offering prayer and spiritual support. The development and implementation of effective programs necessitates a supportive environment and professional autonomy. These characteristics are part of an empowered work environment. Empowerment of parish nurses is necessary to achieve
positive outcomes within faith communities. However, multiple professional demands, interpersonal conflicts, and lack of adequate resources have created situations of powerlessness for PNs (Bokinskie & Kloster, 2008; Weis, Schank & Matheus, 2006).

As both a process and outcome, empowerment is a participatory process within an organization for the development of meaningful work environments. Empowerment occurs through supportive and nurturing environments, and with access to resources, information and power. Empowerment in nursing is important because it has been linked to positive outcomes such as perceived control over nursing practice, or autonomy (Laschinger, Finegan, & Shamian, 2001; Laschinger & Havens, 1996; Spence Laschinger & Finegan, 2005). In addition, empowerment has been positively linked to enhanced nurse accountability (Laschinger & Wong, 1999). High levels of workplace empowerment are reportedly related to a high level of job satisfaction and low levels of job tension (Davies, Laschinger & Andrusyszyn, 2006; Laschinger & Havens, 1996; Laschinger, Wong, McMahon & Kaufmann, 1999). Staff nurses who perceived they were psychologically empowered and worked in an empowered environment expressed positive feelings about their work and greater confidence in their work abilities (Laschinger, Finegan, Shamian, & Almost, 2001). Empowered nurses reportedly promote a positive client climate for safety and enhance patient satisfaction with nursing care (Armstrong & Laschinger, 2006; Donahue, Piazza, Griffin, Dykes & Fitzpatrick, 2008). Perceptions of empowerment may be related to one’s position within the health care setting, one’s level of nursing education, or one’s years of clinical practice. In acute care settings, staff nurses’ perceived empowerment scores were found to be moderate, while nurse managers were significantly higher (Fitzpatrick, Campo, Graham, & Lavandero,
2010; Laschinger, 1996; Laschinger & Havens, 1996). Inconsistencies were found in the literature concerning perceptions of empowerment of staff nurses in relation to level of basic nursing education and years of nursing practice (Davies et al., 2006; Faulkner & Laschinger, 2008; Fitzpatrick et al, 2010; Laschinger & Havens, 1996). Empowering organizational structures include having access to formal position descriptions, relationships within and outside of the workplace, constructive feedback, practical training, current equipment, and financial support (Almost & Laschinger, 2002; Laschinger & Havens, 1997).

Other authors suggest that nurses are oppressed and powerless within the current health care system and empowerment can only occur through liberation (Giddings, 2005; Harden, 1996). As members of a historically female occupation, nurses provide essential care for patients, but are nearly invisible to physicians, policy makers, and health care administrators. According to Sigurdsson (2001), nurses typically have little input or control in acute care settings or in the management of patient care. Nurses experience similar situations in community-based health care settings. Public health nurses reportedly conceptualized empowerment as an “active, internal process of growth” (Falk-Rafael, 2001, p.4). The role of the nurse has been seen as a facilitator of opportunities for clients to gain self awareness and control over their own health “as a matter of responsibility to do so in referring to empowerment as a matter of social justice and equity” (Falk-Rafael, 2001, p.4). It is through empowerment of others that the public health nurses perceived empowerment. Nurses who practice within faith community settings have also expressed concerns about empowerment within congregations or parishes. In the only qualitative study found in the literature that
explored the process of empowerment of PNs, multiple personal and professional demands, conflicts within the faith community, and lack of adequate resources to develop and maintain health and healing programs reportedly created disempowering environments for PNs (Weis, Schank, & Matheus, 2006). These barriers may be further enhanced by the lack of organizational structures within the faith community setting that provide support for lay professionals, such as PNs. The PNs may perceive themselves as guests or novice within the faith community setting. Much time may be spent in forming relationships, developing understanding of the functions of the PN, and integrating the PN role into the structure of the faith community. Because the PN specialty is relatively new, little is known about the organizational structures of faith communities, where parish nursing fits within the organization, the processes that support programs, and the outcomes of parish nursing ministries.

Previous studies found that PNs believe it is essential to work with health care providers, clergy, and congregational boards to effectively develop, facilitate, and implement health promoting and spiritually focused activities for individuals and groups within faith communities (Blanchfield & McLaughlin, 2006; Bokinskie & Kloster, 2008; Brudenell, 2003). Furthermore, empowered nurses perceive more autonomy, create professional environments and create more positive client outcomes (Armstrong & Laschinger, 2006; Donahue et al., 2008; Laschinger & Finegan, 2005; Laschinger, Finegan, & Shamian, 2001; Laschinger & Havens, 1996). Therefore, a workplace with empowering structures for PNs is necessary to achieve positive outcomes for PN initiated activities within faith communities.
Purpose of the Study

The purpose of this study was to explore perceptions of structural empowerment of PNs. The specific aims were to (a) assess the nurses' perceived level of structural empowerment in their role as PNs, (b) investigate the relationship between the nurse's overall perceived level of structural empowerment and the global measure of empowerment in their role as PNs, and (c) examine the relationship between the nurses' demographic variables and perceived level of structural empowerment in their role as PNs.

Significance of the Study

The number of persons currently underserved by the health care system is of concern. On a daily basis, the media provides stories of escalating costs, fragmentation of care delivery, and the inaccessibility of health care services. Attempts to control the escalating costs have resulted in the rationing and denial of health care and dominance of the medical model's focus on illness care (Evans, 1999). Making health care affordable has forced the health care industry and the U.S. government to examine ways to address the current health care crisis.

Nurses have long been concerned about the health care system's focus on illness care and its relative disregard for health promotion and disease prevention. A hospital chaplain, Rev. Granger Westberg (1987) stated, "Nurses have been pleading with the medical profession for 40 years to become more preventive-medicine oriented – to teach people how to stay well" (p.16). Nurses convinced Westberg that a multidisciplinary approach was needed in the provision of care. In an attempt to provide holistic health care in the late 1960's, Westberg and colleagues experimented with placing health clinics
within churches by utilizing physicians, nurses and clergy as care providers (Westberg, 1999). As Westberg noted "it was clear that the nurses in each of these centers were the glue that bound these three professions together in a common appreciation of the healing talents of each." (1999, p. 35). In the early 1980's with a looming economic crisis, Westberg (1999) continued to focus his attention on the care of the body, mind, and spirit. As both a man of vision and action, Westberg found six churches willing to trial nurse-led health centers and provide access to health care services through faith-based communities. From the humble beginnings of six churches has grown a ministry that has surpassed the expectations of many.

The International Parish Nurse Resource Center (IPNRC) reported that there are approximately 12,000 PNs practicing in all 50 states (2009a). This number is a conservative estimate as it reflects those reported by PN educating bodies who are partnered with the IPNRC and does not reflect the PN program alumni who have completed non-affiliated IPNRC educational programs. There were no statistics found in the literature that reported the numbers of faith communities served by PNs throughout the U.S. In the Upper Midwest, the Concordia College Parish Nurse Center has provided basic PN education to an estimated 1,450 nurses who serve in an estimated 650 Christian faith communities. Concordia College, a college of the Evangelical Lutheran Church in American, is located in Moorhead, MN. The alumni of the Concordia College Parish Nurse Center reside primarily in North and South Dakota, Minnesota, Wisconsin, and Iowa.

In an unpublished investigation, Bokinskie and Kloster (2005) found that PNs provided many diverse services within their faith community settings. The estimated
numbers of monthly health risk monitoring events by the 309 currently practicing PN respondents included 3,600 blood pressure assessments, 375 blood glucose screenings, 158 foot assessments, 156 depression risk assessments, and 152 cholesterol screenings. In addition to health risk screenings, the PNs implemented health promotion activities, emotional support and health counseling, offered prayer and rituals, and made referrals within the faith community and to outside community organizations. If the interventions performed by these PNs were extrapolated to other PNs in the country, the impact on the health and wellbeing of the individual parishioners and the faith community could clearly be seen.

PNs must be able to work with health care providers, clergy, and congregational boards to effectively develop, facilitate, and implement health promoting and spiritually focused activities. Empowerment of PNs is necessary to achieve positive program outcomes within faith communities. Empowered nurses perceive more autonomy, create professional environments and create more positive client environments (Armstrong & Laschinger, 2006; DeSisto & DeSisto, 2004; Roche, Morsi & Chandler, 2009). At the present time, there exists a dearth of knowledge related to PNs and their practice settings. This research was important because it provided foundational knowledge on perceptions of structural empowerment of nurses in their role as PNs. This study was expected to provide a baseline of understanding of the components of empowerment within faith communities, as well as the perceived level of empowerment of nurses in their role as PNs. In addition, the relationships between demographic variables and perceptions of structural empowerment of the nurses in their role as PNs were examined. The outcomes of this research will aid in the understanding of empowerment within this unique setting,
and the development and improvement of policies and structures related to empowerment within faith communities. Therefore, the findings from this research will assist PN educators and faith community administrators in developing programs that address the process and outcomes of empowerment and facilitate the understanding and creation of empowering work environments for PNs.

Research Questions and Hypotheses

Research Question 1

The first research question was: What are nurses’ perceived levels of structural empowerment in their role as PNs?

Plan. This question addressed nurses’ perceptions of structural empowerment in their role as PNs using the Conditions of Workplace Effectiveness Questionnaire – II (CWEQ-II). The overall and subscale mean scores on the CWEQ-II were calculated and reported.

Research Question 2

The second research question was: What is the relationship of scores between nurses’ overall perception of structural empowerment on the CWEQ-II and the global measure of empowerment in their role as PNs?

Plan. In order to investigate the relationship between nurses’ overall perceived level of structural empowerment and the global measure of empowerment in their role as PNs, the CWEQ-II and the Global Measure of Empowerment were administered to the
study participants. The global measure and overall CWEQ-II mean scores were calculated, correlated and reported.

Research Question 3

The third research question was: What is the relationship between nurses' years of nursing experience, type of previous nursing experience, level of basic nursing education, presence/absence of a position description, and salaried/unpaid position with overall and subscale perceptions of structural empowerment in their role as PNs?

Plan. In order to investigate the relationship between nurses' demographic variables and perceptions of structural empowerment in their role as PNs, the CWEQ-II and a demographic questionnaire were administered to the study participants. Overall and subscale mean scores on the CWEQ-II were correlated with the demographic variables and reported. A multivariate analysis of variance (MANOVA) with multiple independent variables was utilized. The independent variables were the demographic variables, while the dependent variables were the overall and subscale scores on the CWEQ-II tool.

Hypotheses

Hypothesis 1: The nurses will perceive a moderate level of overall and subscale structural empowerment as reported on the CWEQ-II, in their role as PNs.

Hypothesis 2: There exists a relationship between the nurses' perceptions of a global measure of empowerment and the overall perceived level of structural empowerment in their role as PNs.
Hypothesis 3: There exists a relationship between nurses’ years of nursing experience, type of previous nursing experience, level of basic nursing education, presence/absence of a position description, and salaried/unpaid position with overall and subscale perceptions of structural empowerment in their role as PNs.

Plan. The research questions were addressed through the administration of a survey tool containing a demographic questionnaire, the CWEQ-II, and the Global Empowerment tool. These research questions were explored using a quantitative descriptive approach.

The investigator has long-term research goals that build upon this foundational research and contribute significantly to the scientific nursing knowledge base on the practice and impact of parish nursing upon the faith community. This study extends the body of nursing knowledge, which may enhance current parish nursing curriculum and improve parish nursing practices within faith communities. Ultimately, faith communities and their members will benefit through enhanced health and healing programs developed and implemented by the parish nurse.

Delimitations and Assumptions

The data were collected between October and December of 2009 using a web-based or paper formatted questionnaire. The study participants consisted of currently practicing PNs that were alumni of the Concordia College Parish Nurse Center’s Basic Parish Nurse Preparation program. The majority of PN alumni reside and practice in the Upper Midwest with a small number representing other parts of the U.S.
The intent of the study was to glean insights on empowerment from practicing PNs. Assumptions include that all participants had openness, honesty (credence) and willingness to participate. It was also assumed that participants accurately shared insights regarding empowerment structures, power, and relationship issues in their current faith communities. The study variables were identifiable through self-report and it was assumed that participants were able to read and follow directions on a web-based or paper formatted document. The individuals who chose not to participate may have more negative perceptions of their faith communities and leaders than the participants who chose to participate in the study. However, it was not possible to assess how nonparticipants differ from participants in this study.

When measuring perceptions of structural empowerment, the researcher must be cognizant of other factors that might impact one’s perceptions of relationships and power. These factors include personal issues of communication patterns/styles, impact of family commitments, and personal relationships between individuals at all organizational levels. As with other researchers in this topic area, this researcher believes that empowerment can be quantitatively measured.

Limitations

The investigator’s experience as a researcher may be a limitation to the research study. However, the investigator has nine years of experience as a parish nursing educational program director, thirteen years of experience as a PN, twenty years of experience as a baccalaureate nurse educator, and nearly thirty years of clinical nursing practice. While she has some experience as a co-investigator in a number of research
studies, she has never completed a study as the sole researcher. The investigator has some research experience with PNs. In a three-year quantitative descriptive study, Parish Nurse Performance Measure and Outcome Survey (2003-2005), the researcher and a colleague examined the factors of success and barriers to PN practice. Although this study was not focused on the concept of empowerment, the findings provided foundational knowledge for this current research study. Two additional studies with this population explored the practice of parish nursing within a specific religious tradition and the outcomes of shelter faith community nursing interventions on client-led behaviors. This researcher has successfully completed doctoral education in quantitative research and statistical methods, and has engaged in mentored research guided by experienced quantitative researchers. Therefore, the investigator’s experience in research should not serve as a barrier to the study.

Definition of Terms

The following section identifies the definitions used for this research study.

Although many of the terms have different meanings for others, the definitions selected represent the researcher’s definitions that have been identified in the nursing literature, utilized in PN education, and in PN practice.

Empowerment

Multiple definitions of empowerment exist in the social, psychological, and nursing related literature. These definitions focus on empowerment of individuals, communities, or work settings. This researcher has identified empowerment as a structural process within a work environment that allows individuals to take personal
responsibility to complete work-related goals, with outcomes that impact the nurse’s behavior and attitudes towards self, colleagues or clients. The structural process within the workplace includes formal and informal power systems which influence one’s access to opportunity, resources, information, support and proportions. Power reflects autonomy over one’s work. Formal power is one’s perceived centrality to the organization, while informal power reflects one’s connectedness with others within and outside of the organization. Access to opportunity is defined as access to professional development activities and to challenging work assignments. Resources include money, tools, and time. Information includes institutional policies and procedures, and technical knowledge. Support is defined as feedback from colleagues and managers. Empowerment can be quantitatively measured as a perception of more or less, not all or nothing. This definition is consistent with that of Kanter (1993) who defined power as the “ability to get things done, to mobilize resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet” (p. 166).

Parish Nurse

A PN is a registered nurse, currently licensed in the state of practice, who has completed a basic parish nurse preparation program through educational entities affiliated with the IPNRC. For this study, the nurse completed the Concordia College Parish Nurse Center’s Basic Parish Nurse Preparation course. A PN serves a faith community as a lay professional either directly as a care provider or indirectly as a manager of care provided by other parish nurses or other lay faith-based health and healing ministers. The practice of parish nursing is defined by each state’s nurse practice act and standards of practice. Other names include faith community nurse, church nurse, or congregational nurse.
Clergy

Clergy include lay and professional faith community leaders. The role of the clergy is to lead worship activities and/or participate in rites and rituals of the specific faith denomination. Other names for clergy include priest, pastor, worship leader, deacon, and rabbi.

Faith Community

A faith community has missional roots in a single or multi-faith tradition(s). It may take place within a formal setting (a church or synagogue) or within an informal setting (homeless shelter or neighborhood health care center). It is a setting in which members, residents or guests are offered, but are not obligated to participate in, the rites and rituals of faith tradition(s).

Manager

A manager is a lay church leader or administrator, a rostered or ordained faith community leader, or a health system administrator who coordinates and oversees the health and healing ministry of the faith community. For this study, the manager is the individual responsible for the supervision and the evaluation activities of the PN or PN coordinator. Other names for a manager include priest, pastor, parish nurse coordinator, parish nurse manager, community relations manager, and health and healing ministry coordinator.
Theoretical Framework

Empowerment has been explored in industry and business environments. Much research has been conducted by Rosebeth Kanter (Harvard Business School social scientist) in corporate America. In addition, her research addresses workplace conditions for women. Based on a 5-year ethnographic study at a large American manufacturing corporation, Kanter’s (1977, 1993) structural theory of power in organizations (or theory of empowerment) provides a framework for understanding power and empowerment within organizations (See Appendix A for Kanter’s theoretical framework).

The central thesis of Kanter’s (1977, 1993) theory is that structural aspects of one’s work, which include the environment, culture, and setting, shape one’s job effectiveness, and influence one’s perceptions of empowerment. Kanter stated that a work setting that provides access to support, resources, information, and opportunities shapes one’s job effectiveness and influences one’s perceptions of empowerment. When situations are structured in a way that individuals feel empowered, they are more likely to work towards organizational goals, as they perceive a sense of worth and accomplishment in their work. Kanter (1977) also argued that because people react rationally to situations within the workplace, the impact of organizational structures on organizational behavior is greater than the impact of employee personality traits or socialization experiences. Organizational power is not about taking away power from others, but is about access to power. Organizational power is not about oppression but about control and autonomy over one’s own work situation so that one can be successful in client care or work activities.
To attain power, Kanter (1977) purported that a person must be in a position that has both accountabilities and responsibilities. Brown and Kanter wrote, “Individuals who have accountability without power – responsibility for results without the resources to get them – creates frustration and failure.” (1982, p. 7). Powerless managers may attempt to create their own sense of power by becoming rigid, bossy and coercive. In their inflexibility, they become controlling and “circle the wagons” around their work unit (Kanter, 2001). Conversely, the role of effective and powerful managers is to provide employees with tool or structures to address oppression within the work place (Bigony, Lipke, Lundberg, McGraw, Pagac, & Rogers, 2009).

As a process, empowerment enables one to attain power and gain access to structures that help create a work environment that is conducive to positive outcomes. This view associates empowerment with shared decision-making and autonomy rather than authoritative dictates and submission (Hage & Lorensen, 2005). Kanter maintains that empowered individuals are more likely to empower others, function within the team, participate in decision-making, have an increased quality of work life, and be less likely to suffer from burnout (1977, 1993).

In Kanter's (1977) theory, power is the capacity to organize resources in order to accomplish the work. Formal and informal power comprises the systemic power factors of the theory. Formal power includes one’s job activities, amount of visibility, and perceived importance within the organization. Formal power is acquired by excellent job performance that is creative and relevant to the function of the organization. Informal power comes from collaborative partnerships with others and connections outside of the organization. It is acquired through long-term mentoring relationships with individuals in
positions of power. These relationships provide the nurturing, grooming, and support for upward mobility within the organization. Informal power provides the connections with the people in the know. Kanter (1993) asserts that the combination of formal job characteristics and informal relationships (systemic power factors) influences and facilitates the individual's access to work empowerment structures of opportunity, power, and proportions.

Kanter (1977) described three empowerment structures – opportunity, power, and proportions. Empowerment structures provide opportunities for development within the workplace, access to power and a social network that includes information, support, and resources. The structure of opportunity reflects the individual’s prospect for professional growth and challenges within the organization (Laschinger & Havens, 1997). Opportunity may include autonomy, professional development, and challenging work assignments. Administration may implement a variety of methods to increase opportunity experiences including offering educational seminars and adding new or relevant work challenges. Individuals who perceive a sense of opportunity in their work may heartily invest themselves in the organization. Invested individuals reportedly enjoy their workplace, view work as an exciting and challenging daily venture. Conversely, individuals who lack opportunity may separate themselves from their work and view their employment as laborious tasks. According to Kanter, the structure of power comes from three sources (a) access to resources, (b) access to information, and (c) access to support (Sarmiento, Laschinger, & Iwasiw, 2004). Access to resources necessitates adequate money, resources and time to achieve organizational outcomes. Access to information includes having relevant institutional policies, current technical knowledge, and expertise.
to effectively perform one's job responsibilities. Access to support includes guidance and feedback from supervisors, colleagues, and subordinates. Power may be enhanced through assuring resources to accomplish work, timely constructive criticism, and appropriate sharing of information.

According to Kanter, access to empowerment structures is facilitated by the amount of formal and informal power that the individual has access to within the work setting (Sarmiento, Laschinger, & Iwasiw, 2004). Access enables the individual to successfully accomplish their work within the organization and motivate others through the sharing of empowerment structures (Caspar & O'Rourke, 2008). When situations are structured in a way that individuals feel empowered, they are more likely to work towards organizational goals, as they perceive a sense of worth and accomplishment in their work (Kanter, 1979). Kanter purports that without access to empowerment structures, individuals are unsuccessful in their accomplishment of tasks. Unsuccessful individuals may consider their position as a dead-end job as it does not allow upward mobility and this may lead to a perception of powerlessness, feelings of frustration and failure. Kanter (1977) found that the work of management is to create workplace conditions that ensure employees have access to job-related empowerment structures.

The structure of proportions is the social arrangement of people at the same level and is reflected as a "quantitative measure" (Upenieks, 2002, p. 623). Goddard and Laschinger (1997) identify this specific structure as the "social composition of peer clusters" (p. 42). Most groups are unequally divided by subgroup, often based on gender or ethnicity. The dominant group members, or common group, usually find it easier to: (a) join informal networks, (b) advance more quickly in the organization, (c) find upward
mobility easier to obtain, (d) face less workplace stress, and (e) enjoy a supportive social group. In contrast, the oppressed group reportedly struggle with isolation and job stagnation. Kleinman (2004) identified three conditions that adversely affect the oppressed group’s performance (a) group polarization, (b) performance pressure, and (c) assimilation. In her article on gender differences in nursing, Kleinman (2004) purported that men actually thrive on the conditions that cause adversity for females in the corporate world. In *Men and Women of the Corporation*, Kanter (1977) discussed the concept of proportions in depth. Although her focus was on gender differences, Kanter maintained that the structure of proportions also pertains to racial minorities, foreigners (or the non-locals), or occupational differences. Traditionally, executive leadership of healthcare organizations has been dominated by men, with women serving in low-profile supervisory positions (Kanter, 1979). According to Kanter, as first-line supervisors, women have little opportunity for advancement within the organization; as these positions are seen as “virtual dead end” (1979, p. 68). First-line supervisors are often called to implement programs and enforce policies in which they have had no input in development – they are in fact powerless. In addition, the few women who serve in executive positions are often socially isolated and acutely aware of the performance expectations held by their peers and subordinates. Fairhurst and Snavely (1983) reported that the presence of women at the executive level is a constant threat to traditions long held by the men in power. Therefore, as women enter high-level leadership positions support structures need to be in place to address their unique social needs.

Traditionally, faith community leadership has been centralized with male-dominated clergy, with women serving in lay supportive roles. In recent years faith
communities have seen an increase in the use of lay professionals to address the needs of parishioners. Individuals, primarily women, in these lay professional roles serve as church social workers, church psychologists, and PNs. Within the faith community setting, some PNs serve as program administrators or in ministry positions beyond their role as a PN. Therefore, it is important for faith communities to recognize these new positions within the faith community and address the unique needs of workers within the setting.

Kanter’s theory was expanded to include psychological empowerment as a product of structural empowerment and as a variable between job related empowerment structures and work effectiveness (Laschinger, Finegan, Shamian, & Wilk, 2001; Siu, Laschinger, & Vingilis, 2005). Psychological empowerment is defined by Spreitzer (1995) as a “motivational construct manifested in four cognitions: meaning, competence, self-determination and impact…reflect an active, rather than a passive, orientation to a work role” (p. 1444). Spreitzer further stated that the four components of psychological empowerment involve (a) a self-perceived congruence between the employees' job description and their personal values and beliefs, (b) a sense of control over their work, (c) confidence in their abilities to complete the work, and (d) the ability to influence the outcomes at work. In her initial research with mid-level employees in an industrial organization and lower-level employees from an insurance company, Spreitzer (1995) found that middle managers' perceptions of psychological empowerment were significantly related to access to information about organizational mission and self-esteem. One could argue that psychological empowerment is the personality that the individual brings to the organization. However, Kanter (1977) asserted that because
people react rationally to situations within the workplace, the impact of organizational structures on organizational behavior is greater than the impact of personality traits or socialization experiences. Some researchers have questioned Kanter’s narrow observation of organizational theories (Manojlovich & Laschinger, 2002; Corbally, Scott, Matthews, Gabhann, & Murphy, 2007). These authors believed that certain personality factors add to the individual’s variety of behavioral and emotional responses in the workplace and that it is not possible to separate them into measurable factors. Consistent with Spreitzer’s (1995) dimensions of psychological empowerment, these factors include a personal need for achievement and the need for high levels of mastery.

Kanter’s structural theory of power in organizations (or theory of empowerment) (1977) was selected for use in this research study for a number of reasons. Although for some readers it may be viewed as rather sequential, I believe that it provides an excellent framework to explore the concept of structural empowerment within faith community settings. As I began to explore the concept of empowerment in the literature, my focus was drawn to the aspects of formal and informal power as influencing factors for accessing work-related structures of opportunity, resources, information, support, and proportions. Previous discussions with PNs concerning their strategies for success in the ministry as well as their expressed barriers to practice began to find place within each of the factors and structures for empowerment. The more I explored the framework and Kanter’s work on empowerment within organizations; I saw similarities in the organizational structures of faith communities with industry and traditional health care settings. The theory exemplified the importance of the leadership team, within any setting, to create a workplace that provided access to technology, adequate financial
resources, networking opportunities, and visibility. I see Kanter’s theory (1977) as being useful for future studies that explore the outcomes of structural empowerment for PNs. It has been reported that access to job-related empowerment structures leads to many positive outcomes for the nurses, as well as positive outcomes for the care recipient. As parish nursing is a relatively new specialty nursing practice, there has been little documented within the literature about the organizational structures of faith communities or the structures of empowerment. Therefore, the use of Kanter’s theory provides this researcher with future direction for research activities.

Summary

Empowering practice environments provide nurses with control over their workplace and create positive professional environments (Armstrong & Laschinger, 2006). In addition, empowered nurses promote a positive client climate for safety and enhance patient satisfaction with nursing care (Armstrong & Laschinger, 2006; Donahue et al., 2008). Empowerment occurs through supportive and nurturing work environments, as well as access to information, resources, and power. As a new specialty of nursing practice, parish nurses work to promote wholistic health within faith communities. As community-based care providers, PNs must be able to work with health care providers, clergy, and congregational boards to effectively develop, facilitate and implement health promoting and spiritually focused activities. Empowerment of PNs is necessary to achieve positive program outcomes within faith communities. However, little is known about the structure in which PNs practice, or their perceptions of structural empowerment. This study provided foundational knowledge of perceived levels of empowerment, the process and outcomes of empowerment of PNs. At the present time...
there are no published studies that provide such insights into this subspecialty practice of
nursing. This study was innovative because it was the first descriptive study on
perceptions of levels of structural empowerment of PNs and the relationships between
select variables. Valuable information gleaned from the results will assist PN educators
and faith community administrators in developing programs that address the process and
outcomes of empowerment and facilitate the creation of empowering organizational
structures within faith communities. The long term outcomes of this research may serve
to strengthen parish nursing ministries within faith communities.
CHAPTER TWO

REVIEW OF LITERATURE

This chapter outlines the review of literature. The chapter provides a representative overview of parish nursing and empowerment. Identification of the gaps in knowledge and research conclude the chapter.

Literature Search Sources

This literature review utilized several primary sources to gather a comprehensive view of the concept of empowerment and parish nursing. Scholarly research articles were sought through Pub Med, Cumulative Index for Nursing and Allied Health Literature (CINAHL), SCOPUS, ERIC, PsycInfo, ATLA Religion Database and ATLAS. Throughout the literature search, key words utilized included combinations of the following: empowerment, power, collaboration, faith community, clergy relationships, education, parish nursing, PN, faith community nurse, management, lay faith community leadership, relationships, Kanter, Chandler, Laschinger, quantitative, and dissertation. Reference lists within scholarly articles offered additional insights into relevant literature sources. Efforts were made to review landmark, current and emerging literature.

Expansion of Previous Work

This research was an expansion of the researcher’s previous research that investigated parish nursing practice; specifically strategies for success and barriers to
practice (Bokinskie & Kloster, 2008). The focus of the current research was to explore the concept of workplace empowerment rather than strategies for success in PN practice. This chapter builds upon the author’s previous scholarly work and research by others on empowerment in order to examine perceptions of empowerment as a factor in perceptions of success in PN practice.

Parish Nursing

Historical Perspective of Parish Nursing

The seeds for the development of parish nursing were planted in the 1940s when the Reverend Granger Westberg was convinced that the body could not be treated without concern for the mind and spirit (1987). Believing that congregations should have a key role in wholistic health care, Westberg (1990) and colleagues developed health centers within faith community settings. He stated, “Care for all of the people of God is a part of the church’s mission, of its understanding of the Christian gospel” (Westberg, 1990, p. 9). As a hospital chaplain, Westberg worked with doctors, nurses, clergy, and social workers to care for patients in a wholistic manner and to integrate the role of the church as part of the care team. He quickly found that nurses were best suited to integrate issues of faith and health for patients and to bridge the gap between the medical and faith communities. Under his guidance, the specialty nursing practice of parish nursing (or faith community nursing) began in the early 1980s. The first parish nursing program was established under Westberg’s direction with six churches at Lutheran General Hospital in Park Ridge, Illinois (Westberg, 1990). The initial program included churches from Catholic and Protestant denominations. Thirty years later, there are PNs practicing in all
50 states and throughout the world working within a variety of faith communities, representing many different faith traditions (IPNRC, 2009a).

Parish Nursing Practice

The practice of parish nursing is focused on caring for the whole person - body, mind, and spirit - within faith communities with focused attention to the individual's spiritual health. Working within faith communities, the PN melds spiritual care with nursing practice to wholistically address the needs of faith communities and the surrounding geographic area. According to Joel (1998), nurses are drawn into parish nursing because it encourages the expression of spirituality as a part of health and healing, while others become PNs out of a sense of vocational calling (Mosack, Medvene, & Wescott, 2006). The PN role allows the nurse to practice wholistically by attending to the needs of the body, mind and spirit while in relationship to God, faith community, and colleagues. Brendtro and Leuning maintain that the church is "one constant community resource" available to meet the needs of the underserved and marginalized (2000, p. 286). As community-based care providers, PNs work with other health care providers and church leaders to organize and implement health promoting and spiritually healing activities. A faith-based PN program can provide the health promotion activities, emotional and spiritual support consistent with the beliefs of the faith community.

Although specific or mandatory educational requirements do not exist for parish nursing, a national curriculum was developed in the 1980s by experts within the field of parish nursing and continues to be available through educational bodies affiliated with the
IPNRC (International Parish Nurse Resource Center). It is often referred to as the "endorsed" curriculum by practicing PNs and PN educators. Since its development, the curriculum for basic parish nursing education has undergone four revisions. Recent revisions include an international focus and diverse faith tradition components. Affiliated educational bodies and PN educators are not mandated to follow the exact content outline of each of the twenty modules of the curriculum; however the educators are expected to address all of the curriculum's behavioral objectives during the basic PN preparation course. There are an estimated 130 educational affiliates of the IPNRC and approximately 12,000 PNs in the United States who have completed the coursework which is affiliated with the IPNRC (IPNRC, 2009a).

In 1997, the American Nurses Association designated parish nursing as a specialty practice of professional nursing (ANA, 1998). As the specialty practice grew nationally and internationally, the term "parish nurse" was not appropriate for some faith traditions. Therefore, the title "faith community nurse" was adopted as it is more inclusive of the practice (ANA, 2005). However, the term "parish nurse" is acceptable and often used in the literature. Faith community nursing, or parish nursing, is defined as "the specialized practice of professional nursing that focuses on the intentional care of the spirit as part of the process of promoting wholistic health and preventing or minimizing illness in a faith community" (ANA, 2005, p.1). Therefore, in order to practice in this specialty role, the PN must maintain an active nursing license in the state(s) in which she/he is working in a professional nursing capacity. In addition, the IPNRC recommends that the individual has a bachelor’s degree in nursing and five years of experience as a nurse (IPNRC, 2009b). Preparation at the baccalaureate level provides the groundwork
for community-based nursing interventions, such as congregational assessments, population based program development, and program implementation (Hickman, 2006). Furthermore, IPNRC (2009b) stated that the PN should have experience in medical-surgical nursing and community health nursing as well as theological or clinical pastoral education. There were no studies found in the literature that supported the value of type of nursing background or basic nursing educational level.

Role of the Parish Nurse

The PN serves the faith community by addressing the health needs of the individual parishioner, faith community and surrounding geographic community. Functions of the parish nurse role are (a) health educator, (b) personal health counselor, (c) volunteer coordinator, (d) community liaison/referral agent, (e) developer of support groups, (f) health advocate, and (g) integrator of faith and health (Solari-Twadell, 1999a). Activities within the parish nurse role include (a) providing basic health screenings, (b) organizing health/wellness fairs, (c) integrating faith and health in educational offerings, (d) referring parishioners to appropriate health care providers and support services, (e) actively listening to parishioners’ life stories, (f) advocating for access to health care services and for healthy lifestyles, and (g) offering prayer and spiritual support. In order to address the parishioner’s needs, the PN engages in relationships with clergy, health cabinet/wellness council, general faith community, and community health care agencies.

Some faith community-based health services are provided through health ministry teams. Team leadership is often under the direction of a PN who serves as the
coordinator, although some coordinators may be ordained or rostered clergy, lay faith community leaders, or health system managers (Catanzaro, Meador, Koenig, Kuchibbatla, & Clipp, 2006; McDermott, Solari-Twadell, & Matheus, 1999). Catanzaro et al. (2006) reported that clergy who work with PNs through health ministry teams may be more involved in health promotion and disease prevention activities and typically reported more positive outcomes as compared to clergy without health ministry teams. In addition, such clergy perceived a greater need for congregations to be involved in the health and healing ministries in the faith community.

Structures for Parish Nursing Practice

Brudenell (2003) examined the process of how faith communities formed a PN ministry program using a qualitative design and a grounded theory method. There were thirteen PNs, 8 clergy, 2 chaplains, and 1 PN manager interviewed for this study. The process of program development involved considerable support from the clergy, the faith community and by the individual PN. Forming connections with others was seen as an important component of collaboration and the basis for understanding the needs of the faith community. Brudenell (2003) stated that a mutual relationship between the PN and the clergy was important in the integration of a parish nursing ministry into the faith community. The relationship must be seen as collaborative and not competitive; the PN is not a substitute for a pastoral visit, rather as an enhancement of the health and healing ministry of the faith community (Blanchfield & McLaughlin, 2006). In a descriptive qualitative study to explore pastoral care provider’s perceptions of nurses as spiritual care providers, Cavendish, Edelman, Naradovy, Bajo, Perosi, and Lanza (2007) found that while pastoral care providers, or ordained hospital chaplains, viewed nurses as providers...
of spiritual care, few asked the nurse to help with spiritual care. Through the interview process, the pastoral care providers (n = 8) reported that they believed the nurses were focused on the technical aspects of care, rather than on spiritual components of care; but acknowledged that they (the pastoral care providers) lacked comfort in asking the nurse for assistance with spiritual care. Nelson (2000) identified that PNs need support of the clergy to engage the faith community, to provide theological education, and to facilitate continuing education. However, there were no studies found that addressed aspects of a collaborative relationship with clergy or health cabinet/wellness councils.

While the development and use of position descriptions is encouraged by educators in basic parish nurse preparation programs (IPNRC 2009c) it is not a program requirement. A sample position description is available for PNs to adapt for use within their faith community on the IPNRC web site (See Appendix B for sample position description). Burkhart and Solari-Twadell (2006, n = 1,161) reported that only 26% (n = 299) of PNs identified the need for a written position description as being very important in fulfilling their role and 74% (n = 862) reported the need for a written position description as being of less importance in their work. According to Hickman (2006), one of the first steps in developing a PN program is the development of a position description that accurately reflects the functions, the accountabilities, and the responsibilities of the PN. These aspects are reflective of formal power within work settings (Kanter, 1977). Fite (1999) reported that the position description needs to be a "working document"; one that is clearly written and easily understood by clergy and members of the faith community. The document should be periodically reviewed and updated to reflect changes in the expectations of the position. The position description
should be used as one of the measures of performance evaluation (Smucker, 2009). Position expectations that are clearly articulated may provide the parish nurse, clergy, and faith community members with a better understanding of the role and functions of the PN, thus decreasing levels of frustration and confusion. Although Fite (1999), Hickman (2006), and Smucker (2009) report the importance for position descriptions for PNs, they provided only anecdotal reports and recommendations of the tool’s usefulness and not findings from research studies. Therefore, research within the area of position description development and use is important for the ongoing advancement of structures for parish nursing practice.

Researchers also identified the use of an evaluation process for the PN, but did not provide the types of documents (i.e. position descriptions) utilized in the evaluation process. McDermott and Mullins (1989) stated that one-half of the PNs reported evaluations ranging from informal to formal processes. Evaluations were performed by the clergy, the PN her/himself, the hospital PN coordinator, the parish staff or the parish health cabinet (McDermott & Burke, 1993; McDermott & Mullins, 1989).

Employment, Salary, Nursing Experience, and Basic Nursing Educational Preparation Characteristics of PNs

Demographic characteristics of PNs were explored in the literature. Consistent with findings reported from previous studies, Bokinskie and Kloster (2008) describe the typical PN as being employed in a congregational-based, unpaid model of practice (King & Tessaro, 2009; Kuhn, 1997; McDermott & Mullins, 1989). Bokinskie and Kloster (2005) reported that the majority of respondents identified their own religious affiliation...
as Lutheran (n = 236, 54.6%) followed by Roman Catholic (n = 66, 15.3%) and Methodist (n = 40, 9.3%). In addition, PNs primarily served as the sole PN within Lutheran congregations (n = 184, 42.7%) followed by Roman Catholic (n = 46, 10.7%) and Methodist (n = 33, 8.0%). Other researchers reported similar findings for denominational affiliation, however did not provide information as to the number of PNs practicing within the same faith community (McDermott & Mullins, 1989; McDermott & Burke, 1993). Only Solari-Twadell (2006) reported nearly equal respondents who identified themselves as Lutheran and Roman Catholic (n = 290, 25% and n = 267, 23%, respectively). A plausible reason for the differences could be that Solari-Twadell’s study was completed throughout the U.S., while the other studies were completed in regional areas. Few studies have reported geographical location of faith communities served by PNs. McDermott and Burke (1993) reported that majority of PNs in their study worked in faith communities of less than 2,000 members in urban areas (n = 48, 44%). Solari-Twadell (2006) reported that 47% (n = 546) served in faith communities in “towns”, followed by “city” 42% (n = 488), and “metro” 11% (n = 127). Bokinskie and Kloster (2003) reported that 39.3% (n = 169) practiced in rural setting, 34.7% (n = 149) in metropolitan, and 21.2% (n = 92) in small metropolitan settings.

Some researchers have examined hours worked and salary status of PNs. King and Tessaro (2009) reported that 76% (n = 57) of PNs in their study worked fewer than 10 hours per week, but did not differentiate between salaried and unpaid PNs. Other researchers reported that salaried PNs worked between twenty and thirty hours per week (McDermott & Burke, 1993; McDermott & Mullins, 1989); again they did not provide information about the work hours of unpaid PNs. Only Kuhn (1997) reported basic salary...
information; however no information related to other forms of compensation was reported. Paid PNs received $10 to $18 per hour, well below the average registered nurse salary for that period in history. The Bureau of Labor Statistics of the U.S. Department of Labor (1999) reported that mean salaries for registered nurses in 1998 was $43,070 (with an hourly wage $20.71), therefore PNs were paid between $3 to $10 per hour less than their colleagues in other areas of nursing practice. There were no studies that provided compensation data for recent years.

As a PN educational program administrator, this researcher receives anecdotal reports of salary and hours worked. I have heard few reports of individuals who work full-time as salaried PNs, with even fewer reports of salaries that are equivalent to other acute care or community-based practice areas for nurses. Most salaried PNs are reportedly paid for ten to twenty hours per week, but work many more hours in an unpaid capacity. In the United States, approximately thirty-five percent of PNs reportedly receive a salary for their services (Bokinskie & Kloster, 2008; I PNRC, 2009a; Kuhn, 1997). Some extremes were noted in the literature as King and Tessaro (2009) reported that 91% (n = 75) were unpaid in their study. McDermott and Mullins (1989) found that 67% (n = 37), of PNs were paid and McDermott and Burke (1993) reported that 58% (n = 109) of PNs were paid. PNs in these last studies served faith communities in the same geographic region and were funded by a large foundation. Some PNs reportedly receive stipends to cover mileage, personal liability insurance or program supplies (McDermott & Burke, 1993). Burkhart and Solari-Twadell (2006) found that only 22% of PNs (n = 255) reported that being paid was very important as a factor in fulfilling their role; while, 61% (n = 708) of PNs reported that being paid was unimportant to them. This
finding is of concern as there are distinct advantages to receiving a salary. Advantages of salaried positions for PNs include formal power, enhanced personal commitment, increased program attention by faith community members, and a stronger pool of PN position applicants (Hickman, 2006).

Additional findings by Bokinskie and Kloster (2008) noted that 84% (n = 362) of the PN respondents were well-seasoned nurses with sixteen to twenty-five years of traditional acute care clinical experience but had served less than eight years (66.9%, n = 288) in the PN role. Other studies were similar and included that the average age of the nurse was over 40 years of age and the vast majority were female (King & Tessaro, 2009; Kuhn, 1997; McDermott & Burke, 1993; McDermott & Mullins, 1989; Solari-Twadell, 2006). Mosack et al. (2006) reported that the average PN age was 58 years (n = 165) for their study; while Solari-Twadell (1999b) reported the mean age of 49 to 51 (n = 292, n = 509, and n = 536, respectively) in three national studies on PNs. These findings suggest that individuals enter parish nursing later in their nursing careers, perhaps as a transition into retirement.

Level of basic nursing education for PNs was found to differ between studies (King & Tessaro, 2009; Kuhn, 1997; McDermott & Mullins, 1989; Solari-Twadell, 2006). Preparation at the baccalaureate level or higher ranged from 17% (n = 9) to 59% (n = 685); while preparation at the diploma and associate’s level ranged from 38% (n = 441) to 76% (n = 38). These findings are of interest to this researcher as the (2009b) recommends that the individual has at minimum of a bachelor’s degree in nursing and that preparation at the baccalaureate level provides the groundwork for community-based
nursing interventions, such as congregational assessments, population based program development, and program implementation (Hickman, 2006).

Perceptions of the PN Role

Positive and negative factors related to practice have been explored by researchers. In an early study on PNs, Schreiner (1988) interviewed parish nurses (sample size was not reported) who had participated in the Lutheran General program, Chicago, Ill. The researcher reported that PNs enjoyed the flexibility of the position and enjoyed the work; however they reportedly felt burdened by paperwork and frustrated with unmet parishioner needs. In Schreiner's study (1988) the nurses reportedly provided recommendations for other nurses who were considering serving as a PN. These included an awareness of church politics, importance of relationships with staff within and outside of the faith community, and the need to develop programs slowly. McDermott and Burke (1993) surveyed PNs on satisfying and frustrating aspects of the role and identified that spiritual growth, the ability to practice nursing wholistically, and the opportunity to establish relationships were satisfying. Sources of frustration stated by the PNs were unrealistic expectations in the allotted time and role ambiguity.

Bokinskie and Kloster (2008) examined the factors of success and barriers to parish nursing practice over three-years with alumni of the Concordia College Parish Nurse Center's Basic Parish Nurse Preparation course (n = 431, n = 435, and n = 463, respectively). Only in the first phase of the research (year one) did the researchers explore demographic characteristics of the PN respondents, as well as reasons why PNs were not in current practice. In all phases of the study (year one, two, and three), the
researchers explored factors of success and barriers to PN practice. The researchers found that PNs identified aspects of support as most important for a successful ministry. Actively practicing PNs reported the top five factors for a successful ministry as (a) clergy support, (b) congregational support/involvement, (c) personal faith beliefs, (d) personal spiritual development, and (e) active health cabinet/wellness council. The PNs in Bokinskie and Kloster’s study (2008) also identified barriers to successful ministry as (a) unrealistic expectations of time, (b) lack of financial support, (c) lack of congregational and clergy support, (d) lack of assistance, and (e) “other” findings. These other findings included having a community already rich in health resources, poor attendance of or apathy about wellness/health among health cabinet members, lack of appropriate space for records, small parish size, having a “very senior population”, lack of communication/coordination of services with other ministries, lack of family support, lack of personal skills, poor personal health, lack of knowledge about PN by church leadership, and lack of health/wellness among parishioners as a planning council priority in the church. These findings were consistent with other researchers (Brudcnell, 2003; Kuhn, 1997; McDermott & Burke, 1993; McDermott & Mullins, 1989; Schreiner, 1988). Bokinskie and Kloster (2008) also reported findings from non-practicing PNs regarding the reasons why they were not currently active in church ministry. In phase 1 of the study, one-third of the 122 PNs cited reasons for lack of activity as being: (a) retired, (b) no position available, (c) non-supportive environment, and (d) “other” findings. These additional findings included lack of clergy support, time/scheduling constraints, lack of health insurance benefits/pay, lack of self-motivation and self-esteem, lack of office space, congregational apathy, conflict within the church, and personal burnout. A
limitation to this quantitative descriptive study was that the authors did not provide a
definition of success as it related to parish nursing, but allowed the respondents to self
define the concept.

Summary of Parish Nursing

Much of the published literature on parish nursing focused on the history of the
specialty, role of the PN, application of the nursing process and ways to initiate health
promotion programs. The research does support the need for PNs to engage in collegial
relationships with clergy and leaders to provide spiritual care to parishioners and for the
integration of the PN role into the structure of the faith community – as an enhancement
of health and healing ministry.

Few studies have examined program initiation, development and maintenance or
workplace characteristics. The findings in the literature on the utility of position
descriptions and the evaluation process for the PNs were rather surprising. Perhaps the
reason for low importance is that position descriptions and their tie with performance
appraisals and evaluation have long been a part of nursing practice in other specialty
areas. Nurses may not have seen or reviewed their current position description nor see
the relevance of the document to their clinical practice. Perhaps there is a link to serving
in the PN role in an unpaid capacity. One might not see the value of having a position
description or engaging in the evaluative process if they are not paid for their work within
the faith community. The lack of salaried positions for PNs remains a concern.

According to reports in the literature, the ratio of salaried and unpaid status has not
changed in the last ten to fifteen years. If the PN is paid, the salary lags behind the
national levels and the PN works for additional hours beyond payment thus making their hourly wage even less competitive. The lack of a competitive wage (or total lack of salary) will continue to limit the numbers of nurses able to serve as PNs. At the present time, most nurses have much general nursing experience and are near complete retirement when they begin the PN ministry. Other nurses may be working in other areas of nursing practice, where they are salaried, and are only able to serve in the PN role on a very limited basis. This issue limits the years of available practice by the PN, the development of expertise in the ministry, and the growth of the PN program.

Empowerment

Multiple definitions of empowerment exist in the social, psychological and nursing related literature. These definitions focus on empowerment of individuals, communities, or work settings. Empowerment is “the sharing of power within organizations” (Barnard, 1999, p.73) and occurs when an organization “sincerely engages people and progressively responds to this engagement with mutual interest and intention to promote growth…a state of mind and occurs over time” (Erickson, Hamilton, Jones, & Ditomassi, 2003, p. 96). Lewis and Urmston (2000) noted that empowerment may be more easily understood when it is lacking “powerlessness, helplessness, hopelessness, alienation, victimization, subordination, oppression, paternalism, marginalization, and loss of a sense of control over one’s life and dependency” (p. 210). Conversely, Sigurdardottir and Jonsdottir (2008) stated that empowerment is an abstract and fundamentally positive concept. As both a process and outcome, Maton (2008) has proposed that empowerment is a “participatory, developmental process through which
marginalized or oppressed individuals and groups gain greater control...achieve important life goals and reduced societal marginalization” (p. 5).

For this study, as reported in Chapter 1, the researcher has identified empowerment as a structural process within a work environment that allows individuals to take personal responsibility to complete work-related goals, with outcomes that impact the nurse’s behavior and attitudes towards self, colleagues or clients. Empowerment can be quantitatively measured as a perception of more or less; not all or nothing. This researcher’s definition is consistent with that of Kanter (1977) who defines power as the “ability to get things done, to mobilize resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet” and that power reflects mastery and autonomy over one’s own work, rather than control or subordination of others (p. 166). Work empowerment has been further defined as a “process in which individuals feel confident that they can act and successfully execute certain kinds of actions” (Suominen et al., 2008, p. 42).

Empowerment and Non-Nursing Literature

Total quality management and sociotechnical systems theories include empowerment as a major tenet (Barnard, 1999). Empowerment involves participatory management, where employees are responsible for organizational outcomes through collaborative team decision making processes. Researchers have examined the level of empowerment found based on different team variables. In a qualitative exploratory study by Barnard (1999) on the relationship between levels of empowerment and team variables (e.g., team size, team development, and problem solving approach), a
significant difference (n = 652, t = 11.15, p < .001) was found between the means of perceived empowerment of the teams who were guided by a formal team-development process (M = 6.3381, SD = 1.608) compared with teams who were not (M = 4.7597, SD = 1.927). Mean levels of empowerment were significantly higher (F = 6.4615, p < .001) in teams using non-linear technology to solve problems (M = 6.2845, SD = 1.8942) than teams that used linear problem solving approaches (M = 5.5546, SD = 1.9228). In addition, respondents who participated on empowered teams expressed enthusiasm about the team experience, social interaction and team commitment. The author also noted that team empowerment requires that management be confident in the team-development process, and be willing to share information, provide feedback and collaborate with subordinates (Barnard, 1999).

Reference to empowerment exists in the health promotion literature as a process for recovery and chronic disease management. The empowering process for successful recovery from alcohol dependence involves an initial consciousness arousing through the self-awareness of loss of control (Yeh, Che, Lee, & Horng, 2008). Using a grounded theory method with nine participants, Yeh et al. (2008) reported that support of family, participation in group support and self-desire to resist alcohol empowered the individual to assert control over alcohol consumption. Likewise, management of chronic disease states is both an intrapersonal and interpersonal process (Sigurdardottir & Jonsdottir, 2008). In a quantitative, descriptive study conducted to measure validity and reliability of the Diabetes Empowerment Scale, Sigurdardottir and Jonsdottir (2008) examined empowerment in relation to chronic disease. The researchers found that the empowered patient (n=90) expressed adequate knowledge about their disease state to make informed
decisions and self-control to implement these decisions. The interpersonal process of empowerment is characterized by open communication and a mutual trusting relationship with the health care provider. As a result, the patient may have enhanced self-esteem and autonomy for self-care. The empowerment process may enhance self-awareness, change levels of motivation and encourage one to master difficult life situations (Yeh et al., 2008). Health empowerment may be seen as a process in which one can recognize and engage personal and social support to change health and promote well-being (Shearer, 2007).

There has emerged a relationship between empowering community settings and individuals. Consistent with critical social theory, empowerment in community settings is a process through which the underserved and marginalized members gain liberation from oppression (Bradbury-Jones, Sambrook, & Irvine, 2007). From this perspective, empowerment is equated with a surrendering of power from one to another, or a means to an end (Fulton, 1997; Tengland, 2008). In a community assessment of four organizations, Maton (2008) reported that empowered settings and their empowered members contribute to community and social change. In a review of the literature, Maton (2008) proposed six characteristics of organizations of empowering community settings (a) group-based belief system, (b) core activities, (c) relational environment, (d) opportunity role structure, (e) leadership, and (f) setting maintenance and change. The group-based belief system helps to shape the structure, norms and goals of the group, and incorporate a shared vision for the group. The core activities and relational environment provide for meaningful, engaging and caring activities for members. These activities contribute to empowerment through the development of self-efficacy and coping skills.
Role structures provide for opportunities for skill development, leadership and responsibility exercises. Leadership refers to the formal and informal influences that key individuals have on group members. Leaders take on a more facilitative role by sharing power and decision-making with group members. And finally, organizations must be responsive and adaptive to change. Empowering community settings empower citizens to become civic leaders, participate in political activities and national policy influence. Braunack-Mayer and Louise (2008) add that empowerment approaches should occur in both a top-down and a bottom-up fashion. This process gives the community decision-making power over health promotion program development, strategies and management.

And finally, empowerment as a means to break through social and cultural barriers has been a driving force in women's rights movements in developing countries. In Zambia and Bangladesh, women were taught to manage animal herds, and as an outcome they contribute to the improvement of the economic conditions of families (Commonwealth Veterinary Association, 2007). Conversely, disempowered Pakistani women experience continued barriers due to cultural values, lack of support from family, limited education and cost of health care (Qureshi & Shaikh, 2007). Empowering women through skill development and education may enhance the wellbeing and health of these women and their families.

Participating in group activities is empowering and motivating (Fischer & Gosselink, 2008; Maton, 2008). In a qualitative two-part study, Fischer and Gosselink (2008) reported that power to influence and implement social change was more enhanced through group activities, than individual efforts (n = 19 and n = 12, respectively). In addition, creativity and risk taking may be enhanced through group support and
encouragement. In empowerment of communities, success may be measured by a perceived sense of control of decisions of their lives and health (Braunack-Mayer & Louise, 2008).

Summary of Empowerment and Non-Nursing Literature

Findings from the literature support the need for creating empowering workplace environments. Groups that take the time to utilize team development processes and use collaborative approaches to problem solving may be more cohesive and have more committed team members. Individuals who perceive empowerment within their communities or in the management of their disease process share some common themes. The individuals who have skill and knowledge perceive a sense of control over their personal well-being and the health of family members. It is evident that persons in authority must share information, provide feedback and be willing to collaborate with others to create an empowering team, community and country.

Empowerment and Nursing Literature

Perceptions of Structural Empowerment

Much of the nursing literature on structural empowerment focuses on staff nurses and nurse managers in acute care and long term care settings. Laschinger’s conceptual model based on Kanter’s theory of structural power has provided the framework for understanding power and empowerment in a number of studies. (See Appendix A for Kanter’s theoretical framework). In the review of literature, studies that provided support for Kanter’s theory found that nurses’ perceptions of empowerment scores on both the Conditions of Work Effectiveness Questionnaire (CWEQ) and the CWEQ-II have been
moderate (Armstrong, Laschinger & Wong, 2009; Davies et al., 2006; DeCicco, Laschinger & Kerr, 2006; Fitzpatrick et al., 2010; Laschinger, 1996; Laschinger & Havens, 1996; Lucas, Laschinger & Wong, 2008; Sarmiento et al., 2004). Laschinger (1996) reviewed twelve quantitative descriptive studies that used the Conditions of Work Effectiveness Questionnaire (CWEQ) as the measurement tool for empowerment. These studies investigated perceptions of empowerment of public health nurse managers and staff nurses, as well as acute care first-line managers, middle managers, and staff nurses in Canadian health care facilities. Laschinger (1996) reported that, across these studies, nurses perceived a moderate level of empowerment (M = 10.66, SD = 2.22 to M = 14.66, SD = 2.32). Alpha reliability coefficients ranged from .80 to .88. CWEQ scores ranging from 10 to 14 are considered moderate levels of empowerment by Laschinger (2004b). In a study of Chinese clinical nurses (n = 189), Cai and Zhou (2009) reported that respondents perceived a moderate, but low, overall empowerment score (M = 12.63, SD = 2.67). The researchers provided plausible explanations for the low scores of the Chinese respondents as compared to scores reported by Western nurses. These differences included cultural differences as Chinese nurses have traditionally held a subordinate status in health care, are less likely to state an opinion, and have lower expectations of power (Cai & Zhou, 2009; Chang, Shih, & Lin, 2010).

In a correlational survey, Laschinger, Wong, McMahon, and Kaufmann (1999) examined the link between leader-empowered behaviors to staff nurse perceptions of empowerment in two Canadian hospitals (n = 537). Using the CWEQ and the Leader Empowering Behaviors Scale (LEBS), the researchers reported that acute care staff nurses perceived their work setting to be moderately empowering (M = 10.91, SD = 1.96)
on the CWEQ and the behaviors of their leaders (as reported on the LEBS) to be moderately empowering ($M = 3.79$, $SD = 1.41$). The possible range of scores on the CWEQ was 4-20, while the range of scores on the LEBS was noted to be on a seven-point scale. The nurses rated the most empowering leader to have "confidence in the employee" and "fostering autonomy" ($M = 4.25$, $SD = 1.43$ and $M = 4.21$, $SD = 0.98$ respectively). The total leadership and empowerment scales were strongly correlated ($r = 0.61$) and the overall empowerment scale was significantly and moderately correlated with all leadership subscales (range, $r = .38 - .59$). Similar findings were reported by McDermott, Laschinger and Shamian (1996). Using a descriptive correlational design in an acute care setting, McDermott et al. (1996) reported that there was a significant and strong positive correlation found between staff nurses’ perceptions of empowerment (as reported on the CWEQ) and their perceptions of the manager’s power. However, the published article provided no statistical measures to support their statements (McDermott et al., 1996).

In a descriptive correlational study, Donahue et al. (2008) examined predictors of nurse empowerment ($n = 259$). Results indicated that position within the acute care setting was a significant predictor of nurse empowerment ($p = .023$). Perceived empowerment scores reported by nurse managers were found to be significantly higher than staff nurses' reported scores on the CWEQ-II ($M = 24.39$ and $M = 20.40$ respectively). CWEQ-II overall scores ranging from 14 to 22 are viewed by Laschinger as indicative of moderate levels of empowerment, while scores of 23 to 30 are viewed as high levels of empowerment (2004b). In addition, Laschinger (1996) reviewed four studies completed by herself and fellow researchers that compared managerial work
empowerment to that of staff nurses in the same workplace. All four studies reported that nurse managers perceived higher levels of empowerment than their respective staff nurses (Laschinger, 1996). Fitzpatrick, Campo, Graham, and Lavandero (2010) reported like findings with nurses (n = 6,589). These researchers reported a statistically significant difference between staff nurses and non-staff nurses (nurse managers and advance practice nurses) on CWEQ-II empowerment scores (t = -2.73, p = .006). Goddard and Laschinger (1997) found similar results in a study using the CWEQ tool that examined the differences between first line (n = 75) and middle managers' (n = 16) perceptions of empowerment. Middle managers (M = 14.66, SD = 2.34) perceived significantly higher levels of empowerment than the first line managers (M = 12.82, SD = 1.77) (t(79) = -3.43, p < .001). Both groups scored highest on access to opportunity structures and lowest on access to resources. Likewise, Stewart, McNulty, Griffin, and Fitzpatrick (2010) reported that nurse practitioners perceived a high level of empowerment (n = 74, M = 25.87, SD = 1.70). The level of collaboration with other health care providers, degree of autonomy and ease of communication may be a factor in the perception of empowerment (Stewart et al., 2010). These findings support Kanter's (1977) theory that individuals in positions of power have greater access to job related empowerment structures and power structures, and therefore perceive higher levels of empowerment (Goddard & Laschinger, 1997).

Basic Nursing Educational Preparation, Years of Nursing Experience, Type of Experience, and Characteristics of Nurses

Level of basic nursing education and years of nursing practice may impact nurse's perception of empowerment. In a descriptive correlational study by Donahue et al.
(2008), perceptions of empowerment by acute care nurses (n = 259) was measured using the CWEQ-II. The researchers reported that nurses with a master's degree or higher perceived themselves to be highly empowered (M = 23.98 to 28.83) while diploma nurses had higher perceptions of empowerment (M = 22.25) than nurses with a bachelor's degree in nursing (M = 20.64). In their discussion, the researchers state that the difference in scores may be explained by the years of experience, rather than educational level, as the nurses with diploma degrees had nearly ten more years of clinical experience than the bachelor's prepared nurses (M = 26 years and M = 17 years, respectively) (Donahue et al., 2008). In a large descriptive qualitative study on perceptions of empowerment of nurses in Ohio (n = 1,335), Zurmehly, Martin and Fitzpatrick (2009) reported that nurses between the ages of 50-60 years with baccalaureate or higher degrees reported higher levels of empowerment than other age groups. However, the researchers did not provide the statistics related to this finding in their article. Fitzpatrick et al. (2010) reported significant differences in all empowerment scores on the CWEQ-II in relation to educational levels. Nurses with graduate degrees (master's or doctoral degrees) perceived higher levels of empowerment than diploma or bachelor's prepared nurses; however, the researchers did not provide the statistics related to the differences between diploma and bachelor's prepared nurses.

DeCicco et al. (2006) reported that registered nurses in long term care settings in Ontario considered themselves moderately empowered (n = 154, M = 19.42, SD = 4.48) on the CWEQ-II. In addition, DeCicco et al. (2006) reported that the bachelor's prepared nurses (n = 154; M = 19.42, SD = 4.44) perceived slightly higher levels of empowerment than the diploma prepared practical nurses (M = 17.69, SD = 3.85), although scores for
both groups were at the moderate level of empowerment and the findings were not statistically significant. Wilson and Laschinger (1994) reported that bachelor's prepared nurses' CWEQ subscale score on access to information was significantly higher than perceptions by diploma prepared nurses (M = 3.32 and M = 2.77, respectively). For this study, nearly two-thirds of the respondent nurses worked in critical care areas (n = 92). Fitzpatrick et al. (2010) reported that significant differences were found in all empowerment (as reported on the CWEQ-II) scores in relation to educational levels (associate's degree/diploma [n = 1,463], bachelor's degree [n = 3,341], and graduate degree [n = 1,785]). Respondents with graduate degrees scored higher on the CWEQ-II overall and all subscale scores except access to resources subscale. However, the researchers did not provide the statistics related to these findings in their article. In other studies, no differences were noted in perceptions of empowerment based on level of basic nursing education (Laschinger, Finegan, Shamian & Wilk, 2001; Laschinger & Havens, 1996). A possible explanation for the difference in these findings could be setting of practice, as some researchers have examined the relationship between setting of practice and nurses' perceptions of empowerment.

Researchers have found that critical care nurses scored significantly higher than general adult health nurses on overall and subscale perceptions of empowerment (Laschinger & Havens, 1996). This type of work setting reportedly provides the nurse with more opportunities to learn new skills, work with cutting edge technology, and to attend frequent educational offerings (Wilson & Laschinger, 1994). It is important to note that Laschinger and Havens (1996) did not provide statistical evidence to support these findings in their article.
In addition to acute care settings, perceptions of empowerment for college nurse educators, clinical nurse educators, public health, and school nurses have been explored by researchers. Public health nurses conceptualize empowerment as a self-actualizing process (Falk-Rafael, 2001). Using a focus group approach, Falk-Rafael (2001) explored the public health nurses' (n = 24) conceptualization of empowerment, identified strategies that were empowering, and examined the outcomes of empowering strategies. In Falk-Rafael's qualitative study (2001), the public health nurses viewed their role as a facilitator of opportunities for clients to gain self awareness and control over their health; it was through empowerment of others that the public health nurses perceived empowerment. Empowering strategies that the public health nurses identified included (a) developing a trusting relationship characterized by mutuality, (b) personal and political advocacy, (c) providing information and developing client knowledge and skills, and (d) capacity building through reflective listening and empathy. Interestingly, the author did not provide insights into the nurses' perceptions of empowerment of self as a reciprocal experience (Falk-Rafael, 2001). As the research was a qualitative exploratory study, there were no quantitative measures of empowerment provided. However, rigor of the study was maintained with the use of an interview guide, tape recordings and flip chart record of participant feedback, field notes by the researcher, and data sets that were coded and compared using grounded theory techniques (Falk-Rafael, 2001).

In a descriptive correlational study, Sarmiento et al. (2004) reported that college nurse educators in Canadian community colleges (n = 89) reported moderate levels of empowerment as measured by the CWEQ (M = 12.18, SD = 2.27). Davies et al. (2006) reported similar findings in a quantitative study of clinical nurse educators in acute care
settings (n = 141, M = 13.09, SD = 2.28). Likewise, DeSisto and DeSisto (2004) reported that school nurses (n = 82) perceived moderate levels of empowerment on the CWEQ-II (M = 19.64, SD = 2.53). Although these researchers utilized two slightly different versions of the same tool (CWEQ-II and the CWEQ), all scores fall within the moderate level of empowerment (Laschinger, 2004b).

Suominen et al. (2008) reported that nurses engaged in elderly care in Finland perceived strong work empowerment; notably, there were no comparisons provided by the researchers on perceptions of work empowerment for other nurses practicing in Finland. Other studies found no differences based on practice environment within acute care settings (Laschinger, Finegan, Shamian & Wilk, 2001; Lucas et al., 2008).

The age of the nurse and years worked as a registered nurse have been examined as variables that impact nurses’ perceptions of empowerment. Studies have shown that the age alone of the nurse has little effect on perceptions of empowerment for acute care nurses. Acute care nurses with mean ages 27 to 44 reported moderate perceptions of empowerment (Armstrong et al., 2009; Cho, Laschinger & Wong, 2006; Davies et al., 2006; Laschinger, Finegan, Shamian & Wilk, 2001). None of these researchers reported a correlation between age of the nurse and level of empowerment. Conversely, Ning, Zhong, Libo, and Qiujie (2009) reported that higher levels of structural empowerment was perceived when nurses in Chinese hospitals were younger (B = -0.265, β = -0.173, t = -4.497, p < .01). The researchers postulated that nurse managers may focus more time and energy with the younger nurses and therefore the younger nurse may have greater access to structures of workplace empowerment within Chinese hospitals. In regard to years of nursing experience, studies have shown that nurses reported moderate levels of
perceived empowerment regardless of years of nursing experience. Study respondents included acute care staff nurses who had been employed nearly a decade as registered nurses to new graduate nurses with less than 2 years of experience (Armstrong et al., 2009; Cho et al., 2006; Laschinger & Havens, 1996). In another descriptive study, clinical nurse educators with a mean of 22 years of nursing experience also perceived moderate levels of empowerment on the CWEQ (n = 14, M = 13.09, SD = 2.28) (Davies et al., 2006).

In combination, the age, years and types of nursing experience may impact nurses’ perceptions of empowerment. McDermott et al. (1996) reported significant correlations between job related empowerment and age and years of nursing experience for staff nurses in an acute care setting (n = 112). However, the published article provided no statistical measures to support their statements (McDermott et al., 1996). Conversely, Laschinger, Finegan, Shamian, and Wilk (2001) reported no differences in staff nurses’ perceptions of empowerment (n = 404) based on age, hours worked, type of specialty unit, or years of nursing experience. In a review of these two studies, the sample demographic characteristics differed in gender mix and basic nursing education. In McDermott et al.’s (1996) study, 92% of the respondents were female and 65% prepared at the diploma level; while in the later study, 52% of the respondents were female and 85% were diploma prepared. It is difficult for this investigator to provide a plausible explanation as McDermott et al. (1996) did not explore gender differences with perceptions of empowerment likely due to the small number of male respondents in the study, while Laschinger, Finegan, Shamian, and Wilk (2001) used purposive sampling to
recruited equal numbers of male and female nurses for their study. Therefore the difference in study findings could be related to gender.

In the review of nursing literature, two studies reported differences in perceptions of empowerment related to gender. In a descriptive correlational survey in two U.S. acute care settings, Laschinger and Havens (1996) noted that male nurse respondents scored higher on perceptions of empowerment and significantly higher on informal power and access to information. However, the published article provided no statistical measures to support their statements (Laschinger & Havens, 1996). Perhaps this difference is related to the types of interactions or relationships that male nurses have with physicians and administrations. Within the current health care system, physicians and acute care facility administrators tend to be male and perhaps male nurses are able to assimilate easier into the hierarchical environment as noted in Kanter’s (1977) work on structures of proportions. Fitzpatrick et al. (2010) reported that women reported higher total empowerment scores and subscale scores on opportunity, information, formal power, and informal power than their male counterparts. The rationale provided for this was related to Kanter’s structure of proportions. The researchers purported that women were the majority group in the health care facility, while men were the minority group. Additional study findings indicated a significant difference between the sexes in intent to leave their current work position, \( r = 13.44, df = 1, p < .01 \). Of the respondents who reported an intent to leave their position, men \( n = 1,291, 47.7\% \) were more likely to leave than were women \( n = 1,091, 40.3\% \). Perhaps the work place setting was more conducive to the social needs, advancement potential, and networking opportunities for the women in the setting as compared to meeting the needs of the men. However, other studies found no
differences on perceptions of empowerment related to gender (Laschinger, Finegan, Shamian & Wilk, 2001; Lucas et al., 2008; Manojlovich & Laschinger, 2002). The numbers of male nurses who practice as PNs is unreported at the national level. On the regional level, there are twenty-one alumni who are male (1.4%) of the Concordia College Parish Nurse Center’s Basic Parish Nurse Preparation program (total number is 1,490 alumni). Therefore, quantitative studies which explore gender differences in perceptions of empowerment may not provide adequate anonymity for the male participant. Perhaps an in-depth qualitative study may provide insights into their beliefs about gender differences in relation to perceptions of empowerment.

Researchers explored perceptions of empowerment between administrators and staff nurses. Employing a descriptive correlational design, Laschinger, Almost, Purdy and Kim (2004) stated that middle managers were more empowered (n = 84, M = 21.06, SD = 3.16) and satisfied with their jobs than first-line managers (n = 202, M = 20.08, SD = 2.94). Goddard and Laschinger (1997) found that middle managers reported significantly higher levels of empowerment than first line managers, while Laschinger and Shamian (1994) found that first-line managers perceived a significantly higher degree of empowerment than staff nurses. In a descriptive correlational study, Donahue et al. (2008) found that nurse managers reported a high level of perceived empowerment on the CWEQ-II (n = 72, M = 24.39), while staff nurses reported a moderate level of perceived empowerment (n = 187, M = 20.40). In addition to supporting Kanter’s work, Donahue et al. (2008) provided a plausible explanation of the high perceptions of empowerment in terms of nursing staff’s input into the hospital’s design and the implementation of a patient-centered model of care.
In an exploratory survey of 46 public health nurses and 10 public health nurse managers, Haugh and Laschinger (1996) examined differences in perceptions of empowerment using the CWEQ tool. Public health nurse managers’ perceptions of work empowerment were found to be significantly higher than public health nurses’ overall perceptions of empowerment ($t(48) = 2.73, p < .01$) (Haugh & Laschinger, 1996). Managers also scored higher on access to opportunity and information subscales than did staff nurses. These results support Kanter’s (1977) tenet that access to job-related empowerment structures rises as one advances within the organizational structure (Haugh & Laschinger, 1996).

Certainly further studies are needed to explore the combination of factors in relation to perceptions of empowerment. The nurses’ basic nursing education, years of nursing experience, and setting of nursing practice may impact the nurses’ perception of empowerment. Perhaps as nurses gain more experience in the clinical settings, they use their skills, knowledge and expertise to access opportunities for growth, develop abilities to access power sources, and grow their informal network of colleagues. The movement into management positions may increase responsibilities, but may also provide additional opportunities for advancement, access to information and support, as well as positional and informal networks. No studies were found that addressed the impact of the nurses’ basic nursing education, years of experience, and nursing background on nurses’ perceptions of empowerment in their role as a PN. Although the recommends that the individual has a bachelor’s degree in nursing and five years of experience as a nurse (IPNRC, 2009b) there are no research studies that support this recommendation.
Relationship Between Structural Aspects of the Workplace and Perceptions of Empowerment

According to Kanter (1977) there are structural aspects of the workplace that shape one’s job effectiveness and influence one’s perception of empowerment. Systemic power is located in informal and formal organizational systems, as the combination of these facilitates the individual’s access to the job-related empowerment structures (Kanter, 1993). Laschinger and Havens, (1997) stated that formal job descriptions and informal connections with others influences and facilitates the individual’s opportunity for development within the workplace. The structural aspects of power and access to opportunity, resources, information and support in the workplace, shape one’s job effectiveness (Laschinger & Havens, 1996).

Systemic power as a component of empowerment. Systemic power includes both formal and informal power. Formal or positional power includes one’s job characteristics and activities, amount of visibility within the organization, and perceived centrality and importance within the organization. School nurses reported greater access to informal power than formal power (M = 3.43, SD = 0.76 and M = 2.79, SD = 0.79 respectively); but less than access to opportunity and information (M = 3.86, SD = 0.82 and M = 3.62, SD = 0.82 respectively) as reported using the CWEQ-II (DeSisto & DeSisto, 2004).

Likewise, other studies have found that acute care nurses perceived higher perceptions of informal power, access to opportunity, and access to power structures than perceptions of formal power (Donahue et al., 2008; Faulkner & Laschinger, 2008; Laschinger, 2008). In a mixed-methods study using the CWEQ-II, Kramer et al. (2008) noted that staff nurses
who worked within hospital-wide shared governance models perceived higher levels of informal power than nurses who worked in unit based shared governance models (M = 4.20, SD = 0.30 and M = 3.37, SD = 0.37 respectively). Informal power comes from networks within and outside of the organization and partnerships with others across work group. It is acquired through mentoring relationships with individuals who have powerful positions. Researchers have found that informal power had a strong effect on innovative behavior as it may reduce barriers to change and provide opportunity for creativity (Knol & van Linge, 2009). Attention to systemic power factors is of importance to PN practice. PNs need to have opportunities to network with other PNs and colleagues in the health care system to nurture supportive relationships. PNs need to be attentive to being outwardly visible to the faith community members; this may be accomplished through the publishing of a PN newsletter, leading health promotion activities, or actively participating in the faith community’s worship events.

Job-related empowerment structure of opportunity. Access to opportunities within the organization refers to the individual’s prospects of professional growth and development, as well as opportunities for upward mobility within the organization (Almost & Laschinger, 2002; Laschinger & Havens, 1997). In studies on workplace empowerment, new graduate nurses, acute care nurses, school nurses, nurse practitioners and clinical educators were reported to have the most access to the job-related empowerment structure of opportunity (Cho et al., 2006; Davies et al., 2006; DeSisto & DeSisto, 2004; Faulkner & Laschinger, 2008; Fitzpatrick et al, 2010; Laschinger, 2008; Stewart et al, 2010). Nurses may obtain access to opportunity through unit education activities and participation on committees or task forces. Mobility within the workplace
may be accomplished through staff development programs, clinical laddering, or opportunities to serve as mentors or leaders. According to Laschinger and Finegan (2005), managers need to work with employees to match the individual employee’s abilities and expectations to the work conditions to further enhance opportunity for growth within the workplace. PNs need to have access to opportunities within the faith community as well. Educational activities may involve attention to on-going spiritual development programs, continuing education courses on theology or nursing practice issues, and attendance at local or national conferences which address issues related to PN practice. Opportunities to advance within the faith community may involve returning to school to become a lay or ordained clergy, or may involve leadership on select health and healing related councils/committees.

Job-related empowerment structure of power. Empowerment necessitates that one has access to job-related power structures: (a) resources, (b) information, and (c) support. These power structures are necessary for the individual to effectively complete their work assignments (Almost & Laschinger, 2002). Access to resources consists of having the necessary money, equipment, and time to achieve the organization’s goals and outcomes. These resources must be allocated fairly and consistently across the organization (Laschinger, Finegan, & Shamian, 2001). Cai and Zhou (2009) reported that nurses in two central Chinese hospitals perceived highest access to resources in their workplace (as reported on a Chinese modification of the CWEQ-II). These nurses reported having time to complete needed paperwork and accomplish work related tasks. Information includes having access to current facts and relevant institutional policies. Davies et al. (2006) found that clinical nurse educators reported having the least access to information.
Likewise, two separate studies with Chinese staff nurses reported similar findings (Cai & Zhou, 2009; Ning et al., 2009). And finally, support includes constructive feedback, hands-on training, and guidance from peers and management staff. Access to support has been shown to have a strong relationship to job satisfaction (Davies et al., 2006; Laschinger & Havens, 1996; Ning et al., 2009). Access to adequate resources, relevant information, and support from colleagues is necessary for PNs to function effectively within the faith community. As previously reported, nearly two thirds of PNs are serving in unpaid capacities within the faith community (Bokinskie & Kloster, 2008; IPNRC, 2009a). As a PN educator and administrator, this investigator has heard many anecdotal accounts of PNs funding their own activities within the faith community. This includes purchasing of supplies, covering mileage costs to make home visits, and paying speaker fees.

Job-related empowerment structure of proportions. The structure of proportions is considered the social environment within the workplace. The social arrangements in workplace settings have also been identified as an empowering organizational structure, although little was found in the nursing literature that addressed the impact of the social makeup on perceptions of empowerment (Upenieks, 2002). PNs must have an awareness of the social makeup of the leadership within their faith community. A strong collegial relationship with the clergy may assist the PN in integrating into the existing social structure.
Antecedents to Empowerment

According to Kanter (1977) there are structural aspects of the workplace that shape one’s job effectiveness and influence one’s perception of empowerment. Researchers have explored ways to promote systemic power factors and access to job-related empowerment structures.

Organizational structure. The overall organizational structure may impact perceptions of empowerment. Magnet hospitals have found success in recruiting and retaining nurses by providing empowering work environments (Upenieks, 2002). Autonomy over practice, shared decision making and recognition of expertise are characteristics of empowering environments in magnet facilities. Using a focus group approach, Corbally et al. (2007) found that nurses and midwives (n = 93) perceived greater levels of empowerment when working in smaller facilities. In addition, flattened organizational structures, such as community-based settings (i.e. faith communities), may provide for greater access to opportunity through more decentralized decision making, increased visibility, shared responsibility, work variability, and increased autonomy. Access to power may be enhanced, as there may be a broader need for access to information, resources, and support in smaller and flatter organizational structures.

Changes in healthcare organizations may impact working conditions and affect nurses’ views of empowerment. In a three-year longitudinal study of Finnish hospital nurses (n = 110, n = 109, and n = 101, respectively), Kuokkanen, Suominen, Härkönen, Kukkurainen and Doran (2009) found that organizational change impacted the nurses’ assessments of work-related empowerment, job satisfaction, and motivation. Using a
structured questionnaire of work-related empowerment promoting and impeding categories, nurses’ who gave higher assessments of empowerment-promoting factors were more satisfied (p < .001) and more motivated in their work (p < .001). Empowerment promoting factors were (a) moral principles, (b) personal integrity, (c) expertise, (d) future-orientedness, and (e) sociability. Empowerment impeding factors were (a) conflicts, (b) lack of openness, (c) raising of barricades, and (d) lack of cooperation between professional groups (Kuokkanen et al., 2009). The Cronbach alpha coefficients ranged from .64 to .84 for the 5 subcategories, .90 for the work empowerment promoting scale, and .92 for the work empowerment impeding scale. PNs need an awareness of the constancy of change and a readiness to be part of the change process within the faith community to effectively meet the shifting needs of the parishioners.

Collaborative practice. Empowerment has been shown to be related to use of a nursing practice model of client care (Armstrong & Laschinger, 2006). In an exploratory study using the CWEQ-II as the measure for empowerment, Armstrong and Laschinger (2006) reported that overall empowerment as reported by staff nurses (n = 40) was most strongly related to the use of a nursing model of care (rather than a traditional medical model) (r = .61) and nursing leadership (r = .52). Similar findings were reported by Armstrong et al. (2009) in a correlational study with nurses in an acute care setting (n = 153). Using the CWEQ-II to measure perceptions of empowerment, the researchers reported that overall empowerment was positively related to overall magnet hospital characteristics (r = .72, p < .0001). Total empowerment was strongly related to leadership ability (r = .66, p < .0001) and nurse participation in organizational activities (r = .64,
Likewise, Erickson et al. (2003) used a descriptive comparative design to study perceptions of empowerment between nurses who were members and nonmembers of collaborative governance structures (n = 657) over a three year period. The researchers reported that a collaborative governance structure, which places the authority and accountability for patient care with bedside practitioners, was found to positively influence perceptions of empowerment (Erickson et al., 2003). An independent t-test was used to analyze the data from the CWEQ, however each of the individual subscale means, F and P values were reported, but not the relationship between the overall mean scores and governance groups (Erickson et al., 2003). Committee members from across practice disciplines share in decision making, while learning about each other’s unique role in care delivery and developing respect for different perspectives. Organizational structures must reduce the hierarchy of control, become less bureaucratic and employ more cross-departmental collaboration (Kanter, 1989).

In addition, a collaborative environment that supports professional autonomy clarifies roles and encourages trust and respect may impact staff retention. In a study on acute care staff nurse turnover, Apker, Ford, and Fox (2003) explored the extent to which nursing roles, professional autonomy and supportive communication from colleagues and nurse managers predict nurses’ identification using modified versions of the Organizational Identification Questionnaire (internal consistency reported as .91 for this study). The nurses were more likely to identify with the organization if they perceived control over their work (B = .24, SEB = .04, β = .35, t = 5.45, p < .001) and felt supported by management (B = .11, SEB = .04, β = .20, t = 2.97, p < .01) and colleagues (B = .14, SEB = .05, β = .19, t = 2.94, p < .01). In the study, the nurses (n = 190) described
collaborative roles by activities such as “collaborating with case managers to achieve patient outcomes” and “coordinating patient care with health care providers working for organizations outside the hospital” (Apker et al., 2003, p. 229).

Organizational support. For empowerment to effectively occur, management and team members needs to be educated on team skills, shared decision-making and team power (Barnard, 1999). Incentives to enhance work performance and organizational commitment include finding ways to enhance pride in one’s work, bonuses for performance, opportunities for applying new skills in new environments, through public recognition of success (Kanter, 1989). Laschinger et al. (1999) tested a model linking leader and organizational empowerment using the CWEQ, the Organizational Relationship Scale, and the Leader Empowering Behaviors Scale. Empowering behaviors by nurse managers were shown to significantly influence employees’ perception of systemic power, and access to empowerment structures (n = 537, $\chi^2 = 37.934$, df = 6, GFI = 0.977, AGFI = 0.927). Additionally, nurse manager behaviors indirectly affected access to work empowerment structures through formal and informal power (Laschinger et al., 1999). Likewise, Laschinger (2008) reported that when nurses perceived their workplace was empowering, they also believed that their managers were strong leaders, which in turn was positively related to nurse/physician collaboration, perceived staffing adequacy and participation in workplace decisions ($\chi^2 = 17.9$, df = 11, CFI = 0.95, IFI = 0.95, RMSEA = 0.17). These findings suggest that within health care organizations, having strong leaders who engage in participatory management with staff enhances workplace empowerment. Management practices within faith communities
need to be focused on creating working conditions that support collaboration and professional practice for lay professionals, such as PNs.

Outcomes of Empowerment

The positive outcomes of working within empowering environments have been well documented in the literature. The research supports the premise that empowered individuals are more likely to empower others, function within the team, participate in decision-making, and have increased quality of work life.

Psychological empowerment. Spreitzer (1995) stated that psychological empowerment is an outcome of managerial efforts to create conditions of empowerment for staff. Laschinger, Finegan, Shamian, and Almost (2001) added that “employees must experience [psychological empowerment] for empowerment interventions to be successful” (p. 234). Psychological empowerment involves meaningful work, confidence in one’s abilities, work control, and impact on the outcome of work in meeting the organizational goals. Laschinger, Finegan, Shamian and Wilk (2001) reported that staff nurses perceived that structural empowerment resulted in higher perceptions of psychological empowerment. Stewart et al. (2010) reported similar results with nurse practitioners. These findings are consistent with Kanter’s view (1977) that the impact of organizational structures, through the work of management, on workplace behavior is greater than the impact of the employee’s own personality traits or socialization experiences. When the workplace setting is organized so that employees perceive empowerment, they will behave professionally and respond to situations appropriately.
In addition, Laschinger, Finegan, Shamian and Wilk (2001) reported that staff must feel psychologically empowered by managers for empowerment interventions to be successful. This state occurs when managers are successful in assisting staff to feel confident, in control, and important in the organization. When staff members are psychologically empowered, they are able to work effectively. In a study designed to test a model from Kanter’s (1977) theory of organizational empowerment linking staff nurses perceptions of empowerment to job strain and work satisfaction, Laschinger, Finegan, Shamian and Wilk’s (2001) reported that structural empowerment had a direct, positive effect on psychological empowerment (B = 0.85); psychological empowerment had a direct, positive effect on job satisfaction (B = 0.79) and direct negative effect on job strain (B = -0.57) ($\chi^2 = 1140$, df = 545, $\chi^2$/df = 2.09, CFI = 0.986, IFI = 0.986, RMSEA = 0.052).

Increased job satisfaction. Researchers tested Kanter’s (1977) theory of organizational empowerment in a study examining clinical nurse educators’ perceptions of empowerment, job tension, and job satisfaction. Perceptions of empowerment were measured using the CWEQ; job tension was measured on the Job Tension Index and while job satisfaction was measured using the McCloskey/Mueller Satisfaction Scale (Davies et al., 2006). In this study, clinical nurse educators (n = 141) perceived themselves as moderately empowered on the CWEQ (M = 13.09, SD = 2.28) and moderately satisfied with their jobs (M = 3.54, SD = 0.48). There was a strong positive relationship between overall empowerment and overall satisfaction ($r = .641$, p < .0001). Overall job satisfaction was most strongly related to empowerment structures of access to support ($r = .597$, p < .0001), followed by access to information ($r = .550$, p < .0001),
access to opportunity ($r = .510, p < .0001$), and access to resources ($r = .470, p < .0001$). Conversely, there were significant negative correlations reported between perceptions of empowerment and job tension ($r = -.488, p < .01$) (Davies et al., 2006). Using modified versions of the CWEQ-II (structural empowerment) and the Minnesota Satisfaction Questionnaire (job satisfaction), Ning et al. (2009) found a statistically significant positive correlation between perceptions of empowerment and job satisfaction for nurses in Chinese hospitals ($n = 598, r = .547, p < .01$). These study findings support the importance of empowerment in relation to job satisfaction and reduced job tension.

Structural empowerment has been linked to work life, work engagement/burnout, and organizational commitment and work effectiveness (Cho et al., 2006). Using a survey design, Cho et al. (2006) examined the relationships between empowerment (CWEQ-II), areas of work life (Areas of Worklife Scale), emotional exhaustion (Maslach Burnout Inventory – General Survey), and organizational commitment (Affective Commitment Scale). Cho et al. (2006) reported that structural empowerment had both a direct effect ($\beta = .47$) and an indirect effect ($\beta = .05$) on organizational commitment through the overall degree of fit in the areas of worklife and emotional exhaustion; while structural empowerment had a direct positive effect on the overall degree of fit in work life ($\beta = .69$), which in turn, had a direct negative effect on emotional exhaustion ($\beta = -.51$).

The relationship between staff nurses’ perceptions of structural empowerment, psychological empowerments, job satisfaction and personality variables were explored in a study ($n = 347$) by Manojlovich and Laschinger (2002). Structural empowerment was measured using the CWEQ ($\alpha = .95$), psychological empowerment was measured on the Psychological Empowerment Scale ($\alpha = .88$), mastery was measured on Pearlin and
Schooler's Mastery Scale (α = .80), achievement was measured on a modified version of the Personality Research Form-Achievement Scale (α = .61), and job satisfaction was measured on a modified version of Hakman and Oldham's Job Diagnostic Survey (α = .81) (Manojlovich & Laschinger, 2002). Both structural and psychological empowerment were significant independent predictors of job satisfaction (β = 0.39 and 0.33, respectively). Neither need for mastery or preference for challenging tasks, nor need for achievement or desire to accomplish difficult tasks (β = -0.002, p = .97 and β = 0.02, p = .749, respectively) were found to be predictive of job satisfaction (Manojlovich & Laschinger, 2002). These findings lend further support to Kanter's theory that work behaviors are shaped by factors in the workplace rather than by personality traits.

Organizational commitment and retention. Workplace empowerment strategies may assist organizations in retaining experienced employees. In a descriptive correlational designed study, McDermott et al. (1996) employed the CWEQ to measure perceptions of empowerment and the Organizational Commitment Questionnaire to measure identification with and involvement in the organization to examine the relationship between perceptions of job-related empowerment and organizational commitment. McDermott et al. found positive correlations between staff nurses' perceptions of structural empowerment and organizational commitment with the strongest correlation between the opportunity subscale and organizational commitment (r = .5068, p < .001). There were similar results reported by other researchers (Wilson & Laschinger, 1994). Strong positive correlations (r = .65 -.77) were found between all subscales measured on the CWEQ and organizational commitment (Wilson & Laschinger, 1994). Zurmehly et al. (2009) studied the intention of registered nurses
(RNs) to leave their current position or the nursing profession. Not surprising were the findings that nurses who perceived lower levels of empowerment were more likely to leave their current position \( (r = .45, p < .001) \) and leave nursing \( (r = .73, p < .05) \) than those who perceived higher levels of empowerment. There was a significant difference \( (F = 80.08, p < .001) \) between total empowerment scores among the four groups of nurses in regards to likelihood of leaving their current position, as well as a significant differences \( (F = 75.99, p < .001) \) between total empowerment scores among the four groups of nurses in regards to likelihood of leaving the nursing profession. Nurses identified that reasons for leaving the nursing were related to issues with job satisfaction rather than career advancement (Zurmehly et al.). Perhaps when nurses are provided the chance to work within a satisfying environment, they are more likely to be invested in remaining in the nursing profession.

Nedd (2006) studied registered nurses' perceptions of empowerment and intent to stay in their nursing position. Similar to previous studies (Laschinger, Finegan, & Shamian, 2001; Laschinger & Havens, 1996), nurses \( (n = 206) \) perceived moderate levels of empowerment at their workplace as reported on the CWEQ. Intent to stay was significantly positively correlated \( (r = .52 - .39, p < .01) \) with all empowerment subscale variables (Nedd, 2006). Fitzpatrick et al. (2010) reported similar findings in a study exploring perceptions of empowerment with certified and non-certified acute care nurses \( (n = 6,589) \). The researchers reported that significant differences \( (p < .001) \) were found on total and subscale empowerment scores between nurses who intended to leave their workplace and those who intended to leave professional practice. Those who did not intent to leave their position or the profession perceived higher levels of empowerment
on both the total and subscale CWEQ-II (Fitzpatrick et al, 2010). These findings suggest that access to systemic power (both formal and informal power) and job-related empowerment structures is important for retention of nurses.

Reduced burnout. Work related burnout has been closely linked to the lack of job satisfaction, which in turn has been linked to access to empowerment structures. Burnout is a pressing issue for nursing staff, managers, and nurse administrators. The 2004 National Survey of Registered Nurses identified that more than half of the RN respondents (53%) strongly agreed or agreed that their "job is often so stressful that I felt burned out." (Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2005, p.391) Nurses who are experiencing job strain may require more sick leave, be less productive, and create workplace conflict.

Using a descriptive correlational design, Sarmiento et al. (2004) examined the relationships among nurse educators’ perceptions of workplace empowerment, burnout and job satisfaction. The researchers found that empowerment was significantly related to components of burnout (e.g., emotional exhaustion, depersonalization, and personal accomplishment). Work empowerment was significantly negatively related to emotional exhaustion (r = -.51), significantly negatively related to depersonalization (r = -.40), and positively related to personal accomplishment (r = .38). Analysis with multiple regression revealed that 60% of the variance in perceptions of job satisfaction was explained by high levels of empowerment and low levels of emotional exhaustion \( R^2 = 0.596, F(1, 86) = 25.01, p < .0001 \) (Sarmiento et al., 2004).
These studies are supportive of Kanter’s (1977) premise that access to systemic power and job-related empowerment structures impact the emotional health of workers. An individual who feels exhausted and overloaded will likely experience emotional exhaustion, job dissatisfaction, and burnout.

Increased autonomy and self-efficacy. Nurses may also practice more professionally, autonomously, and creatively when the environment provides structures for opportunity to grow and power through access to information, support, and resources. Using the CWEQ-II (α = .70 overall; α = .71 - .87 subscales) to measure perceptions of empowerment and the Control Over Nursing Practice Scale (α = .94) to measure control over practice, DeSisto and DeSisto (2004) conducted a study with school nurses (n = 82) on empowerment and autonomy. The study found a positive relationship (r = .38 to .59, p < .01) between the nurses’ overall and mean subscale scores of empowerment and autonomy (DeSisto & DeSisto, 2004).

In a study of acute care staff nurses (n = 364), Manojlovich (2005) examined the relationship between empowerment, self-efficacy, and professional practice behaviors. Manojlovich measured perceptions of self-efficacy using the Caring Efficacy Scale (α = .89), perceptions of empowerment with the CWEQ-II (α = .90), and professional practice by the Nursing Activity Scale (α = .90). The results of this study identified that professional practice behaviors were moderately related to empowerment (r = .32, p < .01) and self-efficacy (r = .45, p < .01). In this study, structural empowerment contributed directly and significantly (β = .15, cr = 1.74) to self-efficacy (Manojlovich, 2005). According to Manojlovich (2005), “the task-centered focus of much nursing work may be in part to blame, and one answer to the nursing shortage may
lie in providing opportunities for a more variable and autonomous job” (p.42). Providing bedside nurses with control over their practice may increase their involvement in decision-making. Although the study provides support for Kanter’s theory of structural empowerment (1977), it may also support the argument that employee personality characteristics may have a greater impact in the workplace than Kanter purports. One could argue that staff with greater levels of perceived self-efficacy requires different types of empowerment structures than staff with less self-efficacy. Further studies that explore the relationship between different types of empowerment structures and perceptions of self-efficacy would be beneficial to nurse managers.

Work effectiveness. In nursing, productivity has been used to measure the effectiveness and efficiency of client care. Laschinger and Havens (1996) examined the effects of job-related empowerment on staff nurse’ job strain and work effectiveness. They identified strong positive correlations between access to empowerment structures and overall work satisfaction ($r = 0.656, p < .001$) and perceived work effectiveness ($r = .566, p < .001$) (Laschinger & Havens, 1996). Control over nursing practice was considered more important than access to empowerment structures to the prediction of work effectiveness ($\beta = 0.156$ and $\beta = 0.645$, respectively). Access to empowerment structures was strongly related to high levels of perceived work effectiveness ($R^2 = 0.58, p < .01$), and occupational mental health or perceived job tension was significantly negatively ($r = -.62$) related to perceived work effectiveness (Laschinger, & Havens, 1997). Using a cross-sectional correlational survey design to test a model using Kanter’s (1977) theory of structural empowerment, Laschinger and Wong (1999) stated that staff nurses’ (n = 672) perceptions of empowerment were associated with higher collective
accountability and increased productivity or workplace effectiveness ($\chi^2 = 21.4$, df = 6, GFI = .985, AGFI = .92). These findings underscore the importance of creating systems to allow decision making to occur at the bedside for effective nursing practice. Managers who are willing to share power connect with others and allow staff greater control over client care decisions may enjoy working with a more effective and productive staff (Laschinger & Wong, 1999). As new roles develop within faith communities, administrators need to revise the current organizational structure to create systems of shared decision making.

Personal growth. Empowerment has been linked to personal and professional growth. Certification may increase nurses' perception of empowerment as it validates the nurse’s knowledge in a specialty area. In a descriptive study by Piazza, Donahue, Dykes, Griffin, and Fitzpatrick (2006), the researchers examined the differences in perceptions of empowerment between nationally certified and non-certified nurses (n = 254). Certified nurses perceived higher levels of empowerment ($t = -2.45$, $p < .001$) on the CWEQ-II than noncertified nurses (Piazza et al., 2006). Organizations that encourage national certification in specialty practice may find that this practice increases nurses’ formal power, as well as access to opportunity and power structures. These findings may lend support to the argument that an employee’s desire for achievement and recognition may have an impact on their behavior within the organization (Piazza et al., 2006). At the present time there exists no national certification process for the specialty practice of parish nursing; however, there are broad faith denominational parish nurse groups (e.g., Evangelical Lutheran Church in American Parish Nurse Association, Lutheran Parish Nurses International) in which PNs may have membership. Such organizations primarily
provide support, networking, and resources unique to the religious denomination represented by the organization.

Empowerment structures within the workplace encourage individuals to be self-starters, active participants, and responsible for program outcomes (Barnard, 1999; Braunack-Mayer & Louise, 2008). In a predictive, nonexperimental study, Laschinger, Finegan, Shamian, and Almost (2001) examined the effects of job strain on staff nurses’ quality of work life (n = 404). The tools used to measure the variables were the CWEQ-II, the Psychological Empowerment Scale, the Job Content Questionnaire (to measure psychological demands and decision latitude which indicated high or low strain jobs), an organizational commitment scale, and a job satisfaction scale. Staff nurses who perceived that they were psychologically empowered and worked in an empowered environment expressed positive feelings about their work and greater confidence in their work abilities (Laschinger, Finegan, Shamian, & Almost, 2001). These researchers reported that the means of high and low strain groups were compared using independent t tests, with significant differences between the high strain (M = 10.5, SD = 1.99) and low strain (M = 11.8, SD = 2.31) groups for structural empowerment (t = 5.19, df = 3.49, p < .0001), psychological empowerment (t = 5.27, df = 3.49, p < .0001), organizational commitment (t = 3.49, df = 3.49, p < .0001), and work satisfaction (t = 4.87, df = 3.49, p < .0001) (Laschinger, Finegan, Shamian, & Almost, 2001). These findings support Kanter’s (1977) view that workplaces with structures of empowerment (access to opportunity, information, resources, and support) enhance perceptions of psychological empowerment. This researcher asserts that high levels of workplace strain can be
effectively dealt with by staff nurses through workplace structures that allow greater professional autonomy and control.

Empowerment may enhance creativity in the workplace. In a cross-sectional correlational survey, Knol and van Linger (2009) examined the relationship between innovation (Questionnaire Innovative Behaviors) and perceptions of empowerment (CWEQ-II). Knol and van Linge (2009) found that structural ($r = 0.45, p < .01$) and psychological empowerment ($r = 0.53, p < .01$) were significantly related to innovative behaviors by staff nurses. Clearly, conditions which foster empowerment are necessary for personal well-being, creativity, and professional growth.

Respect and trust. Empowerment may also be linked to perceptions of respect. Respect for employees is an essential cultural value for the organization and is positively related to nurse’s perceptions of structural (Laschinger, 2004a) and psychological empowerment (DeCicco et al., 2006; Faulkner & Laschinger, 2008). Respect is a feeling of self worth and is expressed in the workplace through recognizing and appreciating the intrinsic value of the person (DeCicco et al., 2006).

In a sample of nurses employed in nursing homes, researchers examined relationships between nurses’ perceptions of structural and psychological empowerment, respect, and organizational commitment (DeCicco et al., 2006). There were significant differences between the perception of respect between bachelor’s prepared nurses ($M = 5.10, SD = 1.42$) and diploma prepared nurses ($M = 4.42, SD = 1.49$). Both structural and psychological empowerment were significant independent predictors of respect for both bachelor’s ($[\beta] = .418, t = 4.050, p < .0001$ and $[\beta] = .325, t = 3.146, p < .002$) and diploma prepared nurses ($[\beta] = .444, t = 4.183, p < .0001$ and
[\beta] = .293, t = 2.762, p < .007). A plausible reason for the differences between groups could be that within nursing homes, the bachelor's prepared nurses are often in middle management positions and therefore gain respect through relationships with peers and colleagues. To a lesser degree, the diploma prepared nurses may perceive having access to needed resources for patient care as a measure of respect for their direct client care practice (DeCicco et al., 2006).

In a study to test a model of the antecedents (interactional justice, empowerment, and job stress) and consequences (attitude, mental health, and work effectiveness) of nurses' perceptions of respect, Laschinger (2004a) reported that interactional justice was most strongly related (r = .72) to perceptions of respect, followed by empowerment structures (r = .47 to .34). Job stress factors were found to be significantly negatively related (r = -.24 to -.58) to respect. In addition, Laschinger (2004a) found the strongest relationship between attitudinal variables and respect (r = .52 to .42), followed by a significant negative relationship with mental health outcomes (r = -.21 to -.35), while work effectiveness indicators were also significantly related to perceptions of respect (r = .27 to .30). One-third (n=188, 66%) of staff nurses felt they received the respect they deserved from their peers and colleagues. These findings suggest that a positive organizational climate enhances nurses' perceptions of respect, resulting in positive outcomes for the nurse and for the acute care setting.

In a similar study of staff nurses, Laschinger and Finegan (2005) explored the relationship between structural empowerment, organizational trust, and respect. A nonexperimental predictive design was used to test the proposed model in a random sample of staff nurses (n = 273). As predicted, structural empowerment had a direct effect
on perceived respect and organizational trust ($\chi^2 = 27.79$, df = 5, CFI = 0.96, IFI = 0.961, RMSEA = 0.14). Respect was found to have a direct effect on organizational trust ($[\text{beta}] = 0.13$), which in turn had a direct effect on job satisfaction ($[\text{beta}] = 0.16$), which in turn had a strong direct effect on organizational commitment ($[\text{beta}] = 0.54$) (Laschinger & Finegan, 2005). This study suggests that employees who have access to empowerment structures may feel greater respect and therefore have a greater commitment to the organization. As managers demonstrate respect for staff, staff may experience greater job satisfaction and therefore remain committed to the organization. When respect and structures of empowerment are lacking in the workplace, trust wanes. In these conditions, employees perceive that information is being withheld or hidden (Laschinger & Finegan, 2005).

Client satisfaction and client care safety. Client satisfaction with nursing care may be viewed as the intersect of client’s expectations of care and perceptions of actual care. Employees who are empowered by management are more likely to believe high quality nursing outcomes are achievable (Laschinger, 2004a). In addition, other researchers have examined the relationship between empowerment, professional practice characteristics, and patient safety culture (Armstrong & Laschinger, 2006; Armstrong et al., 2009). In an exploratory study testing the linkage of quality of the nursing practice environment to a culture of patient care safety, Armstrong and Laschinger (2006) surveyed staff nurses (n = 40) in a rural central Canadian hospital. The researchers reported that the combination of structural empowerment and professional practice environment characteristics was a significant predictor to staff nurses’ perceptions of patient safety climate, explaining 46% of the variance ($F = 13.32$, df = 1, 31, p < .0001).
Empowerment was strongly related (r = .61) to the use of a nursing care model (as compared to a medical model) and good nursing leadership within a specific care environment (r = .316). Patient safety climate was most strongly related to access to support (r = .51) and opportunity (r = .45) (Armstrong & Laschinger, 2006). Access to empowering structures has been associated with the development of good relationships with patients and families, and relationships with colleagues (Roche et al., 2009). In an exploratory correlational design with a sample of 115 experienced acute care staff nurses, Roche et al. (2009) found that work empowerment and relationships were positively associated (R = 0.369, p < .001). These findings are consistent with Kanter’s (1977) theory that providing access to structures of power supports professional practice and promotes a positive atmosphere for providing safe and quality patient care.

Emancipation. Other nursing researchers have focused on empowerment from a critical social theory perspective. Evidence suggests that nurses are an oppressed group because they lack autonomy, power, and control over their professional practice and it is further asserted that nurses need to empower themselves to become liberated from oppression before they can empower others (Giddings, 2005; Harden, 1996; Mooney & Nolan, 2006; Sigurdsson, 2001). The link to critical social theory cited in the nursing literature is the work of Paulo Freire. A Brazilian educator, he wrote the book, Pedagogy of the Oppressed, which caused a consciousness raising of underprivileged people and a subsequent reform in rural schools. As a result of continued oppression, individuals tend to focus on negative behaviors rather than see the positive aspects. As a result of prolonged negativity horizontal violence may occur in which individuals attack each other out of frustration with their oppressive work environment (Harden, 1996). Freire
believed that people must emancipate themselves and overcome false perceptions caused by oppression. Under oppressive conditions, the oppressed tend to develop a false understanding of reality by internalizing the oppressor’s world view in order to be powerful like them (Hage & Lorensen, 2005; Hedin, 1986). For nurses, this sense of reality may be the internalized values of the empirically-based medical model, in hopes of becoming powerful like physicians (Harden, 1996). It is the insights gained through critical reflection that will enable the nurses to perceive the oppressive conditions and then act to liberate themselves.

In a study on nurses’ views of empowerment, Fulton (1997) critically examined empowerment using a focus group approach (n = 16). Data were analyzed using thematic content analysis. Four categories emerged from the data (a) empowerment, (b) personal power, (c) relationships, and (d) feeling good about oneself. Empowerment was described as lacking in the workplace and the nurses were not able to articulate the positive aspects as the staff could only provide negative examples as evidenced by many examples of infighting between nurses (horizontal violence). Within the work setting, the nurses reported that scientific empirical knowledge was most empowering. This is interesting as the nurses also reported that they had little input into interdisciplinary discussion as the doctors were unapproachable and prescriptive, with little time or consideration for feedback from the nurses. And finally, the nurses expressed low self-esteem and confidence in their abilities as they spent much of their day appeasing others. The nurses “felt they could not advise, challenge or empower others until they were comfortable with themselves” (Fulton, 1997, p. 533). This researcher found these
findings to reflect polar views on empowerment, as there were no participant statements provided in the study that reflected a moderate approach to the subject matter.

Similar findings were noted by Sigurdsson (2001) in a critical hermeneutical study with six perioperative nurses. Four patterns emerged from the individual interviews (a) working in a different practice setting, (b) defending the specialty practice of perioperative nursing, (c) attempting to do their work within abusive relationships and perceived powerlessness, and (d) the deep sense of connection with patients.

Quantitative Measurement Tools for Empowerment

In nursing, three tools have been widely used and noted throughout the literature to quantitatively measure empowerment using Kanter's (1977) theory of structural empowerment. The first tool, Condition of Work Effectiveness Questionnaire (CWEQ), was developed by Chandler (Roche, Morsi, & Chandler, 2009) and has been used to measure nurses' perceived access to Kanter's four empowerment structures. There were four subscales included in the CWEQ (a) 9 items on access to information, (b) 9 items on access to job-related support, (c) 9 items that address access to resources, and (d) 8 items on access to opportunity within the work setting. The original resource subscale did not have acceptable reliability; therefore a panel of experts modified the subscale for a study by Wilson and Laschinger (1994). Alpha reliability coefficients for the revised subscales ranged from .81 to .97 (Wilson & Laschinger, 1994). All scale items are rated on a 5-point Likert scale ranging from 1 (none) to 5 (a lot). An overall empowerment score is obtained by summing the means of the four subscales. The scale has a possible range of scores of 4 to 20; the higher the score, the more perceived empowerment. Cronbach's
alpha reliability estimates for the overall and subscales have been reported (a) opportunity ($\alpha = .57 - .91$), (b) information ($\alpha = .53 - .99$), (c) support ($\alpha = .73 - .94$), (d) resources ($\alpha = .63 - .91$), and (e) CWEQ ($\alpha = .80 - .96$) (Laschinger, n.d.).

In addition to the CWEQ as a measure of empowerment, Laschinger (1996) developed the Job Activities Scale (JAS) and the Organization Relationship Scale (ORS) as measures of formal power (JAS) and informal power (ORS) within the work environment. These two additional scales are often administered with the CWEQ (Laschinger & Wong, 1999). The JAS was originally a 12-item measure that was later revised into a 9-item instrument that measures nurses’ perceptions of formal power (Laschinger, 2004b). Cronbach’s alpha reliability estimates range from .53 to .86 for the original JAS and .55 to .83 for the revised JAS-II (Laschinger, n.d.). The ORS is an 18-item instrument that measures nurses’ perceptions of informal power (Laschinger, 2004b). Cronbach’s alpha reliability estimates range from .57 to .94 for the original ORS and .63 to .80 for the revised ORS-II (Laschinger, n.d.).

Laschinger, Finegan, Shamian, and Wilk (2001) revised the original CWEQ and titled it, CWEQ-II. The revised and shortened version included 19 items that measure perceptions of empowerment (3 items each) of support, resources, opportunity, information, formal power and informal power (4 items). Therefore, the JAS and the ORS are no longer administered with the CWEQ-II. The CWEQ-II is a self-report questionnaire using a 5-point Likert scale. Scores are calculated for each of the subscales, with possible scores ranging from 1 to 4, and an overall empowerment score by summing the means of the six subscales. The possible range of scores on the CWEQ-II is from 6 to 30; the higher the score, the more perceived empowerment. According to Laschinger
(2004b) scores on the CWEQ-II ranging from 6 to 13 are described as low levels of empowerment, 14 to 22 as moderate, and 23 to 30 as high levels of empowerment.

Cronbach’s alpha reliability estimates for the overall and subscales of the CWEQ-II have been reported (a) opportunity ($\alpha = .75 - .88$), (b) information ($\alpha = .80 - .95$), (c) support ($\alpha = .72 - .90$), (d) resources ($\alpha = .65 - .88$), and (e) CWEQ-II ($\alpha = .78 - .94$) (Laschinger, n.d.; Stewart et al. 2010).

The Global Empowerment tool (a two-item scale) has been administered often with the CWEQ-II as support for construct validity; the score is not included in the total empowerment score (Laschinger, 2004b). Cronbach’s alpha reliability estimates range from .87 to .90 for the tool (Faulkner & Laschinger, 2008; Lucas et al., 2008). In a study by DeCicco et al. (2006), the CWEQ-II was strongly correlated with the global empowerment scale ($r = .66$), with similar findings by others (Laschinger, Finegan, Shamian, & Wilk, 2001; Patrick & Laschinger, 2006; Piazza et al., 2006). These findings reflect further evidence of construct validity for the CWEQ-II.

Summary of Empowerment and Nursing Literature

The importance of structural empowerment within health care settings is well documented. Antecedents of empowering work place settings include a flattened organizational structures which promoting participatory management. Outcomes of empowering workplaces for nurses reflect enhanced perceptions of autonomy, job satisfaction, trust, and respect. In turn, these nurse-centered outcomes reportedly enhance patient care and safety. Much of the research related to nurses’ perceptions of empowerment has been focused on acute care staff nurses and managers, with less...
attention given to community-based settings. As health care continues to expand beyond the acute care settings, a better understanding of structures of empowerment of community-based settings (such as faith communities) is needed.

Empowerment, Parish Nursing, and Faith Communities

Perceptions of Empowerment

One article was found that explored the process of empowerment for PNs. Empowerment was defined as “an enabling process arising from a mutual sharing of resources and opportunities that enhances decision making to achieve change at the individual, congregational, and community levels” (Weis et al., 2006, p. 18). Using a focus group approach, Weis et al. (2006) interviewed twenty-eight PNs who were educated from the same basic parish nurse preparation program in the Midwestern U.S. The audiotapes and transcriptions, field notes, coding system and the multi-researcher analysis constituted the audit trail. Rigor was enhanced by utilizing multiple interviewing approaches, confirmation of findings with participants, and the presence of multiple facilitators at the sessions. Weis et al. (2006) identified themes of PN empowerment as (a) being valued, (b) role implementation, (c) higher power, (d) experience and education, (e) reciprocal interaction, and (f) mentoring. More specifically, the study participants identified the importance of collegial relationships with clients, health care professionals and clergy to one’s perception of empowerment, the value of affirmation by the faith community to enhance self-worth, the importance of trust in a higher power, and value of experience and maturation in the PN role (Weis et al., 2006). Barriers to empowerment were identified as unrealistic personal and professional demands, organizational
structure, and lack of adequate resources and support (Weis et al., 2006). Consistent with Kanter’s theory of structural empowerment (1977), lack of access to organizational structures was seen as a barrier to practice while informal power provided through relationships with others, opportunity, and access to resources was seen as empowering.

Although Bokinskie and Kloster (2008) did not focus on the concept of empowerment in their study on strategies for success in parish nursing, their findings were consistent with Kanter’s (1977) theory on the importance of job-related empowerment structures. Access to systemic power factors and support (relationships with clergy, committees/councils and the congregation) were seen as very important for success in parish nursing practice by study participants (Bokinskie & Kloster, 2008). Contrary to Kanter’s belief (1977) that workplace characteristics are more influential on employee’s attitudes than personal characteristics, Bokinskie and Kloster (2008) found that PNs reported that personal faith belief and spiritual development were also factors in success in their ministry role. These findings need further exploration by nurse researchers.

Structures of Empowerment within Faith Communities

Many faith communities lack formal policies and guidelines for staff, including written position descriptions, salary and benefit structures, and organizational structures that address lines of communication and authority. Discussions with clergy and parish nurse coordinators on a local level have yielded limited information about structures which exist within faith communities. Through anecdotal reports some faith communities have more formal policies in place than other faith communities. According
to Ms. Janet Drechsel, Parish Nurse Coordinator, MeritCare Health Systems, most local rostered and ordained faith community leaders have policies within their organizations for financial compensation and benefit packages, while few noted that they have formal position descriptions (personal communication, June 26, 2009). In addition Ms. Drechsel noted that many new roles are developing within faith communities and the current administrative systems have not addressed the unique needs of these new members of the leadership team. In the role as program director of a parish nurse educational program, this researcher has been engaged in numerous conversations with parish nurses, clergy and faith community administrators to provide foundational information. Discussions focus on clarifying the role of the parish nurse, conversing on issues of salary and benefits, and providing samples of policies and procedures for parish nurse ministries. Such discussions may be of assistance in integrating the PN role into the fabric of the faith community. Kanter (1977) identified these foundational aspects as part of the necessary structures of empowerment within a work setting.

Gender Differences in Faith Community Leadership

In a study on gender and ministry style, Lehman (1993) explored the ministry and leadership styles of male and female clergy (n = 517) from four mainstream Protestant denominations across the U.S. using telephone interview survey data. The results indicated that more men than women were willing to use “coercive power over the congregation” and preferred well-delineated and formalized approaches to decision making (Lehman, 1993, p. 3). Female clergy were more likely than their male counterparts to engage and empower congregational members. There were no differences between the sexes in regards to desire for a position of authority, interpersonal styles,
preaching approaches, status or involvement in social issues. The researcher did not explore gender differences in relationships with other staff or lay leaders within the faith communities. It was interesting to note that ethnic-racial minority men and women tended to be more masculine in ministry style than their white counterparts – male and female. These findings are consistent with Kanter’s (1977) work on the structure of proportions and Kleinman’s (2004) work on minority groups. The minority group strives to “be like” the majority group in order to be powerful like them. There were no studies found in the literature review that addressed gender differences in working relationships between lay professionals and clergy within faith community settings.

Summary of Empowerment within Faith Communities

The few studies found in the literature on empowerment of parish nurses identify that conflicts and lack of resources have created barriers and positions of powerlessness for parish nurses (Weis et al., 2006; Bokinskie & Kloster, 2008). These barriers may be further enhanced by the newness of the role within the faith community and the lack of empowerment structures within faith communities for parish nurses. Research is needed to provide a baseline of understanding of the components of empowerment within faith communities.

Summary

Findings from nursing and non-nursing literature support the need for creating empowering workplace environments. Groups that take the time to utilize team development processes and use collaborative approaches to problem solving may be more cohesive and have more committed team members. The factors and structures for
empowering environments for hospital settings in the U.S. and Canada have been well documented in the literature. Flattened organizational structures, participatory and collegial approaches to management have been shown to create empowering work places. Although nurse managers and nurses in advanced practice reportedly perceive higher levels of empowerment than staff nurses, it is of interest that nurses who perceive that their managers are powerful also have expressed an enhanced perception of empowerment. The nurses' level of nursing education, years of nursing practice, work setting and age of the nurse have shown varying results in the literature. Certainly additional studies are needed to explore the relationship between and among these variables on perceptions of empowerment as the findings may be useful to nurse educators and administrators in developing programs to enhance empowered workplaces. The literature provides much insight into the relationship between the structural aspects of the workplace and perceptions of empowerment. It is evident that the structural aspects of power (informal and formal power) and access to job related empowerment structures (opportunity, resources, information, and support) shape one's effectiveness in the workplace (Kanter, 1977). The literature has shown that nurses' perceive higher levels of informal power than formal power, while access to opportunity has been identified most often as the highest reported access to job-related empowerment structure. Access to opportunity and informal power may be linked. As nurses seek new learning opportunities through professional development they may be networking, communicating, and connecting with others. Outcomes of empowered workplaces for nurses reflect enhanced perceptions of autonomy, satisfaction in the workplace, enhanced work place commitment, emancipation, and psychological empowerment. In turn, these
nurse-centered outcomes reportedly enhance patient care and client perceptions of empowerment. The clients who have skill and knowledge may perceive a sense of control over their personal well-being.

Much of the research related to nurses' perceptions of empowerment has been focused on staff nurses and managers, with less attention given to community-based settings. As health care continues to expand beyond the acute care settings, a better understanding of structures of empowerment of community-based settings (such as faith communities) is needed to address the changing mode of health care delivery.

The majority of the literature on parish nursing has focused on the history of the specialty, role of the PN, application of the nursing process and ways to initiate health promotion programs. It is evident from the literature review that the practice of parish nursing is focused on the care of the body, mind, and spirit of the faith community and its individual members. Working within faith communities, the PN weaves spiritual care into professional nursing practice to wholistically address the needs of parishioners and faith communities. PNs need to work with other health care providers, lay and professional church leaders and staff to develop and implement health and healing activities. Empowerment of PNs is necessary to achieve positive outcomes within the faith community. Demographic data revealed that across the U.S., PNs often serve as the sole PN within a congregational-based model, are employed as unpaid staff, and begin their PN practice as well-seasoned nurses. PNs value collegial relationships with faith community leaders and the opportunity to practice wholistically. PNs struggle with time constraints, lack of support, and unreal expectations of the role. It is evident in the literature review that few studies have examined program initiation, development and
maintenance of the program, outcomes of program activities, or empowering workplace structures. This study will add to the body of knowledge on PN practice by exploring the nurses' perceptions of structural empowerment in their role as PNs.
CHAPTER THREE
RESEARCH DESIGN AND METHODS

Chapter three provides a detailed account of the research design and methods for this study. The chapter includes information pertaining to the study's population, sampling plan, recruitment and retention, instrumentation, data collection procedure, power analysis, reliability and validity of the tool, and plan for data analysis. The chapter concludes with protection of human subjects and potential risks and benefits.

Research Design

The study used a quantitative, descriptive, correlational design to (a) assess nurses' perceived level of structural empowerment in their role as PNs, (b) investigate the relationship between the nurses' overall perceived level of structural empowerment and the global measure of empowerment in their role as PNs, and (c) examine the relationship between the nurses' demographic variables and perceived level of structural empowerment in their role as PNs. This study provided data that could be generalized to PNs in Upper Midwest faith communities as the sample population primarily resided in this part of the U.S. A quantitative approach to this study was appropriate as little was known about the perceptions of empowerment of PNs as compared to other specialty groups of nurses. A quantitative approach allowed the researcher insights into the perceived amount of a behavior and provided a basis for comparisons with other groups (Brockopp & Hastings-Tolsma, 2003). A descriptive, correlational design provided the researcher with a description of what currently existed as structural aspects of
empowerment for PNs. As there was little known about the nurses' perceptions of empowerment in their role as PNs or the structures of job-related empowerment within faith communities, correlations between select demographic variables and groups were examined.

Population and Sample

Population and Setting

Established in 1991 at Concordia College in Moorhead, Minnesota, the Parish Nurse Center has provided the basic parish nursing preparation course to 1,490 nurses, clergy and lay faith community leaders. These individuals serve in an estimated 650 different faith communities. The majority of program alumni reside in the Upper Midwest and practice in rural (<10,000 population), micropolitan (10,001 to 50,000 population), and metropolitan (>50,001 population) areas (U.S. Census Bureau, 2009). The researcher has estimated that the majority (90%) of practicing PNs in this geographic region have been prepared through the Concordia College’s Parish Nurse Center as this program has been in existence longer than any other program in the region. In addition, the nearest PN preparation programs are in Sioux Falls, SD, Helena, MT, and Milwaukee, WI. The subjects selected for this study were PNs recruited from the Concordia College Parish Nurse Center’s Basic Parish Nurse Preparation program alumni list. Restricting the study to alumni of the Parish Nurse Center’s Basic Parish Nurse Preparation program was a means to limit variance that may occur if PNs who had attended different basic parish nursing education preparation programs were included. At the time of the study, there were 1,440 alumni on the mailing list. Reasons for the fifty individuals no longer on the mailing list include (a) deceased, (b) retired and desired to be taken off the mailing list,
(c) desired to be taken off the mailing list for other reasons, and (d) mailing address was lost and the person was not locatable.

Sample

In order to qualify for the study, participants needed to meet the following eligibility criteria (a) currently licensed as a registered nurse, (b) qualify as program alumni of the Concordia College Parish Nurse Center's Basic Parish Nurse Preparation program, (c) involved in the current practice of parish nursing or serving as a coordinator of PNs within the faith community(ies), (d) currently serving faith community(ies) in a salaried or unpaid position, and (e) having the ability to read and comprehend the English language. Exclusion criteria included (a) no longer licensed as a registered nurses, (b) completed the Concordia College Parish Nurse Center’s Basic Parish Nurse Preparation program but not a registered nurse, and (c) not currently involved in the practice of parish nursing or coordinating PNs within the faith community(ies). Because this study proposed to assess the perceived level of empowerment of PNs, the participants had to be actively working in the role as PNs or as PN managers within a faith community.

Sampling Procedure

The sampling methodology for this study was convenience sampling. The sample consisted of individuals recruited from the alumni list of the Concordia College Parish Nurse Center’s Basic Parish Nurse Preparation course. The sampling methodology was chosen because the subjects were accessible to the researcher in large enough numbers to provide meaningful data analysis.
Recruitment and Retention

Institutional Review Board (IRB) approval was sought at the University of North Dakota and Concordia College. The study began after institutional approval was obtained from both institutions. Study participants were recruited through a mailed letter to the Concordia College Parish Nurse Center’s Basic Parish Nurse Preparation course alumni. The letter was mailed to all alumni who are on the current mailing list, inviting them to participate in the study, and included (a) a basic description of the study, (b) the voluntary nature of participation, (c) information on time to complete the survey tool, (d) participant benefit/risk, and (e) directions to accessing the survey. This study was administered in either a web-based format or mailed paper-format, based on the participant’s request. The reason these two options were provided was based on this researcher’s experience as the program administrator in assisting PNs in the navigation of the World Wide Web for resources and program materials. Some PNs had previously expressed difficulty in obtaining access to the use of a computer in their workplace or home setting, or having the appropriate computer software. For those who desired a mailed paper-formatted version of the survey, there was a contact number to call to have the survey mailed to them. Prior to the start of the study, information concerning the upcoming research was included in the Parish Nurse Center’s quarterly newsletter that was mailed to the alumni.

As this research study was focused on nurses’ perceptions of empowerment in their role as PNs, the survey was designed to separate practicing PNs from those who do not meet the inclusion criteria. Therefore, the first question addressed activity level in the PN role within a faith community. For those participants who were not currently
practicing as PNs, they were asked a second question regarding the reasons for inactivity as PNs. Participants who were active in parish nursing within faith communities were asked to complete the entire survey.

There were no incentives provided to individuals for participation in the study; however a plan was in place to share at continuing education events sponsored by the Concordia College Parish Nurse Center, or at national or international nursing conferences.

Power Analysis

A power analysis was completed a priori to ascertain the number of participants needed for a small to medium effect size. As the hypotheses were non-directional, the level of significance was set at $p = .05$. Citing Fisher’s work on determining statistical significance, Cowles and Davis (2003) identified that $p = .05$ level was an acceptable probability level for statistical significance. The level of power was specified at the .80 level. Cohen (2003) states that a power value less than .80 increases the risk of a Type II error and a much larger value would require an exceeding large n. The power analysis for detecting the effect of a dichotomous predictor (presence/absence of a formal position description and salaried/unsalaried position) was the following: sample size needed to provide .80 power to detect an effect size of 0.35 standard deviation units (halfway between Cohen’s “small” and “medium” effect sizes) for a $p = .05$ would be 300 participants (Cohen, 2003). Previous research findings have noted that nearly two-thirds of parish nurses report that they serve in unsalaried positions, therefore it was estimated that 200 subjects who report unsalaried and 100 subjects who report salaried were needed.
for this study (Bokinskie & Kloster, 2008; IPNRC, 2009a; Kuhn, 1997). Similar requirements were needed when testing the effect of the continuous predictor variable (years of nursing experience, level of basic nursing education and type of previous nursing experience). A sample size of 300 provided power = .80 to detect a population correlation of 0.16 with \( p = .05 \) (Cohen, 2003). Although this sample size may be considered large, the estimates were not out of reach. These estimates were consistent with the response rate from a previous study with the same population (estimated 400 respondents), therefore an anticipated response rate of 40% of currently practicing parish nurse alumni was sought (Bokinskie & Kloster, 2008).

Instrumentation

Variables and Measures

Empowerment. The Conditions of Work Effectiveness Questionnaire-II (CWEQ-II) was utilized for this research study. As noted in Chapter 3, Laschinger, Finegan, Shamian, and Wilk (2001) revised the original CWEQ and included the JAS and the ORS into the CWEQ-II instrument. The revised and shortened version included 19 items that measure perceptions of empowerment. The CWEQ-II is a self-report questionnaire using a 5-point Likert scale. Scores are calculated for each of the subscales, with possible scores ranging from 1 to 4, and an overall empowerment score by summing the means of the six subscales. The possible range of scores on the CWEQ-II is from 6 to 30; the higher the score, the more perceived empowerment. According to Laschinger (2004b) scores on the CWEQ-II ranging from 6 to 13 are described as low levels of empowerment, 14 to 22 as moderate, and 23 to 30 as high levels of empowerment.
The CWEQ-II includes 6 subscales: support, resources, opportunity, information, and formal power (3 items each), and informal power (4 items). The subscale of access to opportunity addresses the individual’s chance for professional growth and development (Laschinger & Havens, 1997). Subscale items include access to “challenging work” and “the chance to gain new skills and knowledge” (Laschinger, 2001, p. 1). The subscale of accessing information focuses on the individual’s access to current facts and relevant policies of the organization. Items included on this subscale include “current state of the faith community” and “values of the leadership” (Laschinger, 2001, p. 1). The access to support subscale addresses the individual’s perceptions of guidance and feedback. The subscale items include “specific information about things you do well” and “problem solving advice” (Laschinger, 2001, p. 1). The subscale on access to resources addresses consists of having “time available to do necessary paperwork [and] ...to accomplish job requirements” (Laschinger, 2001, p. 1). Perceptions of formal power include one’s job visibility and importance within the work setting. Items on this subscale include “the amount of flexibility in my job” and “the amount of visibility...” (Laschinger, 2001, p. 1). The last subscale focuses on informal power. Informal power focuses on one’s relationships from networking within and outside of the organization. Items on this subscale include “collaborating on faith community member care with clergy and other leaders”, “being sought out by peers for help with problems”, and “seeking out ideas from other health professionals...” (Laschinger, 2001, p. 2). Cronbach’s alpha reliability estimates for the overall and subscales of the CWEQ-II have been reported (a) opportunity (α = .75 - .88), (b) information (α = .80 - .95), (c) support (α = .72 - .90),
(d) resources ($\alpha = .65 - .88$), and (e) CWEQ-II ($\alpha = .78 - .94$) (Laschinger, n.d.; Stewart et al., 2010).

The Global Empowerment tool (a two-item scale) was administered with the CWEQ-II as support for construct validity; the score is not included in the total empowerment score (Laschinger, 2004b). Cronbach’s alpha reliability estimates range from .87 to .90 for the tool (Faulkner & Laschinger, 2008; Lucas et al., 2008). Items included in this tool include “overall, my current work environment empowers me to accomplish my work...” and “overall, I consider my workplace and empowering environment” (Laschinger, 2001, p. 2).

This investigator made minor revisions of the CWEQ-II tool to focus on faith communities rather than hospitals and hospital administrators, and to format the tool for a web-based and paper-format design. The Global Empowerment questions were not revised, but were placed in a web-based and paper-format design. Approval was given by Dr. Laschinger to make these modifications (See Appendix C for approval letter from Dr. Laschinger). In addition, a demographic tool was developed by the researcher. The survey and demographic items were combined into one survey tool for use for this study. This combined survey was placed in a web-based software program, Qualtrics (http://www.qualtrics.com), and in a paper-formatted version for this research study.

Demographic variables. Demographic data were collected through a questionnaire, they included (a) activity level as a PN, (b) religious affiliation – personal and faith community serving, (c) geographic location of faith community, (d) size of faith community, (e) number of years of service as a RN and PN, (f) highest level of nursing
and non-nursing education, (g) previous/current nursing practice experience, (h) type of PN position, (i) model of PN practice, (j) numbers of PNs serving, (k) hours worked as PN, (l) salary status, (m) faith community manager, (n) presence/absence of formal position description, and (o) characteristics of the position description.

A pilot study was completed using six PNs to provide content and face validity for the adapted survey instrument and the demographic questionnaire. The study’s reliability and validity of the revised CWEQ-II are reported in Chapter 4.

As noted in the recruitment section, all respondents completed the first question on activity level. Only those who met the inclusion criteria (as noted in the Recruitment and Retention Section of Chapter 3) completed the entire survey.

Data Collection Procedure

After IRB approval was obtained from the two institutions, a letter was mailed to all alumni who were on the current mailing list, inviting them to participate in the study. The letter included a basic description of the study, the voluntary nature of participation, information on time to complete the survey tool, and participant benefit/risk. Also included in the letter was information regarding technological support if the web-based survey format was found to be problematic. Finally, the letter included directions to accessing the web-based survey through a web link. Participants who preferred a paper-format version of the survey were provided the telephone number for the Concordia College Parish Nurse Center. An office assistant mailed out a survey tool with a self-addressed stamped envelope included in the mailing. The consent information was located at the start of the web-based survey or included in the mailed survey. Completion of the web-based survey or paper-format mailed survey implied informed consent.
As noted in the recruitment and retention section of Chapter 3, all respondents completed the first question on activity level. The first question of the survey addressed level of activity in their role as PNs. Respondents who were inactive in parish nursing completed an additional question regarding reasons for inactivity in their role as PNs. Respondents who met the inclusion criteria completed the entire survey.

Once the information letters were mailed, the participants had two months to complete the survey. As the response rate was less than 40% of the desired goal, three reminder postcards or electronic messages (e-mail) from the researcher with a link to the website for the web-based format and information concerning mailing of a paper-format version of the survey were sent to all potential participants (See Appendix D for sample postcard and electronic mail). There was no tracking of individual participants, other than the total numbers of letters and survey tools mailed.

The electronic data were stored through the Qualtrics Company. It was secured and segmented on the host’s server (Qualtrics, 2008) by institution and subcoded by user. The investigator did not have access to data of other researchers, nor did other researchers have access to this investigator’s data. The printed data and paper versions of the survey were stored at the Parish Nurse Center, Concordia College, Moorhead, MN.

Data Analysis Procedure

Data received through the web-based survey were stored and secured through the Qualtrics Company. The investigator entered all data received from the mailed paper-format surveys into the web-based system. All data were then analyzed using the
Descriptive statistics were calculated for each demographic variable. These included frequency distributions, percentages, ranges, means, and standard deviations. Subscale and overall scores were calculated for the CWEQ-II, with Cronbach’s alphas estimated and reported.

Hypotheses and Research Design

Hypothesis 1: The nurses will perceive a moderate level of overall and subscale structural empowerment as reported on the CWEQ-II, in their role as PNs.

Research design. To assess the nurses’ perception of structural empowerment in their role as PNs, the Conditions of Workplace Effectiveness Questionnaire – II (CWEQ-II) was administered to the study participants. The overall and subscale mean scores on the CWEQ-II were calculated and reported.

Hypothesis 2: There exists a relationship between nurses’ perception of a global measure of empowerment and the overall perceived level of structural empowerment in their role as PNs.

Research design. In order to investigate the relationship of scores between nurses’ overall perception of structural empowerment and global measure of empowerment in their role as PNs, the CWEQ-II and the Global Measure of Empowerment were administered to the study participants. The global measure and overall CWEQ-II mean scores were calculated, correlated and reported.
Hypothesis 3: There exists a relationship between nurses' years of nursing experience, type of previous nursing experience, level of basic nursing education, presence/absence of a position description, and salaried/unpaid position with overall and subscale perceptions of structural empowerment in their role as PNs.

Research design. In order to investigate the relationship between nurses' years of nursing experience, type of previous nursing experience, level of basic nursing education, presence/absence of a position description, and salaried/unpaid position with overall and subscale perceptions of structural empowerment in their role as PNs, the CWEQ-II and a demographic questionnaire were administered to the study participants. Overall and subscale mean scores on the CWEQ-II were correlated with the demographic variables and reported. MANOVAs with multiple independent variables were utilized. The independent variables were the demographic variables, while the dependent variables were the subscale scores on the CWEQ-II tool.

Human Subjects Research

Institutional Review Board Approval

Permission to access the mailing addresses of the Concordia College Parish Nurse Center's Basic Parish Nurse Preparation course alumni was obtained through Dr. Mark Krejci, Provost of Concordia College. Institutional Review Board (IRB) approval was sought at the University of North Dakota and Concordia College. The approval met the exempt status.
Anonymity and Confidentiality

All potential participants of the study received a letter informing them about the purpose of the research study, voluntary participation, anonymity and confidentiality. All potential participants had the option to not take part in the research study, without loss of benefit or support from the University of North Dakota, Concordia College, the Parish Nurse Center or from the staff. Participants had the option to submit a partially completed survey tool and withdraw from the survey.

For the web-based survey, the investigator had no access to the respondent's internet protocol (IP) address as the college's system administrator removed this function. For the mailed paper-format, the office manager of the Concordia College Parish Nurse Center was responsible for mailing out the paper-format survey tools. Mailed surveys were coded with a random number. There were no participant identifiers (names, initials, or client record numbers) on the survey tool. The Concordia College Parish Nurse Center's office manager kept the mailing addresses and corresponding numbers separate from the data in a locked cabinet in a locked office. The investigator had no access to the respondents' names or addresses.

The electronic data were stored and secured through the Qualtrics Company. It was secured and segmented on the host's server (Qualtrics, 2008) by institution and by user. The security was established by Concordia College, Moorhead, MN. Additional details concerning data security through Qualtrics is available upon request. The investigator did not have access to data of other researchers through the company, nor did other researchers have access to this investigator's data. The printed data and paper
versions of the survey were stored and secured in a locked cabinet and a locked office at the Concordia College Parish Nurse Center, Moorhead, MN. Jean Bokinskie, study investigator and Director of the Parish Nurse Center, was responsible for maintaining these records for three years.

The investigator was not on site while participants completed the web-based or paper-formatted survey tools. All data were shared in an aggregate format; no individual information was recognizable.

Health Information Portability and Accountability Act (HIPAA) Compliance

There was no request for health information (past, present or future physical or mental health or condition) in this study. Therefore, the Health Information Portability and Accountability Act (HIPAA) Compliance was not a factor.

Potential Risks

The probability and magnitude of risk to the participant were minimal and not greater than those experienced in daily life. However, two potential risks were that the person’s perception of empowerment may cause some emotional feelings, or the person experiences technical difficulties with their computer or the web-based format. It was estimated that it took no more than thirty minutes to complete the survey and the participants had two months to participate in the study.

Potential Benefits and Knowledge Gained

There were no incentives provided to participate in the study; however a plan was in place to share the findings at continuing education events sponsored by the Concordia
College Parish Nurse Center, or at national or international nursing conferences. Findings may be beneficial to participants as educational programs may be developed to address issues of empowerment for parish nurses and faith community leaders may create more empowering work environments. Therefore, the risks associated with the proposed study were minimal, while the potential benefits may enhance their parish nursing practice.

Summary

This quantitative descriptive study design explored the nurses' perceptions of structural empowerment of PNs in their role within faith communities. As there were no studies found in the literature review on nurses' perceptions of structural empowerment in their role as PNs, this study design was an appropriate method. Descriptive and correlational statistics were employed to examine the data. Measures were put in place to protect the anonymity of the participant and to maintain the confidentiality of their responses. Findings, implications and areas for future studies will be addressed in the following chapters.
CHAPTER FOUR
DATA ANALYSIS

This chapter outlines the results of this study. The overall purpose of this study was to explore perceptions of structural empowerment of PNs. The specific aims were to (a) assess the nurses' perceived level of structural empowerment in their role as PNs, (b) investigate the relationship between the nurses’ overall perceived level of structural empowerment and the global measure of empowerment in their role as PNs, and (c) examine the relationship between the nurses’ demographic variables and perceived level of structural empowerment in their role as PNs.

Data Management

The electronic data were stored, secured and segmented on the server of the Qualtrics Company (Qualtrics, 2008). The paper-formatted versions of the survey were stored and secured in a locked cabinet and a locked office at the Concordia College Parish Nurse Center, Moorhead, MN. Data from the paper versions were entered into the software system by the researcher. The data was imported into SPSS® for analysis. Data were kept on the researcher’s office computer’s hard drive. Access to the data was secured through the college’s firewall, and two passwords into the computer system, while access to the computer was only accessible through a locked office door and a locked office area door. The data were backed up on a external storage device (thumb
drive) and kept in the researcher's locked filing cabinet in a locked office and only accessible to the researcher.

Sample Description

Response Rates

At the time of the research study there were 1,490 nurses, clergy and lay faith community leaders who had completed the basic parish nurse preparation course offered by the Concordia College Parish Nurse Center, Moorhead, MN. There were 1,440 alumni on the initial mailing list. Reasons for the fifty individuals no longer on the mailing list include (a) deceased, (b) retired and desired to be taken off the mailing list, (c) desired to be taken off the mailing list for other reasons, and (d) mailing address was lost and the person was not locatable. In addition, there were eight non-nurses who completed in the basic parish nurse preparation course and did not meet the criteria to participate in the survey. Therefore, the initial mailing went to 1,432 alumni on October 20, 2009. Letters were returned for "unavailable address" for 37 individuals and from one family who explained that their family member (parish nurse alumni) was recently deceased. Therefore, the true sample size was 1,394 (N=1,394). A follow up postcard was sent on November 27, 2009, and an electronic message (e-mail) was sent on December 1, 2009. The third, and final, follow up electronic message (e-mail) was sent on December 21, 2009. The final response rate was 20.44%; 285 surveys were returned. Of the returned surveys, 10 surveys were completed through the consent item only. There were 275 usable surveys that included demographic and CWEQ-II findings. And finally, only 159
respondents completed the entire survey (demographic and CWEQ-II sections). See Figure 4.1 for a description of the sample and response rates.

Demographic Information

One hundred and ninety-eight respondents completed the full survey; seventy-seven respondents completed through question three. The respondents who completed the survey through question three (n = 77) indicated no current active practice in PN ministry in a faith community. All of these respondents provided a reason why they were not currently actively practicing as a PN in a faith community as shown in Table 1. "Retirement" was the most common reason (n = 31, 40.2%) for lack of current practice as a PN, followed by "working full time in another nursing position" (n = 14, 18.2%), and "no position available" (n = 14, 18.2%).

Table 1

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency (n=77)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retired</td>
<td>31</td>
<td>40.2</td>
</tr>
<tr>
<td>&quot;Other&quot;</td>
<td>18</td>
<td>23.4</td>
</tr>
<tr>
<td>Working full time in another nursing position</td>
<td>14</td>
<td>18.2</td>
</tr>
<tr>
<td>No position available</td>
<td>14</td>
<td>18.2</td>
</tr>
</tbody>
</table>

Nurses who were not currently practicing in the role as a PN provided a variety of "other" reasons for lack of current activity. The "other" category also included reasons that had three or fewer responses. The "other" reasons included (a) non-supportive
Figure 4.1. Description of Study Sample and Response Rates

1,490 alumni on mailing list → 50 deceased, retired, off list

1,440 alumni → 8 non-nurses not eligible for study

1,432 available alumni → 38 unavailable addresses/deceased

1,394 received mailing (N=1,394)

285 surveys returned → 10 completed through consent

275 useable surveys → 77 completed through Q3 (non-active)

198 completed through demographic section → 78 salaried and 116 unpaid (4 = no response to salary)

159 completed entire survey tool → 75 salaried and 84 unpaid

Figure 1. Description of the study's sample and response rates. The center boxes denote the sample size and changes, while the boxes to the right denote the reasons for the changes.
environment, (b) lack of time, (c) working in other areas of church ministry, (d) personal issues, (e) no intention of practicing within a faith community, (f) completed the course to support others, and (g) employed in non-nursing positions.

One hundred and ninety-eight respondents completed at least the demographic part of the survey indicating that they were actively practicing as a PN within a faith community. These individuals were asked a number of demographic questions concerning their personal nursing practice background as well as their current practice as a PN within a faith community. Participants were first asked about their personal religious affiliation (See Table 2). Most respondents were affiliated with "Lutheran" faith communities (n = 99, 50.0%), followed by "Roman Catholic" (n = 32, 16.3%), "Methodist" (n = 18, 9.0%), "Lutheran Missouri Synod" (n = 7, 3.5%), and "Covenant" (n = 7, 3.5%). The "other" category included frequency responses of 4 or less. These religious affiliations included Lutheran Brethren, Episcopal, Evangelical Free, Reformed Church of American, Presbyterian, United Church of Christ, Assembly of God, Baptist, Jewish, Evangelical Covenant, Lutheran Congregations in Mission for Christ, and Seventh Day Adventist.

Respondents were then asked about the religious affiliation of the faith community they served as a PN (See Table 3). Most respondents served as a PN in "Lutheran" faith communities (n = 102, 51.5%), followed by "Roman Catholic" (n = 30, 15.2%), and "Methodist" (n = 18, 9.1%).
Table 2

Personal Religious Affiliation of the PN by Frequency and Percentage

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>Frequency (n=198)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lutheran</td>
<td>99</td>
<td>50.0</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>32</td>
<td>16.3</td>
</tr>
<tr>
<td>Other</td>
<td>28</td>
<td>14.2</td>
</tr>
<tr>
<td>Methodist</td>
<td>18</td>
<td>9.0</td>
</tr>
<tr>
<td>Lutheran Missouri Synod</td>
<td>7</td>
<td>3.5</td>
</tr>
<tr>
<td>Covenant</td>
<td>7</td>
<td>3.5</td>
</tr>
<tr>
<td>Non-denominational</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td>Not reported</td>
<td>2</td>
<td>1.0</td>
</tr>
</tbody>
</table>

PNs were then asked to identify the geographical location of their faith community according to metropolitan (> 50,001), micropolitan (10,001 - 50,000), and rural (< 10,000) criteria (See Table 4). Of the 198 respondents, most PNs identified that their faith community was located in a metropolitan area (n = 77, 38.9%), followed by rural (n = 72, 36.4%), and micropolitan (n = 46, 23.2%).
Table 3
Religious Affiliation of the Faith Community Served by the PN by Frequency and Percentage

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>Frequency (n=198)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lutheran</td>
<td>102</td>
<td>51.5</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>30</td>
<td>15.2</td>
</tr>
<tr>
<td>Other</td>
<td>26</td>
<td>13.2</td>
</tr>
<tr>
<td>Methodist</td>
<td>18</td>
<td>9.1</td>
</tr>
<tr>
<td>Covenant</td>
<td>7</td>
<td>3.5</td>
</tr>
<tr>
<td>Lutheran Missouri Synod</td>
<td>6</td>
<td>3.0</td>
</tr>
<tr>
<td>Multiple denominations</td>
<td>6</td>
<td>3.0</td>
</tr>
<tr>
<td>Not reported</td>
<td>3</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Table 4
Geographic Location of Faith Community by Frequency and Percentage

<table>
<thead>
<tr>
<th>Geographic location</th>
<th>Frequency (n=198)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan (&gt; 50,001)</td>
<td>77</td>
<td>38.9</td>
</tr>
<tr>
<td>Micropolitan (10,001 - 50,000)</td>
<td>46</td>
<td>23.2</td>
</tr>
<tr>
<td>Rural (&lt; 10,000)</td>
<td>72</td>
<td>36.4</td>
</tr>
<tr>
<td>Not reported</td>
<td>3</td>
<td>1.5</td>
</tr>
</tbody>
</table>

PNs were asked to identify the size of the faith community in which they served as a PN (as an estimate of numbers of individuals in the faith community). As shown in Table 5, the most common size of faith community served by PNs was "101-300".
individuals (n = 45, 22.7%), while nearly 19% (n = 37, 18.7%) of PNs served in faith communities of "2001-5000" individuals.

Table 5
Size of Faith Community Served by PNs by Frequency and Percentage

<table>
<thead>
<tr>
<th>Size of faith community</th>
<th>Frequency (n=198)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-100</td>
<td>9</td>
<td>4.5</td>
</tr>
<tr>
<td>101-300</td>
<td>45</td>
<td>22.7</td>
</tr>
<tr>
<td>301-600</td>
<td>34</td>
<td>17.2</td>
</tr>
<tr>
<td>601-900</td>
<td>23</td>
<td>11.6</td>
</tr>
<tr>
<td>901-2,000</td>
<td>34</td>
<td>17.2</td>
</tr>
<tr>
<td>2,001-5,000</td>
<td>37</td>
<td>18.7</td>
</tr>
<tr>
<td>&gt; 5,001</td>
<td>11</td>
<td>5.6</td>
</tr>
<tr>
<td>Not applicable</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Not reported</td>
<td>3</td>
<td>1.5</td>
</tr>
</tbody>
</table>

PNs were then asked to indicate their number of years of service as a RN and as a PN. The respondents (n = 198) reported a mean of 32.73 (SD = 12.8) years of service as a RN. The range of years was zero (new graduate nurse) to 60 years of service as a RN. Only 7 respondents (3.5%) of PNs had less than eight years of service as a RN, while 170 PNs (85.9%) had more than 16 years of service as a RN. In addition, the respondents (n=198) reported a mean of 7.55 (SD = 5.0) years of service as a PN. The range of years was zero (recently completed the basic parish nurse preparation program) to 29 years of service as a PN. One hundred and fourteen PNs (57.5%) had less than 8 years of service
as a PN, while only 10 (5.0%) of the PNs had more than 16 years of service as a PN (See Table 6).

Table 6

Years of Service as a RN and as a PN by Frequency and Percentage

<table>
<thead>
<tr>
<th>Years of service</th>
<th>RN Frequency (%)</th>
<th>PN Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; or =3</td>
<td>3(1.5)</td>
<td>48(24.2)</td>
</tr>
<tr>
<td>4-8</td>
<td>4(2.0)</td>
<td>66(33.3)</td>
</tr>
<tr>
<td>9-15</td>
<td>14(7.1)</td>
<td>70(35.5)</td>
</tr>
<tr>
<td>16-25</td>
<td>32(16.2)</td>
<td>8(4.0)</td>
</tr>
<tr>
<td>26-40</td>
<td>77(38.9)</td>
<td>2(1.0)</td>
</tr>
<tr>
<td>&gt; or =41</td>
<td>61(30.8)</td>
<td>0(0)</td>
</tr>
<tr>
<td>Not reported</td>
<td>7(3.5)</td>
<td>4(2.0)</td>
</tr>
</tbody>
</table>

n=198

Respondents were queried as to their highest level of nursing education. One hundred and twenty-nine (65.2%) of the PNs had attained a bachelor's degree or higher in nursing, followed by diploma degree (n = 46, 23.2%), and associate's degree (n = 21, 10.6%) (See Table 7).
Table 7

Highest Level of Nursing Education Attained by PNs by Frequency and Percentage

<table>
<thead>
<tr>
<th>Highest level of nursing education</th>
<th>Frequency (n=198)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploma</td>
<td>46</td>
<td>23.2</td>
</tr>
<tr>
<td>Associate</td>
<td>21</td>
<td>10.6</td>
</tr>
<tr>
<td>Bachelor</td>
<td>100</td>
<td>50.5</td>
</tr>
<tr>
<td>Master or Doctorate</td>
<td>29</td>
<td>14.7</td>
</tr>
<tr>
<td>Not reported</td>
<td>2</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Respondents were also asked if they had attained a degree other than nursing, as well as the area of degree focus (See Table 8). The majority of the PNs reported "none" (n = 133, 67.2%), while nearly 25% (n = 46, 23.2%) reported the completion of a degree in an area other than nursing. Nineteen PNs did not provide a response to the question. The most frequently cited degree areas provided by the respondents included (a) general studies, (b) education, (c) theology/ministry, and (d) administration.

Table 8

Highest Level of Non-nursing Education Attained by PNs by Frequency and Percentage

<table>
<thead>
<tr>
<th>Highest level of non-nursing education</th>
<th>Frequency (n=198)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>133</td>
<td>67.2</td>
</tr>
<tr>
<td>Associate</td>
<td>6</td>
<td>3.0</td>
</tr>
<tr>
<td>Bachelor</td>
<td>20</td>
<td>10.1</td>
</tr>
<tr>
<td>Master or Doctorate</td>
<td>20</td>
<td>10.1</td>
</tr>
<tr>
<td>Not reported</td>
<td>19</td>
<td>9.6</td>
</tr>
</tbody>
</table>
The PNs were then asked to identify their previous and current nursing practice areas in addition to their PN practice. As respondents could identify multiple areas of practice, the majority of PNs had more than one response (See Table 9). The majority of PNs either currently or previously practice in an inpatient hospital setting (n = 129, 65.2%). This was followed by long term care/extended care (n = 55, 27.8%), ambulatory care/clinic (n = 52, 26.3%), and community/public health (n = 51, 25.8%). The "other" practice areas included advanced nursing practice, administration/program coordinator, and a variety of community based practice arenas.

Table 9

Previously and Current Nursing Practice of PNs by Frequency and Percentage

<table>
<thead>
<tr>
<th>Practice area</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital</td>
<td>129</td>
<td>65.2%</td>
</tr>
<tr>
<td>Long term care/extended care</td>
<td>55</td>
<td>27.8%</td>
</tr>
<tr>
<td>Ambulatory care/clinic</td>
<td>52</td>
<td>26.3%</td>
</tr>
<tr>
<td>Community/public health</td>
<td>51</td>
<td>25.8%</td>
</tr>
<tr>
<td>Home health</td>
<td>43</td>
<td>21.7%</td>
</tr>
<tr>
<td>Academic/education</td>
<td>41</td>
<td>20.7%</td>
</tr>
<tr>
<td>Other</td>
<td>28</td>
<td>14.1%</td>
</tr>
<tr>
<td>School health</td>
<td>25</td>
<td>12.6%</td>
</tr>
<tr>
<td>Hospice</td>
<td>23</td>
<td>11.6%</td>
</tr>
<tr>
<td>Psych/Mental health</td>
<td>20</td>
<td>10.1%</td>
</tr>
<tr>
<td>Occupational health</td>
<td>7</td>
<td>3.5%</td>
</tr>
</tbody>
</table>
The PNs were then asked a number of questions about their current PN positions within faith communities. The first question focused on the nature of their PN positions. They were asked if their position was as a PN only, a PN Coordinator only, or a joint PN and Coordinator position. Nearly two-thirds (n = 127, 64.2%) of PNs reported that their positions were as a "PN only", while one-third (n = 65, 32.8%) practiced in a joint "PN & Coordinator" position. Few PNs reported practicing as a "Coordinator only" and five PNs (2.5%) did not respond to the question.

The model of PN practice used within faith communities served was then explored. PNs were asked to describe the model of practice as either congregational-based, health system-based, or a combination of congregational and health system-based. As reported in Table 10, the majority (n = 141, 71.2%) of PNs practiced within a congregational-based model of PN practice, while 41 PNs (20.7%) practiced in a combination model of PN practice.

Table 10
Model of PN Practice by Frequency and Percentage

<table>
<thead>
<tr>
<th>Model of PN practice</th>
<th>Frequency (N=198)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congregational-based</td>
<td>141</td>
<td>71.2</td>
</tr>
<tr>
<td>Health system-based</td>
<td>6</td>
<td>3.0</td>
</tr>
<tr>
<td>Both congregational &amp; health system-based</td>
<td>41</td>
<td>20.7</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>1.5</td>
</tr>
<tr>
<td>Not reported</td>
<td>7</td>
<td>3.6</td>
</tr>
</tbody>
</table>
The next survey item focused on the number of PNs that serve with (or were supervised by) the PN respondent within the faith community. As reported in Table 11, the mean reported number of PNs that serve with the respondent was 1.55 (SD = 2.7), with a range of zero to 12. One hundred and forty-two (71.7%) PNs reported serving in faith communities as solo PN providers or with one other PN. Eight PNs (4.0%) reported practicing with ten or more PNs within a faith community.

Table 11
Number of PNs that Serve with the PN by Frequency and Percentage

<table>
<thead>
<tr>
<th>Number of PNs</th>
<th>Frequency (n=198)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None (solo practice)</td>
<td>103</td>
<td>52.0</td>
</tr>
<tr>
<td>One</td>
<td>39</td>
<td>19.7</td>
</tr>
<tr>
<td>Two to Three</td>
<td>16</td>
<td>8.1</td>
</tr>
<tr>
<td>Four to Five</td>
<td>18</td>
<td>9.1</td>
</tr>
<tr>
<td>Six to Nine</td>
<td>6</td>
<td>3.1</td>
</tr>
<tr>
<td>Ten to Twelve</td>
<td>8</td>
<td>4.0</td>
</tr>
<tr>
<td>Not reported</td>
<td>8</td>
<td>4.0</td>
</tr>
</tbody>
</table>

PNs were asked to provide an average number of hours worked per week in their PN roles. One hundred and eighty-five PNs provided a response to this question and 13 did not respond to the question. The mean number of hours worked per week as a PN was 10.36 (SD = 9.6), with a range of zero to 45 hours per week. Nearly one-fourth (n = 47, 23.7%) worked less than 2 hours per week as a PN or between 3 and 8 hours per week.
(n = 48, 24.2%). Seventy-five percent of PNs (n = 149, 75.2%) worked 16 hours or less per week. Few PNs worked 40 hours per week in their PN role (See Table 12).

Table 12

Hours Worked as a PN per Week by Frequency and Percentage

<table>
<thead>
<tr>
<th>Hours worked</th>
<th>Frequency (n=198)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 or less hours</td>
<td>47</td>
<td>23.7</td>
</tr>
<tr>
<td>3 to 8 hours</td>
<td>48</td>
<td>24.2</td>
</tr>
<tr>
<td>9 to 16 hours</td>
<td>54</td>
<td>27.3</td>
</tr>
<tr>
<td>17 to 24 hours</td>
<td>17</td>
<td>8.6</td>
</tr>
<tr>
<td>25 to 32 hours</td>
<td>11</td>
<td>5.6</td>
</tr>
<tr>
<td>33 &gt; hours</td>
<td>8</td>
<td>4.0</td>
</tr>
<tr>
<td>Not reported</td>
<td>13</td>
<td>6.6</td>
</tr>
</tbody>
</table>

The PNs were then asked two questions about their work status and financial compensation (if they worked in a salaried capacity as a PN). The PNs were first asked if they worked in a salaried or unpaid capacity in their roles as PNs. One hundred and ninety-four respondents provided a response to this question and four (2.0%) did not respond. One hundred and sixteen PNs (58.6%) reported that they were employed in an unpaid capacity. Seventy-eight PNs (39.4%) identified that they were serving faith communities in salaried PN positions.

PNs who were serving in salaried PN positions were asked to provide their annual gross salary as a PN. As reported in Table 13, sixty-one of the salaried PNs (78.2%) provided salary information, while 17 PNs (21.8%) did not respond. The mean salary
reported by the PNs was $15,895.20 (SD = $10,441.98), with a salary range of $1,000 to $40,000 annual gross salary. Twenty-two PNs (28.2%) reportedly earned between $1,000 to $10,000 per year. Forty-two PNs (53.8%) reportedly earned less than $20,000 per year in their position as PNs. Hourly wages were calculated from the sixty-one respondents who provided salary information. The mean hourly wage was $16.96 (SD = $6.56). The hourly wage range was $1.28 to $38.46.

Table 13
Annual Gross Salary as a PN by Frequency and Percentage

<table>
<thead>
<tr>
<th>Annual gross salary</th>
<th>Frequency (n=78)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000 to $10,000</td>
<td>22</td>
<td>28.2</td>
</tr>
<tr>
<td>$10,001 to $20,000</td>
<td>20</td>
<td>25.6</td>
</tr>
<tr>
<td>$20,001 to $30,000</td>
<td>12</td>
<td>15.4</td>
</tr>
<tr>
<td>$30,001 to $40,000</td>
<td>7</td>
<td>9.0</td>
</tr>
<tr>
<td>Not reported</td>
<td>17</td>
<td>21.8</td>
</tr>
</tbody>
</table>

Inquiries were also made into who provided supervision for the PNs in their role within the faith community. PNs were asked to identify who provided the management/supervision for their role as PNs within faith communities. The majority of PNs (n = 99, 50.0%) identified that the senior pastor was the faith community manager/supervisor, followed by the PN coordinator in a faith community (n = 23, 11.6%), and the health cabinet/wellness council (n = 21, 10.6%) (See Table 14). The "other" category included responses of 3 or less, as well as additional responses. These
responses included a variety of lay and professional leadership roles within faith communities.

Table 14

Faith Community Manager/Supervisor for the PN by Frequency and Percentage

<table>
<thead>
<tr>
<th>Manager/supervisor</th>
<th>Frequency (n=198)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior pastor</td>
<td>99</td>
<td>50.0</td>
</tr>
<tr>
<td>Parish nurse coordinator in a faith community</td>
<td>23</td>
<td>11.6</td>
</tr>
<tr>
<td>Health cabinet/wellness council</td>
<td>21</td>
<td>10.6</td>
</tr>
<tr>
<td>None</td>
<td>15</td>
<td>7.6</td>
</tr>
<tr>
<td>Associate pastor</td>
<td>13</td>
<td>6.6</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>6.1</td>
</tr>
<tr>
<td>Parish nurse coordinator in a health system</td>
<td>10</td>
<td>5.0</td>
</tr>
<tr>
<td>Not reported</td>
<td>5</td>
<td>2.5</td>
</tr>
</tbody>
</table>

The final questions focused on the presence or absence of a PN position description, as well as additional information concerning the use of the PN position description for those who had the document. The first question asked if the PN had a position description for their faith community PN role. One hundred and ninety two PNs (97.0%) responded to this question, while 6 PNs (3.0%) did not respond. One hundred and forty-six PNs (73.7%) reported that they had a PN position description, 35PNs (17.7%) reportedly did not have a PN position description, while 11 PNs (5.6%) reported that they were "not sure" if they had a PN position description for their faith community. The PNs were then asked three questions about their PN position description. The first question
asked if the PNs felt that the PN position description reflected their current position responsibilities. Of the PNs who provided a response to the question (n = 143), nearly all of the PNs (n = 137, 95.8%) reported that it did reflect their current PN responsibilities, while only a few PNs (n = 6, 4.2%) reported that the PN position description did not reflect their current PN position responsibilities. The second question asked if the PN position description was reviewed and/or updated yearly. Of the one hundred and forty-two PNs who responded to the question, 64 PNs (45.1%) reported that the PN position description was examined yearly, while 78 respondents (54.9%) reported that the PN position description was not reviewed and/or updated yearly. And finally, the PNs were asked if the PN position description was used for evaluation purposes. Of the PNs who provided a response to the question (n = 141), 58 PNs (41.1%) identified that the tool was used for evaluation purposes, while 83 (58.9%) reported that the tool was not used for evaluation (See Table 15).

Table 15

PN Position Description Usage in the Faith Community by Frequency and Percentage

<table>
<thead>
<tr>
<th>Position description</th>
<th>Percent</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does it reflect your current position responsibilities? (n=143)</td>
<td>137</td>
<td>6</td>
</tr>
<tr>
<td>Is it reviewed and/or updated yearly? (n=142)</td>
<td>64</td>
<td>78</td>
</tr>
<tr>
<td>Is it used for evaluation? (n=141)</td>
<td>58</td>
<td>83</td>
</tr>
</tbody>
</table>
Research Question 1

The first research question was: What are nurses’ perceived levels of structural empowerment in their role as PNs? The hypothesis for this question was: The nurses will perceive a moderate level of overall and subscale structural empowerment as reported on the CWEQ-II, in their role as PNs.

Findings

The perceived level of structural empowerment as reported by the PNs (n = 159) using the CWEQ-II was a mean overall score of 20.88 (SD = 3.82). According to Laschinger (2004b) scores on the CWEQ-II ranging from 6 to 13 are described as low levels of empowerment, 14 to 22 as moderate and 23 to 30 as high levels of empowerment. Therefore, the perceived level of empowerment for these PNs would be at the moderate level. The study PNs reported greater access to formal power, followed by access to information, opportunity, informal power, resources and lastly, access to support. Cronbach alpha coefficients for each of the subscales and overall scale were calculated with a range of $\alpha = .54$ to $\alpha = .91$. Individual coefficients are reported in Table 16. The perceived level of structural empowerment as reported by the PNs on the subscales scores of the CWEQ-II is reported in Table 16.
Table 16

Summary of the CWEQ-II Overall and Subscale Mean Scores and Alpha Coefficients as Reported by PNs

<table>
<thead>
<tr>
<th>CWEQ-II scale</th>
<th>Cronbach alpha coefficient</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunity</td>
<td>.77</td>
<td>n=166</td>
<td>3.51</td>
<td>.85</td>
<td>1.33-5.00</td>
</tr>
<tr>
<td>Information</td>
<td>.90</td>
<td>n=165</td>
<td>3.73</td>
<td>.98</td>
<td>1.00-5.00</td>
</tr>
<tr>
<td>Support</td>
<td>.86</td>
<td>n=166</td>
<td>3.05</td>
<td>.98</td>
<td>1.00-5.00</td>
</tr>
<tr>
<td>Resources</td>
<td>.69</td>
<td>n=160</td>
<td>3.15</td>
<td>.87</td>
<td>1.00-5.00</td>
</tr>
<tr>
<td>Formal power</td>
<td>.54</td>
<td>n=165</td>
<td>3.88</td>
<td>.73</td>
<td>1.00-5.00</td>
</tr>
<tr>
<td>Informal power</td>
<td>.78</td>
<td>n=165</td>
<td>3.43</td>
<td>.86</td>
<td>1.00-5.00</td>
</tr>
<tr>
<td>CWEQ-II overall</td>
<td>.91</td>
<td>n=159</td>
<td>20.88</td>
<td>3.82</td>
<td>10.00-28.58</td>
</tr>
</tbody>
</table>

Research Question 2

The second research question was: What is the relationship of scores between nurses’ overall perception of structural empowerment on the CWEQ-II and the global measure of empowerment in their role as PNs? The hypothesis for this question was: There exists a relationship between nurses’ perceptions of a global measure of empowerment and the overall perceived level of structural empowerment in their role as PNs.

Findings

There exists a relationship between nurses’ perceptions of a global measure of empowerment and the overall perceived level of structural empowerment in their role as...
PNs. The mean score reported by the PNs (n = 162) on the Global Empowerment scale was 3.92, the Cronbach alpha coefficient for the Global Empowerment scale was \( \alpha = .90 \) for the two item scale. The Pearson's coefficient was \( r = .71 \) (\( p < .01 \)) for this study. This finding provides support for the construct validity of the CWEQ-II with the Global Empowerment scale.

Research Question 3

The third research question was: What are the relationships between nurses' years of nursing experience, type of previous nursing experience, level of basic nursing education, presence/absence of a position description, and salaried/unpaid position with overall and subscale perceptions of structural empowerment in their role as PNs? The hypothesis for this question was: There exists a relationship between nurses' years of nursing experience, type of previous nursing experience, level of basic nursing education, presence/absence of a position description, and salaried/unpaid position with overall and subscale perceptions of structural empowerment in their role as PNs.

Findings

The relationships between years of nursing experience with the overall and subscale perceptions of structural empowerment, as reported on the CWEQ-II, were examined using descriptive statistical methods. Both Pearson r correlations and 1-way analysis of variance were used to examine relationships between empowerment total and subscale scores with respect to select demographic variables. Additional analyses were undertaken to determine relationships between select variables and perceptions of empowerment (as reported on the CWEQ-II). Access to opportunity (\( r = .16 \)) and
information \( (r = .16) \) were found to have a statistically significant positive correlation with years of nursing experience \( (p < .05) \). All of the other subscales showed a positive relationship with years of nursing experience, but they did not show a significant correlation. The findings included (a) access to support \( (r = .05, p = .55) \), (b) access to resources \( (r = .04, p = .66) \), (c) formal power \( (r = .12, p = .13) \), and (d) informal power \( (r = .08, p = .29) \).

The relationship between the PNs level of nursing education with the overall and subscale perceptions of structural empowerment, as reported on the CWEQ-II, were examined using an analysis of variance (ANOVA). There were limited responses in the “Doctorate” category; therefore, these results were collapsed with the “Master” category and reflect the subjects that held any form of graduate degree in nursing. There were no significant relationships found between the PNs level of nursing education and the overall and subscale scores as reported on the CWEQ-II.

Further descriptive statistics were not possible to complete with the PNs type of previous nursing experience. Most PNs provided multiple past and current practice areas and statistical analysis was inconclusive.

The relationship between the presence or absence of a PN position description with the overall and subscale perceptions of structural empowerment, as reported on the CWEQ-II, were examined using multivariate analyses of variance (MANOVA). This test was performed to compare the reported empowerment (CWEQ-II scores) and report of presence or absence of a PN position description. The MANOVA was not significant for all of the six subscales \( \text{[Wilks' Lambda} = 0.949, F(6, 148) = 1.314, p > .05\). The
responses from 11 individuals were not included in the statistical analysis as they reported “not sure” as to whether they had a PN position description in their faith community. Table 17 provides the individual univariate results (individual ANOVAs).

Table 17

Univariate Results of Relationship Between Presence/Absence of a PN Position Description and CWEQ-II Subscale Scores as Reported by PNs

<table>
<thead>
<tr>
<th>CWEQ-II subscale</th>
<th>Presence of PN Position Description (n=140)</th>
<th>Absence of PN Position Description (n=15)</th>
<th>F</th>
<th>Sig.</th>
<th>Eta²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunity</td>
<td>3.58±0.78</td>
<td>3.27±1.18</td>
<td>1.889</td>
<td>&gt;.05</td>
<td>.012</td>
</tr>
<tr>
<td>Information</td>
<td>3.79±0.98</td>
<td>3.40±1.04</td>
<td>2.209</td>
<td>&gt;.05</td>
<td>.014</td>
</tr>
<tr>
<td>Support</td>
<td>3.10±0.94</td>
<td>3.04±1.11</td>
<td>.054</td>
<td>&gt;.05</td>
<td>.000</td>
</tr>
<tr>
<td>Resources</td>
<td>3.17±0.81</td>
<td>3.22±1.17</td>
<td>.049</td>
<td>&gt;.05</td>
<td>.000</td>
</tr>
<tr>
<td>Formal power</td>
<td>3.90±0.69</td>
<td>3.93±0.88</td>
<td>.032</td>
<td>&gt;.05</td>
<td>.000</td>
</tr>
<tr>
<td>Informal power</td>
<td>3.50±0.85</td>
<td>3.12±0.97</td>
<td>2.759</td>
<td>&gt;.05</td>
<td>.018</td>
</tr>
</tbody>
</table>

The relationship between serving as a salaried or unpaid PN within the faith community with the overall and subscale perceptions of structural empowerment, as reported on the CWEQ-II, were examined using multivariate analyses of variance (MANOVA). This test was performed to compare the reported empowerment (CWEQ-II subscale scores) and report of salaried or unpaid status as a PN. The MANOVA was significant for five of the six subscales [Wilks’ Lambda = 0.833, F(6, 152) = 5.083, p < .001]. Only “access to resources” was not found to show a relationship to salaried or unpaid status. Table 18 provides the individual univariate results (individual ANOVAs).
Univariate Results of Relationship Between Salaried/Unpaid Status and CWEQ-II Subscale Scores as Reported by PNs

<table>
<thead>
<tr>
<th>CWEQ-II subscale</th>
<th>Salaried PNs (n=75)</th>
<th>Unpaid PNs (n=84)</th>
<th>F</th>
<th>Sig.</th>
<th>Eta^2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunity</td>
<td>3.80±0.72</td>
<td>3.32±0.87</td>
<td>14.016</td>
<td>&lt;.001</td>
<td>.082</td>
</tr>
<tr>
<td>Information</td>
<td>4.06±0.80</td>
<td>3.46±1.03</td>
<td>16.590</td>
<td>&lt;.001</td>
<td>.096</td>
</tr>
<tr>
<td>Support</td>
<td>3.35±0.83</td>
<td>2.84±1.01</td>
<td>11.986</td>
<td>&lt;.01</td>
<td>.071</td>
</tr>
<tr>
<td>Resources</td>
<td>3.22±0.83</td>
<td>3.11±0.87</td>
<td>.721</td>
<td>&gt;.05</td>
<td>.005</td>
</tr>
<tr>
<td>Formal power</td>
<td>4.09±0.63</td>
<td>3.73±0.72</td>
<td>11.229</td>
<td>&lt;.01</td>
<td>.067</td>
</tr>
<tr>
<td>Informal power</td>
<td>3.80±0.68</td>
<td>3.14±0.89</td>
<td>27.159</td>
<td>&lt;.001</td>
<td>.147</td>
</tr>
</tbody>
</table>

Additional Findings

Further data analysis was completed on select demographic findings. The relationship between years of PN experience with the overall and subscale perceptions of structural empowerment, as reported on the CWEQ-II, were examined using descriptive statistical methods. All but one subscale and the overall CWEQ-II scores showed slight positive relationships, however they were not significant (p > .05). Access to opportunity showed a slight negative correlation (r = -.003) to years of service as a PN, however it was also a nonsignificant finding.

The differences between PN respondents based on salaried or unpaid status were further explored using a number of the demographic variables. There was no correlation found between the number of hours worked in the role and the hourly wage earned by the PN. The hours worked per week was compared between the paid and unpaid PNs. The salaried PNs (M = 17.06, SD = 9.53) worked significantly more hours per week than the...
unpaid parish nurses \( (M = 5.34, SD = .572) \) \( (t = 10.285, df = 182, p < .001) \) (See Table 19).

Table 19

Summary of Means and Standard Deviations for Salary Status and Hours Worked for PNs

<table>
<thead>
<tr>
<th>Salary status</th>
<th>Frequency ( (n=194) )</th>
<th>Means number of hours worked per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaried</td>
<td>78</td>
<td>17.06 ( (SD=9.53) )</td>
</tr>
<tr>
<td>Unpaid</td>
<td>106</td>
<td>5.34 ( (SD=5.88) )</td>
</tr>
</tbody>
</table>

Not reported \( n=10 \) \( (t=10.285, df=182, p<.001) \).

The differences between salaried or unpaid status of the PN respondents were examined based on the religious affiliation of the faith community served by the PN. As there were fewer numbers of PN respondents in many of the categories, only the differences between the religious affiliations of Lutheran, Methodist, and Roman Catholic were examined. There were no differences found between salary/unpaid status and religious affiliation of the faith community served by the PN \( \chi^2 (2) = 2.714, p > .05 \) (See Table 20).

Table 20

Salary Status and Religious Affiliation of the Faith Community Served by the PN by Frequency

<table>
<thead>
<tr>
<th>Salary status</th>
<th>Religious affiliation of faith community served</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lutheran ( (n=101) ) Methodist ( (n=18) ) Roman Catholic ( (n=29) )</td>
</tr>
<tr>
<td>Salaried</td>
<td>45 7 8</td>
</tr>
<tr>
<td>Unpaid</td>
<td>56 11 21</td>
</tr>
</tbody>
</table>

\( \chi^2 (2) = 2.714, p > .05 \)
The differences between paid or unpaid status of the PN respondents were examined based on the geographic location of the faith community served by the PN. As reported in Table 21, there were a significantly larger proportion of unpaid PNs serving in micropolitan or rural faith communities, while nearly equal numbers of salaried and unpaid PNs serving in metropolitan faith communities ($\chi^2 (2) = 6.023, p < .05$).

### Table 21
Salary Status and Geographic Location of Faith Community Served by the PN by Frequency

<table>
<thead>
<tr>
<th>Salary status</th>
<th>Geographic location of faith community</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Metropolitan (&gt; 50,001)</td>
<td>Micropolitan (10,001-50,000)</td>
</tr>
<tr>
<td>Salaried</td>
<td>38</td>
<td>18</td>
</tr>
<tr>
<td>Unpaid</td>
<td>39</td>
<td>27</td>
</tr>
</tbody>
</table>

$\chi^2 (2) = 6.023, p < .05$

The differences between salaried or unpaid status of the PN respondents were examined based on the size of the faith community served by the PN. As there were fewer numbers of PN respondents serving in some of the faith communities, the data from the seven categories were collapsed down into three broad categories (a) 0-600, (b) 601-2,000, and (c) > 2,001. These numbers represent individuals served within faith communities. The statistical analysis revealed a much larger proportion of unpaid PNs serving in faith communities of 0-600 individuals than in faith communities of >2,001 individuals, while a significantly greater proportion of paid PNs reportedly serve in faith communities of 601-2,000 individuals ($\chi^2 (2) = 15.107, p < .001$) (See Table 22).
Table 22

Salary Status and Size of Faith Community Served by the PN by Frequency

<table>
<thead>
<tr>
<th>Salary status</th>
<th>Size of faith community served by PNs (estimated # of individuals)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-600</td>
</tr>
<tr>
<td>Salaried</td>
<td>23</td>
</tr>
<tr>
<td>Unpaid</td>
<td>64</td>
</tr>
</tbody>
</table>

$\chi^2(2) = 15.107, p < .001$

The differences between salaried or unpaid status of the PN respondents were examined based on the nature of the PN position. As there were few numbers of PN respondents in the “Coordinator” category, it was collapsed with the “PN & Coordinator” category. There were no differences found between salary/unpaid status and the nature of the PN position ($\chi^2(1) = 2.035, p > .05$) (See Table 23).

Table 23

Salary Status and Nature of PN Position by Frequency

<table>
<thead>
<tr>
<th>Salary status</th>
<th>PN position</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PN only</td>
<td>PN &amp;/or Coordinator</td>
</tr>
<tr>
<td>Salaried</td>
<td>47</td>
<td>31</td>
</tr>
<tr>
<td>Unpaid</td>
<td>80</td>
<td>34</td>
</tr>
</tbody>
</table>

$\chi^2(1) = 2.035, p > .05$

The differences between salaried or unpaid status of the PN respondents were examined with the usage of the PN position description in the faith community. There was a statistically significant difference between salaried and unpaid PN respondents who reported use of a PN position description ($\chi^2(1) = 24.133, p < .001$). Nearly equal
numbers of salaried and unpaid PNs reported having a PN position description, while a large proportion of unpaid PNs reported having no PN position description or were not sure there was a PN position description within the faith community where they served (See Table 24).

Table 24
Salary Status and PN Position Description Usage in the Faith Community by Frequency

<table>
<thead>
<tr>
<th>Salary status</th>
<th>PN position description usage in the faith community</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Salaried</td>
<td>72</td>
</tr>
<tr>
<td>Unpaid</td>
<td>74</td>
</tr>
</tbody>
</table>

\( \chi^2 (1) = 24.133, p < .001 \)

<table>
<thead>
<tr>
<th>Summary</th>
</tr>
</thead>
</table>

Chapter four revealed the results of this quantitative, descriptive, correlational study. The study's purpose and data management processes were reviewed and discussed. Every attempt was made to ensure anonymity of the study participants and confidentiality for participant's responses. The sample size was 1,394 with a final survey return rate of 285 (20.44%). There were 198 currently practicing PNs and 77 PNs who reported no current activity as a PN. Not surprising, the most common reason for lack of current practice was due to retirement. The majority of practicing PNs were personally affiliated with, and served in, small Lutheran congregations in metropolitan or rural communities. The majority of PNs were prepared at the baccalaureate level, had many years of acute care nursing practice, but few years of service as PNs. Working as an unpaid staff, most of the PN respondents served as alone or with one other PN. Working within a
congregational-based model of PN practice, the majority of the PNs were supervised by the senior pastor. Although many PNs reportedly had a relevant PN position it was often neither reviewed or updated yearly, nor was it used in the PN's evaluation process. Quantitative analysis revealed that the revised CWEQ-II met the criteria for a valid and reliable instrument.

The quantitative results identified that the PNs perceived a moderate level of overall and subscale structural empowerment in their role as PNs, with greatest access to formal power, followed by access to information and opportunity. Access to opportunity and information were found to have a significant relationship to years of nursing experience. There were no significant differences found between the CWEQ-II subscales and years of PN experience, level of nursing education, presence or absence of a PN position description. However, there was a significant relationship found between the CWEQ-II subscales and report of salaried or unpaid status. Salaried PNs worked significantly more hours per week than unpaid PNs, however working more hours in a salaried position did not result in a higher hourly wage. There were no differences found between salaried and unpaid status as a PN and religious affiliation of the faith community served by the PN, or with the nature of the PN position. More unpaid PNs served in small congregations (0-600) in micropolitan or rural geographic locations, while more salaried PNs served in metropolitan-based faith communities of 601-2,000 individuals. Nearly equal the number of salaried and unpaid PNs reported having a position description, more unpaid PNs reported having no position description. The study findings provide an insight into the structures of empowerment within faith
communities. The following chapter will provide an interpretation of the findings, recommendations for future exploration.

Study Findings

The sample size was 1,394 (N = 1,394) with a response rate of 20.44% (n = 285). Of the 285 respondents, 77 PNs reported that they were not serving in a current PN practice. The most common response for lack of current service was retirement (n = 31, 40.2%), followed by working full time in another nursing position or no PN position available.

One hundred and ninety-eight practicing PNs completed the demographic section of the survey. For this study, PNs were well-seasoned hospital nurses with a mean of 32.73 (SD = 12.8) years of experience, while only an average of 7.55 years (SD = 5.0) years as a PN. The majority of the PNs had a bachelor's degree or higher in nursing (n = 129, 65.2%). PNs worked an average of 10.36 hours (SD = 9.583) per week, while 75% (n = 149, 75.2%) worked 16 hours or less per week. Two-fifths of PNs received a salary for their service (n = 78, 39.4%), with a mean salary of $15,895.20 (SD = $10,441.98) and an hourly wage of $16.96. Salaried PNs (M = 17.06, SD = 9.53) worked significantly more hours per week than the unpaid parish nurses (M = 5.34, SD = .572) (t = 10.285, df = 182, p < .001), however working more hours per week was not shown to affect the amount of salary.

The majority of respondents worshipped and practiced in the same denomination. The PNs primarily served in small (0-600 individuals, n = 88, 44.4%) faith communities. The majority of PNs practiced as a PN in a congregational-based model and served alone or with one other PN in the faith community setting. Fifty percent of PNs reported their
manager was the senior pastor. The majority of PNs reported to have a PN position description (n = 146, 73.7%); while most (n = 137, 95.8%) reported that the description reflected their work, but less than one-half reported that it was reviewed yearly or was used in evaluation.

The level of structural empowerment as reported by the PNs was moderate as reported on the CWEQ-II, with a mean overall score of 20.88 (SD = 3.8). The mean subscale scores ranged from 3.88 (SD = .73) on formal power to 3.05(SD = .98) for access to support. Construct validity for the CWEQ-II was supported with the Global Empowerment Scale (r = .71, p < .01).

Access to opportunity (r = .16) and information (r = .16) were found to have a statistically significant positive correlation with years of nursing experience (p < .05). However, there were no significant differences found between PNs' level of nursing education, PNs' years of experience as a PN, and presence/absence of a PN position description with the overall and subscale scores of the CWEQ-II. There was, however, a statistically significant relationship found between five of the six subscales of the CWEQ-II (not “access to resources”) and service as a salaried or unpaid PN. There was no difference found between salaried or unpaid status as a PN and denomination of faith community served or with the nature of the PN position.

There were a significantly larger proportion of unpaid PNs serving in small congregations (0-600) in micropolitan or rural settings, while nearly equal numbers of salaried and unpaid PNs served in metropolitan faith communities (χ² (2) = 6.023, p < .05). A significantly greater proportion of paid PNs were serving in faith communities of 601-2,000 individuals (χ² (2) = 15.107, p < .001). There was a
statistically significant difference between salaried and unpaid PN respondents who reported use of a PN position description ($\chi^2(1) = 24.133$, $p < .001$). Although the number of salaried and unpaid PNs reported having a position description, more unpaid PNs reported having no position description.
CHAPTER V
DISCUSSION

Chapter V includes the interpretation of findings, discussion, recommendations, and suggestions for future research. A restatement of the study purpose begins this section as a guide for the reader. Interpretation of findings is approached through a review of the demographic characteristics and through each of the research questions. Results are discussed from Kanter’s structural theory of power in organizations. Final recommendations related to this research for nursing education, practice, administration, research, and politics conclude this chapter.

Purpose

The purpose of this study was to explore perceptions of structural empowerment of PNs. The specific aims were to (a) assess nurses' perceived level of structural empowerment in their role as PNs, (b) investigate the relationship between the nurses' overall perceived level of structural empowerment and the global measure of empowerment in their role as PNs, and (c) examine the relationship between the nurses' demographic variables and perceived level of structural empowerment in their role as PNs.
Sample

At the time of the research study there were 1,490 nurses, clergy and lay faith community leaders who had completed the basic parish nurse preparation course offered by the Concordia College Parish Nurse Center, Moorhead, MN. Chapter 4 provides the several reasons why individuals did not meet the eligibility criteria to participate in the research study. The final sample size was 1,394 ($N = 1,394$). Three follow-up attempts were made via postcard mailing and electronic messages in an effort to increase the sample size. The final overall response rate was 20.44% ($n = 285$). It was anticipated that the response rate would have been well over 300 subjects for this study, based on previous research completed using PNs as subjects. Previous research studies with this population by this researcher and a colleague garnered a response rate of 37.7% ($n = 435$) to 43.1% ($n = 431$) using a mailed paper-formatted survey tool (Bokinskie & Kloster, 2008). Each of these tools was 4 to 6 pages in length. In addition, Solari-Twadell (1999b) mailed a multiple paged paper formatted survey tool to PNs throughout the US, with a response rate of 54% ($n = 1,161$). Steward, McNulty, Griffin, and Fitzpatrick (2010) reported a response rate of 20% in an online survey with nurse practitioners. Therefore, the response rate for this study may be considered consistent with other web-based surveys on nurses. Ten of the 285 respondents did not complete the study beyond the study’s consent page for the web-based survey as all mailed out paper surveys were accounted for by their assigned number.

There could be a number of factors that led to this study’s response rate. The first factor could be type of format used to complete the research study. While respondents could request a mailed paper-formatted version of the study tool, this study was primarily
a web-based format. This researcher received nearly twenty telephone calls and electronic messages requesting assistance with accessing the tool via the web-based format. Although, detailed instructions were provided over the telephone and an active link was provided as part of the response in the electronic messages, this researcher was not certain that the individuals completed the survey after the assistance was provided to them. Another factor could be a combination of the individual’s inexperience with web-based surveys and computer access issues. Although respondent age was not included as a demographic question, one could surmise an average age of the PN to be 53 to 55 years of age. This was calculated by adding the average age of a diploma or bachelor’s degree graduate (20 to 22) to the mean years of service as a RN, which was 32.73 years. Perhaps this age of individual prefers the paper and pencil method to completing surveys and did not have the computer savvy to complete the survey. The respondents could have had difficulty in locating a computer with adequate internet access. Another factor could be the timing of the study. The survey was completed during the end of October through the month of December. During these months there are many church related activities within Christian parishes that occur and the PN could have been too involved with faith community activities to complete the research study. There were an estimated twenty to thirty PNs who telephoned, electronically mailed, or sent a letter to the researcher describing their recent or past retirement from nursing and parish nursing practice. Although all were encouraged to complete the first three questions of the survey, this researcher has no way of knowing if these individuals completed any part of the survey tool. However, there were many anecdotal comments provided through these messages that validated and supported the ministry of parish nursing. These writings could be the
impetus for further qualitative studies on the impact of the practice of parish nursing on the lives of PNs. And finally, the reasons for lack of completion of the study beyond the consent page could be related to the need to scroll down through the consent information and click an accept button to continue with the study. If the PN could not see the accept button they would likely close out of the study and end the survey attempt.

Future studies with this population would necessitate one to reconsider the survey method. One possible alternative would be to mail out the paper-formatted survey with an option for the individual to complete it in a web-based format which is opposite of this study’s format.

Demographics

Demographic characteristics of PNs were examined and compared to the literature. Of the 275 PNs who completed the survey, 77 respondents completed through question 3. The third question asked if the PN was active or not currently active in PN ministry in a faith community. It was not surprising to see that the majority of non-active PNs cited “retirement” as the most common reason for lack of current PN activity (n = 31, 40.2%). The additional reasons given for lack of activity in the PN role included "other", “working full time in another nursing position”, and “no position available” were findings consistent with those of a previous study by Bokinskie and Kloster (2008). The principal reason cited from this study for non-activity in the role of a PN was not surprising – retirement. As noted earlier, the average PN has nearly 33 years of nursing experience. Many nurses are near or at retirement when they complete the basic parish nurse preparation program and have less than eight years of practice in the PN role before
a complete retirement from the workplace. These nurses come into the PN role with a wealth of nursing knowledge, which provides an excellent foundation of practice for the nurse. Of interest to this researcher is the category of "other" reasons. Some PNs see their role within faith communities as support providers to the practicing PNs, or they attended the basic parish nurse preparation program to enhance their nursing knowledge. However, lack of available PN positions may be due to economic climate induced staffing reductions, no pay or benefits with only unpaid positions available, and/or no positions created for nurses who have completed the basic PN preparation course. These findings support the anecdotal reports that this researcher has heard in the role as program administrator. Some of the program attendees express no current interest in becoming a PN but desire to take the course to enhance their nursing practice within their workplace setting, or desire to be of support to the salaried PN within their faith community. It is disheartening to hear from nurses who are not able to practice in the role due to lack of salary and benefits, or lack of positions for the PN within a faith community. Therefore, it is important to provide nurses with the tools and resources to begin health and healing programs within faith communities prior to their attending a basic parish nursing preparation program, or to provide support and consultation for the development of PN positions after the nurse has completed the educational program. If a position is not available within the PN’s geographic area or within the PN’s religious denomination, the PN needs to network with parish nursing leaders or program coordinators to identify and secure available PN positions.

Of the 198 survey respondents, only 159 completed the CWEQ-II as well as the demographic section of the survey. There were 39 respondents who only completed the
demographic section. The majority of the non-respondents (n = 32) were individuals who were of unpaid status as PNs. The possible reasons for this would be inability to follow the web-based survey tool and inadvertently closed out of the study after the demographic section (as all of the returned mail paper-formatted surveys were complete for salaried and unpaid respondents). The demographic section ended at the bottom of a page on the web-based survey tool and perhaps the individual thought that the survey was completed. The individuals could have experienced emotional concerns that they should not complete the empowerment survey as they were unpaid in their roles as PNs. The survey tool was reexamined to see if the software platform through the Qualtrics (2008) program had technological issues and this was found not to be the case. This is a significant study finding and further exploration into perceptions of empowerment of unpaid PNs should be further explored using a qualitative study approach. Additional insights into thoughts and feelings could be uncovered and more deeply explored through this approach. However, a sample size of 194 (116 salaried versus 78 unpaid) was sufficient to provide .80 power to detect an effect size of 0.41 standard deviation units (between Cohen’s “small” and “medium” effect sizes). A sample size of 198 provided power = .80 to detect a population correlation of .20 with p = .05 (Cohen, 2003).

Consistent with findings reported from previous studies, the typical PN respondent was affiliated with the Lutheran denomination (n = 99, 50.0%) and practiced within a Lutheran faith community (n = 102, 51.5%) (Bokinskie & Kloster, 2003; McDermott & Burke, 1993; McDermott & Mullins, 1989). The "Lutheran" affiliation and practice was followed by "Roman Catholic" (n = 32, 16.3% and n = 30, 15.2%, respectively) and "Methodist" (n = 18, 9.0% and n = 18, 9.1%, respectively). The
dominance of the "Lutheran" as the religious affiliation may be due in part to the study's geographic large numbers of Lutheran faith communities and that the educating body, which provided the basic parish nurse preparation program, was affiliated with a college of the Evangelical Lutheran Church of America. Nurses from Lutheran faith communities may gravitate to a Lutheran-based basic parish nurse preparation program similar to Roman Catholic nurses enrolling in a basic parish nurse preparation program affiliated with the Roman Catholic Church.

Nearly three-fourths of PNs practiced alone or with one other PN within a faith community. Fifty percent of PNs practice as the sole practitioner within the faith community (n = 103, 52.0%); while nearly one-fifth (n = 39, 19.7%) practiced with one other PN. These findings reflect the independence of the PN role; perhaps for some it could be considered isolation of the PN within the faith community. To work within this environment, PNs need to have excellent assessment skills, the ability to independently problem solve, and knowledge of community resources to assist with parishioner care when the need arises. The importance of networking within denominational groups and with other PNs in one's geographic area also is necessary to provide support and reduce the potential for isolation within the faith community setting. Networking with other PNs is also an excellent way to gather new programming ideas and assist in problem solving. Anecdotal comments from PNs support the need for continuing education related to PN practice, as well as the gratefulness for opportunities to gather in small and large groups to discuss issues unique to this specialty nursing practice. The isolation of the PN in the faith community also provides support that the PN must be willing to work independently and have confidence in his/her abilities to make decisions, this role may not be ideal for
the new nurse graduate who may be still unsure of his/her abilities to assess, plan, intervene, and evaluate outcomes alone.

The PN respondents represented small-sized faith communities situated in rural and metropolitan settings. The most common size of faith community served by the PN was 101 to 200 individuals; this was followed by service to a faith community of 2,001 to 5,000 members. Consistent with McDermott and Burke (1993), the majority of PNs practiced in faith communities of less than 2,000 members (74.3%). In addition, nearly eighty percent (76.4%) of the PNs serve in metropolitan or rural communities, while just over twenty percent (23.6%) of the PNs serve in micropolitan communities. These findings are similar to those reported by other researchers (Bokinskie & Kloster, 2003; Solari-Twadell, 2006) and are not surprising for the Upper Midwest region served by the Concordia College Parish Nurse Center, Moorhead, MN. This wide variation in geographic location as well as the differences in size of faith community served by the PN may provide strengths and challenges for the PNs in relation to access to resources, support, networking, and information. It is likely that the PNs from the metropolitan area would have a wealth of community based resources available to meet the needs of the faith community members, while the PNs in the rural settings would need to mobilize local resources, travel a distance to obtain support services, or be innovative in accessing resources through non-traditional means or through web-based activities. The micropolitan based PN may also experience a variety of challenges with accessing and obtaining resources within their community, and these may be quite dependent upon the current state of the economy at the local or regional level. In addition, the variation in size of faith communities served by PNs may add some strengths and challenges to
(a) developing health/wellness councils, (b) engaging others in health and wellness programs/activities, and (c) finding resources to meet the needs of fellow faith community members. Creative approaches to accessing resources, information and support may be necessary to develop and maintain a health and healing ministry for the PN in a variety of faith community locations and sizes. As noted in the previous paragraph, these PNs likely practice alone or with one other PN within their faith community. A typical PN in this study may be the sole PN provider in a small rural congregation. These findings present a challenge for PN educators as the needs of each faith community setting and geographic location provides unique opportunities and barriers when educating PNs about serving as an advocate, referral agent or health resource. PN administrators must be acutely aware of the resources available to the faith community and work to assist the PN in locating adequate and appropriate support services for the individuals within their faith community.

The PN respondent reported a mean of 32.73 (SD = 12.76) years of nursing experience as a RN and a mean of 7.55 years (SD = 5.03) of nursing experience as a PN. There were few PNs who reported experience in the role as a PN over 16 years, while nearly 90% of the PNs reported having general nursing experience over 16 years. Conversely, over 90% of the PNs reported experience as PNs less than 16 years, while ten percent of PNs reported less than 16 years of nursing experience. These findings reflect a very experienced pool of nurses in clinical practice but a rather new group of nurses to the practice of parish nursing. Although respondent age was not included as a demographic question, one could surmise an average age of the PN to be 53 to 55 years of age. This was calculated by adding the average age of a diploma or bachelor’s degree
graduate (20 to 22) to the mean years of service as a RN, which was nearly 33 years. The rationale for not requesting the individual’s age was that it was this researcher’s experience as a PN educator that the majority of nurses did not go into the nursing profession as a second career and therefore one could assume that adding the years of nursing experience to the usual age of graduation from a nursing program would be reflective of the individual’s age. This assumption was supported by other studies that included that the average age of the nurse was in the mid-40s to early 50s (King & Tessaro, 2009; Kuhn, 1997; McDermott & Burke, 1993; McDermott & Mullins, 1989; Solari-Twadell, 1999b; Solari-Twadell, 2006). This is evidence that the practice of parish nursing is considered a new specialty practice. One would assume that current research would show a similar average in years of nursing experience but an increase in mean years of practice as a PN. Bokinskie and Kloster's (2008) study explored years of nursing and parish nursing experience with alumni of the Concordia College Parish Nurse Center’s Basic Parish Nurse Preparation program five years previous to this current study and reported that PNs had an estimated 20 years of clinical experience but fewer than ten years in the PN role. Anecdotal information from PNs provide support for these findings as these nurses identify that they have retired from their previous nursing position and have gone into parish nursing as a transition into retirement from a long career in the profession. Such nurses often have financial security from past employers and are able to work in an unpaid capacity as a PN. These findings support the fact that nurses enter the PN ministry at the end of their nursing careers and are able to practice as PNs for a short time before full retirement. Younger nurses are needed in the specialty practice of parish nursing to encourage and support others to grow the practice as a career option for nurses.
rather than a transitional time to retirement. However a major barrier to enticing younger nurses is the financial considerations. New graduate nurses have expressed much interest in the practice of parish nursing to this researcher; however they are dismayed at the lack of financial support for the role. Without funding options, it will be difficult to recruit and retain younger nurses into the PN ministry unless faith communities provide adequate salaries and benefits, and financial support for program development. Parish nursing educational bodies could partner with local and regional health care systems to provide the financial resources and support to assist in the placement of parish nurses within faith communities.

As noted in Chapter 4, this researcher did not explore gender differences on perceptions of empowerment for nurses' in their role as PNs, due to the small numbers of males who practice as PNs. An exploration of gender differences could be an additional future study for this researcher, however it would need to be completed on the national or international level in order to provide adequate anonymity for the male PNs.

The majority of PNs also either currently or previously practice in inpatient hospital settings, followed by experiences in long term care, ambulatory care, and community/public health settings. It was interesting to note that there were few respondents who identified only practice in one type of setting. Thus these nurses bring a variety of diverse nursing expertise into their PN practice. These findings are consistent with those of an earlier study with this population by Bokinskie and Kloster (2003), who noted that the PN had an average of 20 years of traditional acute care clinical experience but had served less than ten years in the PN role. These findings support the recommendation by the IPNRC (2009b) that the PN should have experience in medical-
surgical nursing and community health nursing. Combined with the study's findings that the majority of PNs practice alone or with one other PN in their faith community, it is important that the nurse has practical experience and confidence in assessment, planning, implementation and outcome evaluation with individuals and groups.

Fifty percent of PN respondents reported having a bachelor's degree in nursing, followed by diploma (23.2%), and associate degree (10.6%). Very few PNs were educated at the master's or doctoral level. These findings are slightly different than those found in the literature as others reported preparation at the diploma and associate's level ranged from 38% to 76%, bachelor's level ranged from 13% to 46%, master's degree from 4% to 18%, and doctorate ranged from 0 to 1% (King & Tessaro, 2009; Kuhn, 1997; McDermott & Mullins, 1989; Solari-Twadell, 2006). One reason could be that the state of North Dakota required the bachelor's degree as entry level for professional nursing practice from 1987 to 2003; therefore, the pool of basic parish nurse preparation program participants with bachelor's degrees would be higher than in other parts of the nation. These findings support the IPNRC (2009b) recommendation that the PN has a bachelor's degree in nursing as the nurse needs expertise in community assessment, knowledge of the referral process within and outside of the faith community, and an understanding of population-focused care (Hickman, 2006). Of interest to this researcher was the frequency of non-nursing education attained by the PN respondents. Nearly 25% (n = 46, 23.2%) completed additional non-nursing degrees, with the majority (n = 40, 20.2%) at the bachelor's or higher levels. Individuals reported bachelor's and master's degrees in the areas of theology and Christian studies. Degree foci at the master's and doctoral levels included education, administration, and counseling. Although this study
did not ask if the additional degrees in non-nursing areas were completed before or after becoming a PN, these findings reflect the PNs focus on continuing one's education. This may be one of the reasons why the PNs reported greater levels of access to information than most other subscales on the CWEQ-II. Future studies could explore types of continuing formal education desired by the PN to enhance their knowledge and skill in the ministry and practice of parish nursing.

The PN respondents were queried as to the nature of their PN role with the faith community they served. Nearly two-thirds of the PN respondents were employed in the role as a "PN only", while one-third practiced in a joint "PN & Coordinator" position. This is of interest as the majority of PNs practice alone within faith communities. As a PN Coordinator, these individuals would likely be managing very small groups of PNs. The majority of PNs also practiced in a congregational-based (n = 141, 71.4%) model of practice, rather than a health system-based model. These findings are similar to those noted in the literature review (Bokinskie & Kloster, 2008; King & Tessaro, 2009; Kuhn, 1997; McDermott & Mullins, 1989). These findings are consistent with additional study findings that PNs reported to practice alone or with one other PN in the faith community. As the PN practice is based within faith communities, it is not surprising that the primary model is congregational-based. Further analysis of the data on practice models was not possible as the numbers of PNs who reported to practice in health system-based models was too small. Future studies should explore the variables associated with practice models and the impact of the practice model on perceptions of empowerment of PNs.

The mean number of hours worked by both salaried and unpaid parish nurses was slightly greater than ten hours per week. Consistent with findings from King and Tessaro...
(2009), nearly one-half of the nurses in this study reported to have averaged less than eight hours per week in their role as PNs. Less than 10% of the nurses worked more than 25 hours per week as a PN. When one considers an employment situation of ten hours per week, it would likely be configured into two or three partial days of work. One needs to question if this allotted amount of time provides enough opportunity to develop, implement, and evaluated programs by the PN. One answer could be that the PN spends much of the time in implementation of programs that were purchased by the church or obtained from a continuing education event. In addition, the PN spends little time in creatively developing programs unique to the faith community and in the evaluation process. This researcher believes that these answers may have some truth as PNs request that the Parish Nurse Center staff develop health and healing activities for use within faith communities and that the follow through of evaluating outcome measures is not often completed by the PNs. There simply are not enough hours of time to devote to PN practice especially for the nurse who is employed in a full-time capacity in another nursing position that provides a salary.

Slightly over one-half of the PN respondents were employed in an unpaid capacity. These findings are similar to those noted in the literature review (Bokinskie & Kloster, 2008; IPNRC, 2009a; King & Tessaro, 2009; Kuhn, 1997; McDermott & Mullins, 1989). Those who served in a salaried capacity were asked to provide salary information. The mean salary reported by the PNs was $15,895.20 with a salary range of $1,000 to $40,000 per year. When further calculated, the mean hourly salary was $16.95 (with a range of $1.28 to $38.46 per hour). One could hardly imagine any other professional health care provider working for less than $2.00 per hour. In 1997, Kuhn
reported basic salary information of $10.00 to $18.00 per hour for parish nurses, while in
1998 the average hourly wage for all registered nursing position was $20.71 (Bureau of
Labor Statistics of the U.S. Department of Labor, 1999). Therefore, the findings from this
study reflect a salary lag of over ten years. One could wonder if the salary lag in the next
ten years will continue grow. In addition, it must be noted the large numbers of PNs
serving in unpaid capacities within faith communities. Prior research has shown that few
PNs reported financial reimbursement was an important factor (Solari-Twadell, 2006),
but there are many advantages reported in the literature of the benefits of having salaried
positions. These advantages include (a) formal power, (b) enhanced personal
commitment, (c) increased program attention by faith community members, and (d) a
stronger pool of PN position applicants (Hickman, 2006). Overall, these salary findings
are disconcerting to this researcher in her role as a PN educator. Recruitment and
retention of younger and/or highly qualified nurses into parish nurse as a career may
hinge on creating salaried positions that are competitive with hospitals and community-
based settings. Anecdotal findings from personal discussions with PNs in this
researcher's role as a PN educator and administrator reflect the nurse's sense of calling
into the ministry of parish nursing, the desire to “give back” to the church, and the
seemingly lack of desire to seek reimbursement for their services in the PN role. These
reasons may be detrimental to the future development of parish nursing if financial
compensation is not addressed. However, further studies need to done to address the
trends in salary and benefits provided for PNs, the level of altruism, as well as the reasons
why PNs do not seek financial reimbursement for their work in the PN role.
Fifty-percent of PN respondents (n = 99) reported that the senior pastor provided the overall supervision of the PN within the faith community, followed by nearly 12% (n = 23, 11.6%) who reported that a PN coordinator provided the supervision, and 10.9% (n = 21) supervision by the health cabinet/wellness council. Although there were no studies found in the literature that addressed supervision, Brudenell (2003) stated that a mutual relationship between the PN and the clergy was important in the integration of a parish nursing ministry into the faith community. Bokinskie and Kloster (2008) reported that PNs identified "clergy support" as the top (of five) factor for a successful PN ministry and "health cabinet/wellness council" as an additional priority factor. Therefore, strong supervisory relationships with senior pastors, PN coordinators, and health cabinet/wellness councils may aid in the integration of PNs into the faith community's structure and provide the validation for the PNs' role. These findings support the continued need for educational programs for PNs that focus on building relationships with leaders and groups within one's faith community, the need for a strong relationship with the clergy, and the importance of supervision within the role as a PN. Of concern to this researcher are the numbers of PNs who reported that they were provided no supervision within the faith community; for without supervision and guidance there may be an increased risk of burnout and attrition from the role. Additional factors of concern are the socially isolated nature of rural locations and the likelihood that the PN practices alone within the faith community setting. Perhaps this is one reason why PNs reported access to support as the least perceived aspect of empowerment. Program initiation, development and evaluation may be hampered as the PN may receive little guidance and support for health promoting and spiritually healing activities. Further studies could be
completed to explore aspects of supervision, the supervisor's role, and characteristics of relationships between clergy, PN coordinators, health cabinet/wellness councils, and the PN.

Finally, the PNs provided information about the presence or absence of PN position descriptions used in the faith community. Nearly three-fourths of PN respondents reported having a PN position description. These findings assist in validating the educational content provided in the basic parish nurse preparation course on the importance of having a PN position description. Of concern to this researcher is that about one-fourth of PNs did not have a PN position description or did not know if they had a PN position description. These findings support the need for continuing the content materials in the basic parish nurse preparation program and for the need to include this information in continuing education programs for PNs. Perhaps hands-on sessions to assist PNs in developing a document would be of value.

Further exploration on the utility of the PN position was completed by the researcher. Nearly all of the PNs reported that the position description reflected their responsibilities; however, less than fifty percent of the PN respondents reviewed and updated it yearly or used it for their performance evaluation. While the development and use of position descriptions is encouraged by educators in basic parish nurse preparation programs, researchers have reported that PNs found position descriptions to be not very important for their role as a PN (Solari-Twadell, 2006). Hickman (2006) would argue that a position description is useful as it reflects the functions, accountabilities, and responsibilities of the PN. Position expectations that are clearly articulated may provide the faith community members and leaders with a better understanding of the role and responsibilities of the PN.
functions of the PN; thus assisting the PN in defining the PN role. There was little found in the literature that discussed the use of position descriptions as part of one's evaluation process. McDermott and Mullins (1989) reported that fifty percent of the PNs completed an evaluation process. These findings are of concern to this researcher, and PN educator and administrator as much time is spent in the basic PN educational program on the usefulness of a PN position description. Multiple samples of PN position descriptions are provided to the program participants to assist them with development of a document for legal purposes, as an evaluation tool, and as a practice guide. Further research within the area of position description development and usage in the evaluation process is important for the ongoing advancement of organizational structures for PN practice within the faith community.

Research Questions

Research Question 1

The first research question was: What are nurses' perceived levels of structural empowerment in their role as PNs? The hypothesis for this question was: The nurses will perceive a moderate level of overall and subscale structural empowerment as reported on the CWEQ-II, in their role as PNs. The findings from this study on nurses' perceptions of empowerment in their role as PNs provide support for this hypothesis.

The perceived level of structural empowerment as reported by the PNs using the CWEQ-II was a mean overall score of 20.88 (SD = 3.82); thus reflecting a moderate level of perceived empowerment by the nurses' in their role as PNs (Laschinger, 2004b). These PNs reported greater access to formal power, followed by access to information,
opportunity, informal power, resources and lastly, access to support. Cronbach's alpha coefficients for each of the subscales and overall scale were calculated and reported as (a) opportunity (α = .77), (b) information (α = .90), (c) support (α = .86), (d) resources (α = .69), (e) formal power [JAS-II] (α = .54), (f) informal power [ORS-II] (α = .78), and (g) CWEQ-II (α = .91). When compared to the reliability estimates provided by Laschinger (n.d.) and Stewart et al. (2010), all but one of the coefficients fall within the ranges provided. The coefficient for formal power was slightly lower than the range of .55 to .83 (Laschinger, n.d.). It is of note that the original tool was revised to reflect practice within faith communities; however none of the items for "formal power" were revised.

The findings of perceptions of empowerment of nurses' in their role as PNs are consistent with those found in the literature. Multiple studies have found that hospital based nurses report a moderate perception of empowerment on the CWEQ-II (Armstrong, Laschinger & Wong, 2009; Davies et al., 2006; DeCicco et al., 2006; Fitzpatrick et al., 2010; Laschinger, 1996; Laschinger & Havens, 1996; Lucas et al., 2008; Sarmiento et al., 2004). Likewise, it has been reported that school nurses and long term care nurses reported moderate levels of empowerment using the CWEQ-II (DeCicco et al., 2006; DeSisto & DeSisto, 2004). It is worthy to note that the perception of empowerment by PNs is consistent with nurses who practice in other areas of nursing, especially since the specialty practice on parish nursing is relatively young and not firmly established throughout faith communities in the U.S. Future studies should be completed to explore perceptions of empowerment within other community-based nursing settings as most of the documented reports reflect acute care. As health care shift from acute to community
care settings, it is important that structures are in place to provide positive and empowering work environments for the staff.

Rather surprising was the finding that PNs in this study reported greatest access to formal power, followed by access to information, opportunity, informal power, resources and lastly, access to support. Other studies have found that acute care nurses perceived higher perceptions of informal power, access to opportunity, and access to power structures than perceptions of formal power (Donahue et al., 2008; Faulkner & Laschinger, 2008; Laschinger, 2008), while school nurses, new nurse graduates, and nurse practitioners reported greatest access to opportunity (Cho et al., 2006; Davies et al., 2006; DeSisto & DeSisto, 2004; Stewart et al., 2010). Formal power is associated with one's job activities, amount of organizational visibility, and perceived importance within the organization. One plausible reason for this finding is that perhaps these PNs perceive their work as being central to the faith community's mission and vital for the health and wellbeing of the congregation. The work of the PN is valued by the faith community and reflected in the PN’s perceptions of formal power. The typical PN is serving as a sole PN provider within a small rural faith community and may perceive moderate levels of empowerment because their service is sorely needed and they may be one of few professionals serving the faith community. This finding supports the need for creating PN positions that are central and aligned to the mission of the faith community, creating PN position descriptions that are consistent with the work of the church, and developing opportunities for the PN to be visible within the church in worship and events.

The low level of access to support is not a surprising finding as this specific structure focuses on having constructive criticism, training and guidance from colleagues.
and supervisors. Many of the study's respondents reported they served alone or with one other PN in their faith community, therefore having feedback and guidance from others may be more difficult to obtain, as well as having the ability to informally network with others within and outside of the faith community. These findings are supportive of the anecdotal comments received by this researcher from practicing PNs in the community. PNs have expressed concerns about the limited numbers of PN colleagues within their geographic area and the importance of gathering with others for support and networking opportunities. This finding supports the need for building relationships with other professionals within the faith community, and networking with other PNs outside of the church. In small faith communities, the only other professional may be the clergy member or youth leader; while in larger faith communities the professional disciplines may be broader. PNs need to be encouraged by PN educators and administrators to seek out guidance and support from others, whether they are nurses or non-nurses.

And finally, it is affirming and exciting to see such a high perception of empowerment in a practice area where the majority of practitioners are functioning alone, serving in rural congregations, practicing with few years of PN expertise, and serving in an unpaid capacity. Future research studies should be completed to explore perceptions of isolation and means to overcome this barrier.

Research Question 2

The second research question was: What is the relationship of scores between nurses' overall perception of structural empowerment on the CWEQ-II and the global measure of empowerment in their role as PNs? The hypothesis for this question was: There exists a relationship between the nurses' perceptions of a global measure of
empowerment and the overall perceived level of structural empowerment in their role as PNs. The findings from this study on nurses’ perceptions of empowerment in their role as PNs provide support for this hypothesis.

This research study found that there was a relationship between the nurses’ perceptions of a global measure of empowerment and the overall perceived level of structural empowerment in their role as PNs. The mean score reported by the PNs (n=162) on the Global Empowerment scale was 3.92 (SD = .89), with a Pearson's coefficient r = .708 (p < .01). This finding provides support for the construct validity of the CWEQ-II with the Global Empowerment scale. The PNs perceived that their overall workplace was a moderately empowering setting for the accomplishment of their tasks. These findings are similar to those found in the literature (DeCicco et al, 2006; Laschinger, Finegan, Shamian, & Wilk, 2001; Patrick & Laschinger, 2006; Piazza et al., 2006). As the CWEQ-II was modified for this study to focus on faith communities rather than hospital settings, the revisions made on the CWEQ-II questionnaire did not appear to alter the tool in a detrimental fashion. No further modifications of the CWEQ-II tool are needed for future use with PNs. As the Global Empowerment scale is primarily used with the CWEQ-II as evidence of construct validity, this researcher would likely not include this as a research question in future studies on perceptions of empowerment.

Research Question 3

The third research question was: What are the relationships between the nurses’ years of nursing experience, type of previous nursing experience, level of basic nursing education, presence/absence of a position description, and salaried/unpaid position with
overall and subscale perceptions of structural empowerment in their role as PNs? The hypothesis for this question was: There exists a relationship between the nurses' years of nursing experience, type of previous nursing experience, level of basic nursing education, presence/absence of a position description, and salaried/unpaid position with overall and subscale perceptions of structural empowerment in their role as PNs. The findings from this study on the nurses’ perceptions of empowerment in their role as PNs provide support for some components of this hypothesis; however, since they were not all statistically significant the hypothesis was not fully supported.

The relationship between years of nursing experience with the overall and subscale perceptions of structural empowerment, as reported on the CWEQ-II, were examined using descriptive statistical methods. Access to opportunity (r = .162) and information (r = .16) were found to have a statistically significant positive correlation with years of nursing experience (p = <.05). All of the other subscales (access to support, access to resources, formal power, or informal power) showed a positive but non-significant relationship with years of nursing experience (p = > .05). These findings are consistent with two studies found in the literature. Cho et al. (2006) reported that new graduate nurses (less than 2 years of experience in a hospital setting) reported having the most access to opportunity. Although these PNs likely had many more years of general nursing experience, perhaps the change in role to parish nursing provided a new challenge - the impetus to seek out new learning and skill development for the role.

Nurses begin their work as PNs with much expertise on caring for the body and the mind; it is through their work and education as PNs where they hone their skills at caring for the spirit. PNs have often stated to this researcher that they finally can take care of the
patient's spiritual needs when they serve as PNs - that they can finally practice nursing in the way that they were educated to provide nursing care. Working in a community-based position similar to that of PNs, DeSisto and DeSisto (2004) reported that school nurse respondents reported a higher access to opportunity. These researchers stated that plausible reasons for higher access to opportunity was related to the school nurses' work in autonomous positions and that they likely have more years of nursing education and nursing experience than nurses in hospital settings (DeSisto & DeSisto, 2004). This researcher would concur that PNs also work in very autonomous roles, have higher academic degrees than acute care staff nurses, and have many years of nursing experience. There was no support found in the literature for the relationship with access to information and years of nursing experience. Perhaps the seasoned PN has greater access to information because they are familiar with the faith community or denominational practices, they are developing policies that have not existed in the faith community, or perhaps they have more self-confidence because of their past nursing expertise. Whereas, the nurses that are new to the PN role does not feel confident in requesting more information about the faith community, policies do not exist and the PNs do not have the abilities to develop these tools, or they lack the expertise to complete the tasks. There were a number of studies that identified that nurses reported moderate levels of overall perceived empowerment regardless of years of nursing experience although these were all completed in hospital settings (Armstrong et al., 2009; Davies et al., 2006; Laschinger & Havens, 1996). Future studies exploring the relationship between years of general nursing experience and years of community-based nursing experience with perceptions of empowerment may provide additional insights into this matter.
The majority of PN respondents either currently or previously practice in inpatient hospital settings, with lesser experience in community-based settings. These results are consistent with those of other researchers (Bokinskie & Kloster, 2003; McDermott & Mullins, 1989). These findings support the recommendation by the IPNRC (2009b) that the PN should have experience in medical-surgical nursing and community health nursing. However, further descriptive statistics were not possible to complete with the PN’s type of previous nursing experience as the researcher did not request information about years within each area of practice or information about the most recent, or current, nursing practice areas. PN respondents provided multiple past and current practice areas and statistical analysis was inconclusive. Inconsistencies have been noted in the literature regarding the relationship between combinations of age, years and types of nursing experience and hospital nurses’ perceptions of empowerment (Laschinger, Finegan, Shamian, & Wilk, 2001; McDermott et al., 1996). It was of interest for this researcher to see the different areas of nursing practice for each of the respondents, as very few individuals practiced nursing within one area. During each of the basic parish nurse preparation courses, the participants are asked to share their employment history and share their expertise during class sessions on referral making, advocacy skills, support group development, and policy formation. It is through these sessions that class participants share expertise in clinical practice areas and provide guidance to other class members. PNs should be encouraged to continue collaborating with other nurses to share expertise in practice and to assist in problem solving. Future studies could be completed to examine the relationships between length of service within each of the clinical practice areas and the perceived benefits to nurses’ practice with each of the areas, as well as the
combined impact of age, years of service, and types of nursing specialty practice experience.

The relationship between the PNs level of nursing education with the overall and subscale perceptions of structural empowerment was explored. As there were limited responses in the graduate degree categories, the results were collapsed. There were no significant differences found between educational level and overall and subscale scores as reported on the CWEQ-II. These findings are consistent with those found in the literature (Laschinger & Havens, 1996; Laschinger, Finegan, Shamian & Wilk, 2001). These results are not surprising to the researcher as anecdotal reports from PN respondents identify their overall satisfaction in parish nursing practice regardless of nursing educational background. However, the findings do not support the importance of baccalaureate preparation for a community-based nursing practice. Although the IPNRC (2009b) recommends that the individual has a bachelor's degree in nursing and that preparation at the baccalaureate level provides the groundwork for nursing interventions, educators who present the basic parish nurse preparation course provide resources and support to nurses who have little knowledge or background in health promotion activities or community-based care. PNs are encouraged by PN educators to network with other PNs who have expertise in health promotion programs, community assessment and population-based care. PNs are also encouraged to partner with baccalaureate nursing programs in their region to provide opportunities for students and faculty to assist with population-based program development, and community or congregational assessments. This provides a learning opportunity for the baccalaureate nursing student, a clinical practice area for the nursing faculty, and support for the PN within the faith community.
Nurses prepared at the diploma or associate's degree level should be encouraged to continue their education so they are better prepared for practice in this community-based setting. There are few programs in the U.S. that offer a certificate or master's degree in parish nursing. PNs who desire an advanced degree should be encouraged to consider courses of study focused on faith community nursing at the graduate level.

The relationship between the presence or absence of a PN position description with the overall and subscale perceptions of structural empowerment were examined. The relationship between all six subscales on the CWEQ-II and the presence or absence of a PN position description were found to be non-significant. There were no studies found in the literature that discussed relationship between position descriptions and perceptions of empowerment as it is likely that the nursing facilities (i.e. hospitals, long term care facilities, community health centers) have defined position descriptions already in place. One would have assumed that a position description would be linked with formal power or access to information. Formal power arises from one’s job activities and is acquired by excellent job performance. Likewise, access to information necessitates having relevant policies to complete one’s work in the setting. It is apparent that these PNs did not identify this link between the presence of a formal position description and their perceptions of formal power and access to information. One plausible reason for this finding is that parish nursing is a relatively new specialty practice of nursing and the utility of a position description for the role is still in development. Perhaps there exists a relationship between the development and use of position descriptions, as a form of a program policy, and educational preparation of the nurse. Further research needs to done
to explore the components of written PN position descriptions, the development and usefulness of the position description within faith communities.

The relationship between serving as a salaried or unpaid PNs within the faith communities with the overall and subscale perceptions of structural empowerment were also explored. There was a statistically significant relationship found between five of the six subscales (not resources) of the CWEQ-II and services as a salaried or unpaid PN. There were no studies found in the literature that discussed relationship between salary status and perceptions of structural empowerment for nurses, as nurses in hospital settings most likely serve in only paid positions. However, this study's findings do support the value in providing a salary to the PNs. Having a salaried position may provide the PNs with a sense of value, recognition, and appreciation by their faith communities as a part of formal power, and provide the PNs with the time to connect with others within and outside of the faith communities as a part of informal power. This researcher has heard many comments from PNs who state that their faith community members may appreciate them more and utilize their PN services if the parishioners had to pay for the service. PNs have also related that they would have more commitment to their PN position if they had to be accountable for the dollars spent for a salary within the faith community. Having a salaried position also may provide the PNs with greater access to job-related empowerment structures of opportunity, information and support. Salary dollars provide the PN with financial resources to attend educational workshops, and provides monies to purchase supplies and equipment to implement the health promotion activities of the faith community. One plausible reason why access to resources was not a significant finding is that both salaried and unpaid PNs may have the same amount of.
time and available people resources to complete their work; therefore salary status is not a factor in the time to complete tasks. As many of these individuals are nearly complete retirement from nursing they may not have additional pressures from family or work commitments on their time.

Additional Findings

The relationship between years of PN experience with the overall and subscale perceptions of structural empowerment were examined using descriptive statistical methods. All but one subscale and the overall CWEQ-II scores showed slight positive but nonsignificant relationships (p > .05). Access to opportunity showed a slight negative but nonsignificant correlation (r = -.003) to years of service as a PN. These results are consistent with the findings related to years of nursing experience and CWEQ-II scores. When examining the relationship between years of nursing experience and the CWEQ-II, four of the six subscales also did not show a significant relationship. However, access to opportunity was found to have a statistically significant positive correlation with years of nursing experience, yet a slight negative (but not significant) relationship with years of PN experience. Access to opportunity refers to the prospects of professional growth, autonomy and work challenges (Laschinger & Havens, 1997). Perhaps these PNs do not feel challenged in their role or have the opportunity for professional development after the initial few years of parish nursing practice. Lack of funding for professional educational activities may also hinder the PN's ability to grow and develop in the role. It is possible that the advancing age of the PN may be a factor as they may attend fewer educational activities or be willing to develop new programs if retirement is looming. The work may be limiting within the faith community setting, especially if the nurse lacks the
finances, creativity, resources, or ability to develop new health promotion and spiritually healing activities. Further studies are needed to explore this area to identify the needs of PNs as they develop and mature in the role.

Although the mean number of hours worked by both salaried and unpaid parish nurses was just over 10 hours per week, there was a statistically significant difference found between the number of hours worked per week between the salaried and the unpaid PNs ($t = 10.285$, df = 182, $p < .001$). The salaried PNs worked more than three times as many hours per week than unpaid PNs. PNs in salaried positions would more likely be available throughout the week (two to four days per week) at the faith community site to meet the needs of the members and be visible within the setting, while unpaid PNs would provide episodic services (less than one day per week) within the faith community. It would appear to be more difficult to effectively develop and implement programs for faith community members when one is not available to do so. In order to provide consistency of care and to develop relationships, PN services need to be offered more than one day per week. However, if the PN is serving in an unpaid capacity he/she may need to have full-time employment in another setting. Therefore, the only day of service provided by the unpaid PN may be during the days and times of worship events. Unpaid PNs have expressed frustration to this researcher about the difficulties in meeting the needs of parishioners due to the PN's lack of time and scheduling conflicts to attend to their PN role. This concern may lead to increase role strain and burnout because of unresolved personal conflicts with personal expectations of the PN to serve the faith community members in an unrealistic time commitment.
The differences between PN respondents based on salaried or unpaid status were further explored based on numbers of hours worked, the religious affiliation, geographic location, and size of the faith community served by the PN. There was no correlation found between the number of hours worked in the PN role and the hourly wage earned by the PN. The hourly wage did not improve as the numbers of hours worked per week increased. One might assume that the PN who works few hours per week would be paid a lesser amount and that more full-time status PNs would be paid a salary closer to a competitive hourly wage. This supposition was not supported in the study's findings. On three of the paper-formatted surveys the respondents had noted that they only reported the hours that they were paid for and that the unpaid hours were not reported on the completed survey. It is likely that other respondents (those who completed the web-based survey) also only reported their salaried hours and not their unpaid hours of service to the church. Therefore, the hourly rate of payment should be less than reported and this finding reflects a bleaker earned wage for the PN.

There was not a significant difference between salary/unpaid status and religious affiliation of the faith community served by PNs ($\chi^2 (2) = 2.714, p > .05$). Due to the small numbers of some of the denominations only differences between Lutheran, Methodist and Roman Catholic affiliation were examined. This finding supports the anecdotal reports received by this researcher from PNs in current practice that no denominational group has taken the lead in paying PNs.

There were a significantly larger proportion of unpaid PNs serving in micropolitan or rural faith communities, while nearly equal numbers of salaried and unpaid PNs serving in metropolitan faith communities ($\chi^2 (2) = 6.023, p < .05$). In
addition, statistical analysis revealed a much larger proportion of unpaid PNs serving in faith communities of less than 600 individuals than in large faith communities, while a significantly greater proportion of paid PNs were serving in medium-sized faith communities ($\chi^2 (2) = 15.107, p < .001$). It was surprising to see the greater number of paid PNs served in medium-sized faith communities, rather than large settings where one would assume had more financial resources than smaller congregations. It was not surprising to see that more unpaid PNs served the smaller faith communities that were situated in rural or micropolitan geographic areas. These rural and micropolitan faith communities perhaps do not have the financial resources to support a salary, or provide a competitive salary, for the PNs. These findings support the information received by this researcher on the financial status of small congregations in rural communities. PNs report that these faith communities lack the ability to pay the salary for a pastor or support staff, let alone for the services of the PN. PNs relate that rural clergy are serving in multiple faith communities in their region and that the need for the PN services continues to rise as the clergy become less available to meet the growing needs of the elderly congregational members. It is important to address salary issues for PNs in non-metropolitan areas as these providers may be one of the few practitioners in the geographic region. PNs should consider enlisting the help of grant writers to assist in securing funding to support health promotion and spiritually healing activities for the faith community, as well as for outreach activities for the local community. Encouraging faith communities to collaborate with local or regional health systems may be one way to address the financial compensation for the PN, and programmatic support of the ministry.
The differences between salaried or unpaid status of the PN respondents were examined based on the nature of the PN position. As there were few numbers of PN respondents in the "Coordinator" only category, it was collapsed with the "PN & Coordinator" category. There was not a significant difference between salary/unpaid status and the nature of the PN position ($\chi^2 (1) = 2.035, p > .05$). PNs that provide administrative services, in addition to parish nursing functions, are not paid differently than those without administrative duties. This is of concern as these administrative responsibilities add to the workload of the practicing PN; however the nurse is not compensated for these added responsibilities. PNs may need additional educational courses to assist in (a) developing and administering budgets, (b) writing of policies and procedures, (c) addressing issues of program management and outcome measures, and (d) tackling personnel issues. Future exploration of the administrative responsibilities needs to be completed to ascertain the impact on the PNs workload, as well as the educational needs of the nurse to complete the assigned duties.

And finally, the differences between salaried or unpaid status of the PN respondents were examined with the usage of the PN position description in the faith community. There was a statistically significant difference between salaried and unpaid PN respondents who reported use of a PN position description ($\chi^2 (1) = 24.133, p < .001$). Although nearly equal numbers of salaried and unpaid PNs reported having a PN position description, large proportions of unpaid PNs reported having no PN position description or were not sure there was a PN position description within the faith community where they served. Much time is spent in the basic parish nurse preparation course on the development of the position description. Samples of documents are provided in the
participant manuals as resources for the PN to create a position description unique to their faith community. Continued efforts must be made by PN educators to encourage PNs to complete this work at the start of their ministry. This researcher is most concerned that some PNs (primarily unpaid PNs) were not aware if a PN position description even existed within their faith community. One plausible explanation is that the unpaid PN may serve in the role very sporadically and see the position description document as something needed only for full-time nurses or for those serving in salaried positions.

Theoretical Framework

As a review to the reader, Ranter’s (1977, 1993) structural theory of power in organizations provides a framework for understanding power and empowerment within organizations. The fundamental thesis of her theory is that structural aspects of work shape one’s job effectiveness and influence one’s perceptions of empowerment. Kanter stated that a work setting that provides access to support, resources, information and opportunities shapes one’s job effectiveness and influences one’s perceptions of empowerment. When situations are structured in a way that individuals feel empowered, they are more likely to work towards organizational goals. In Kanter’s (1977) theory, power is the capacity to organize resources in order to accomplish the work. Formal and informal power comprises the systemic power factors of the theory. Kanter (1977) described three empowerment structures – opportunity, power and proportions – these structures provide opportunities for development within the workplace, access to power and a social network. According to Kanter, the structure of power comes from access to resources, information, and support (Sarmiento et al., 2004). Access to empowerment
structures is facilitated by the amount of formal and informal power that the individual has access to within the work setting (Sarmiento et al., 2004).

In this study, PNs reported a moderate level of perceived empowerment and reported greater access to formal power, followed by access to information, opportunity, informal power, resources and support. In addition, there was a statistically significant relationship found between the overall and five of the six (all but access to resources) subscales of the CWEQ-II and the service as a salaried or unpaid PN.

Systemic power is reflected in access to formal and informal power subscales on the CWEQ-II. Formal power includes job characteristics, visibility of position within the organization, and is acquired by work performance that is both applicable and innovative, while informal power comes from networking and partnerships with others (Kanter, 1977). PNs reported greater access to formal power than any other subscale measure. Perceptions of informal power were also moderate but ranked fourth of the six scales. This study’s findings are not consistent with the literature. Other studies have shown that acute care nurses and school nurses perceived higher perceptions of informal power, access to opportunity, and access to power structures than perceptions of formal power (DeSisto & DeSisto, 2004; Donahue et al., 2008; Faulkner & Laschinger, 2008; Laschinger, 2008). Findings from this study may reflect that the PNs perceive their work to be more meaningful, important and relevant in the faith community in which they serve than access to other power factors or empowerment structures. PNs need to remain cognizant of the need to remain visible in the faith community. This may occur through leading of health promotion activities and assisting with worship services. Although the use of a PN position description is considered a part of formal power development, there
was no relationship found between presence or absence of a PN position description and formal power. Rather there was a significant relationship found between presence of a PN position description and perception of informal power. Efforts in enhancing perceptions of informal power are needed for PNs through collaboration with faith community leaders, developing partnerships with others within their faith communities. PNs need to be encouraged to engage in networking with other PNs and health ministers outside of faith communities, perhaps at the denominational level or with regional PN program coordinators.

Access to job-related empowerment structures of information and opportunity ranked second and third of the six subscales by the PNs. Informal power was fourth, followed by access to resources and support. These findings are not consistent with those found in the literature. New graduate nurses, acute care nurses, school nurses and clinical educators were reported to have the most access to the job-related empowerment structure of opportunity (Cho et al., 2006; Davies et al., 2006; Laschinger, 2008; DeSisto & DeSisto, 2004; Faulkner & Laschinger, 2008). Davies et al. (2006) found that clinical nurse educators reported having the least access to information. Access to information consists of having access to relevant policies, current technology and having the expertise to complete one’s work, while access to opportunity reflects one’s chance for professional growth and mobility within the organization. For this study, PNs reported a moderate level of perceived access to information, this was found to have a significant positive correlation with years of nursing experience ($r = .16, p < .05$). Continued efforts need to be made to provide PNs with current information and technology. PNs may need additional support and education to develop policies and procedures related to health and
healing programs for faith communities. In addition, access to opportunity was also found to have a significant positive correlation with years of nursing experience ($r = .16, p < .05$). PNs need to have continued opportunities to develop skills and abilities in parish nursing practice through continuing education and ongoing spiritual development. Formal educational programs could be developed and implemented to address the ongoing development of parish nursing at the master’s and doctoral levels.

Access to resources and support were reported as the lowest two measures on the CWEQ-II subscales. Access to resources was also not shown to be a factor with salaried or unpaid service as a PN. Access to resources consists of having enough money, time and supplies to complete one’s work, while access to support includes timely feedback and guidance from others. Nearly 60% of the PN respondents reported serving in an unpaid capacity, and those who were salaried reported an hourly salary of less than $17.00 per hour. In addition, anecdotal information by PNs identify that many PNs pay for their own work related supplies, guest speaker honoraria, liability coverage, continuing education and travel expenses. In order to address the lack of access to resources for the PNs, attention should be given to providing the PNs with allocated funds to support parish nursing program development and implementation. The lowest measure, access to support, may be reflective of a number of factors. Most PNs practice as sole providers, working very part-time, and serving in an unpaid capacity in a small and rural faith community. In combination, these factors may cause social isolation for the PNs. It is important for PNs to be attentive to developing and maintaining relationship with others in the faith community, as well as PNs in the local or regional area. The PN may need to find creative ways to stay connected with others if finances are a factor for
travel and continuing education activities. Faith community leaders need to remain connected to the PNs and provide ongoing guidance and feedback. Although this study did not address the outcomes or impact of empowerment on employees, the literature has shown a strong relationship to job satisfaction with access to support (Davies et al., 2006; Laschinger & Havens, 1996).

The CWEQ-II does not address access to the job-related empowerment structure of proportions. In addition, there were few men or individuals with minority status in the study’s population. Therefore, this researcher did not explore the impact of the social makeup on the perceptions of empowerment due to the risk of compromising participant's anonymity. Future studies should be done to explore the relationships between PNs and their PN colleagues, as well as other faith community leaders, clergy, and health cabinet/wellness councils. In addition, studies which explore the relationship between men and women and their perceptions of empowerment in faith communities would be of interest.

Finally, this study did not address the personal impact on PNs or outcomes of work effectiveness as a result of perceptions of empowerment. As this study was descriptive in nature, the focus was to explore the perceptions of empowerment and the job-related empowerment structures. Future studies are needed to explore the impact of structural empowerment upon personal job satisfaction, organizational commitment and retention, autonomy, work effectiveness, personal growth, and control over practice. In addition, further studies need to examine the outcome of empowerment on faith community member satisfaction.
Strengths and Limitations of the Study

The information gleaned from this study attempts to fill the gap in current literature regarding perceptions of empowerment of nurses' in their role as PNs. Limitations of this study are few. The first limitations are related to the sample itself. The geographic location and gender of this sample are assumed to be upper Midwestern, and female, based on a review of the alumni list of the Concordia College Parish Nurse Center's Basic Parish Nurse Preparation program. Limitations associated with mail survey research and web-based research has their own limitations with self-reporting. These include a reliance on the respondents to answer honestly and accurately to the survey questions; or to take the web-based survey a single time. In addition there were limits on the number of follow-up mailings due to costs of supplies and postage. However the survey was anonymous and there were no benefits or risks to the participants. While the study is limited by data reflected from a homogenous population in the upper Midwest, the primary focus of the Concordia College Parish Nurse Center, Moorhead, MN, is to provide education, consultation, and support to all PNs and program alumni, who typically reside and practice in the Center’s geographical region. Therefore the generalizability to PNs in other parts of the U.S. may be limited.

Recommendations

This section will discuss the implications of the study's findings for nursing education, practice, research, administration, and policy.
Nursing Education

Nursing education programs are designed to provide the knowledge and skills needed to prepare professional nurses to practice safely and effectively in a variety of care settings. The study's findings have significant implications for general nursing education. It would be important to collect information on nursing programs throughout the U.S. to determine which programs are utilizing faith communities as clinical practice sites and how programs are teaching nursing students about the role of nurses in the faith community setting. By increasing the awareness of parish nursing as a specialty nursing practice, perhaps more new graduate nurses will consider the faith community setting as a practice area. The inclusion of faith communities as a clinical site would provide nurses with a deeper understanding and appreciation of the PN role. Research on the role of the PN, program development and outcomes of health promotion and healing activities could be disseminated through on-line resources, continuing education events and discussion groups. As sixty percent of the PNs surveyed were employed in micropolitan and rural areas, it is important to provide an appropriate and accessible means to disseminate research findings and current information about parish nursing practice for a variety of denominations, size of faith communities and geographic locations.

Parish nursing educational programs are also designed to provide the knowledge and skills needed to prepare professional nurses to practice safely and effectively in a variety of faith denominations. Novice parish nurses would be taught the importance of having a formal position description, defined lines of communication, financial support, access to technology and collaborative relationships. These findings have significant implications for parish nursing education at the international level. It would be important
to further explore the recommendations provided by the IPNRC regarding educational preparation, types of nursing care, and use of a PN position description as they related to perceptions of empowerment in parish nursing. Dialogue with parish nurse educators need to focus on the development of the basic parish nurse core curriculum to meet the learning needs of program participants who are not presently prepared at the baccalaureate level. Ongoing educational activities would provide opportunities for parish nurses to network about organizational issues, strategies for success and ways to overcome barriers to practice.

These findings suggest a need to continue to educate faith communities, faith community leaders, clergy, and nurses about the role of PNs. Perhaps through education about the impact of the PNs’ health promotion and healing activities on the faith community, awareness of the need for the PN role would increase and the services of the PNs would be valued and financially reimbursed.

Nursing Practice

Previous research on perceptions of empowerment of nurses’ in their role as PNs has not been conducted. This research provides foundational knowledge of empowerment of PNs and knowledge of the structures of empowerment within faith communities. PNs who received a salary reported higher perceptions of empowerment and worked more hours in their role as PNs. Although the PN salary range was not comparable to salaried of other nursing positions, PNs perceptions of empowerment were consistent with their counterparts in hospital settings.
The study's findings support the need for PNs to serve in positions of formal power, positions that are visible in the faith communities and positions that are relevant to the mission of the congregation. Activities within formal power may include assisting or leading worship events or prayer meetings, participating in staff meetings, and providing educational activities in the form of workshops, newsletters, or bulletin boards. The PN should have access to opportunities for professional development through formal continuing education and informally with colleagues. As support was perceived as the least empowering in this study, PNs need to work towards seeking out feedback and guidance from others within and outside of the faith community.

The study results may validate perceptions of empowerment within their work setting. If the findings are used to enhance the workplace, the parish nurse may be more apt to remain in the faith community setting, express less dissatisfaction with the work environment and feel more self-confident in their role. Empowerment has been linked to enhanced workplace creatively; therefore the parish nurse may develop more unique programs to promote health of the faith community members. The outcome on the parishioner could reflect a better sense of overall health and well-being.

Nursing Research

The potential for future studies related to parish nursing are great and would provide this researcher with a long research agenda. Because the parish nursing specialty is new, little is known about the organizational structures of faith communities and the fit with lay professionals (such as parish nurses), the processes which support programs and the outcomes of parish nursing ministries. Future research on organizational structures is
essential since this is the only known quantitative descriptive study to focus on perceptions of empowerment of nurses' in their role as PNs. The PNs in this study reported a moderate level of perceived empowerment within the faith community setting. Because the study sample was most likely comprised of women, it would be beneficial to conduct research on the perceptions of empowerment of male PNs. Ethnicity might also need exploration as it could influence the perceptions of empowerment. Future research studies, using both qualitative and quantitative approaches, should examine the outcomes of empowerment on personal psychological empowerment, job satisfaction, burnout, workplace trust and respect, autonomy, control over work. In addition, research studies should address the faith community member’s satisfaction with care and perceptions of collaboration with other faith community leaders and health care providers.

Future studies would be focused on the exploration or description of the experience of empowerment or one of the subconcepts of structural empowerment within the faith community. The subconcepts could include: a description of formal and informal power systems, a discussion on the types of opportunities, access to resources, information and support, or the social structures. Additional studies would explore perceptions of empowerment of nurses in other community-based settings.

Because the focus of this study was on aspects of structural empowerment of PNs, it would be beneficial to explore the outcomes of empowerment on the faith communities and with the nurses. This would include research to explore the relationship of perceived level of structural empowerment to outcomes such as perceptions of respect, job satisfaction, collaboration and parishioner satisfaction.
Using a participative action approach, research could focus on emancipation through group discussion and action towards moving to a health promotion model of care. Research on relationships with faith community leaders and clergy could explore communication patterns, relationships, collaboration arrangements, and support. As there was little information provided in the literature review on the development, implementation and use of the position descriptions for PN, research should be focused on the usefulness of this tool. This study's findings showed that PNs reported a higher level of informal power in relation to the presence of a PN position description. Further research in this area needs to occur as job descriptions are more closely linked with formal power or access to information. Research on relationships with faith community members could explore empowerment as a shared endeavor to motivate and encourage parishioners to take personal responsibility and self-control for their health and care needs.

Nursing Administration

Parish nursing program administrators and coordinators face a daunting task of providing support for PNs who practice in a variety of faith communities - different denominations or faith traditions, a range of congregational sizes, non-traditional settings, and diverse geographical regions. In addition, the needs of the faith community may range from primarily health promotion activities for youth within the faith community to bereavement support for the elderly in their homes. This research provides parish nursing managers with foundational knowledge of perceptions of empowerment and organizational structures. The majority of respondents reported a supervisory relationship with their senior pastor, while few reported that they were unsupervised in
their role as PN. Future studies should explore the aspects and value of supervisory relationships between PNs, clergy, parish nurse coordinators, and health cabinet/wellness committees. This research provides support that PNs who receive a salary perceive higher levels of empowerment than their unpaid PN colleagues. Efforts need to be made to increase the numbers of PNs paid and the salary level provided. Future studies should explore the salary and benefit package provided to the PNs as compared to other professionals who are employed within faith communities. Research completed on the outcomes on the health and wellbeing of the faith community members needs to be completed and the findings disseminated to nursing colleagues as well as to the leaders of faith communities.

As a program administrator, I have found that parish nurses provide rich accounts of program development and implementation but limited insights into the impact of the interventions on the health and well-being of the parishioner, on the faith community, or on the surrounding geographic area. In the present economic conditions, it may be more difficult for administrators to provide support for programs (such as parish nursing) that do not demonstrate program outcomes. In addition, granting agencies tend to look more highly upon funding programs that have demonstrated positive outcome measures. The other challenge is a lack of clarity of the role of the parish nurse within the faith community. The youthfulness of the practice also brings opportunities for creativity and the development of the practice, as there are few entrenched traditions. Faith-based programs that are found to be beneficial could be adapted for use in secular settings. Foundational studies are needed to explore the practice, unique issues and strategies for
ministry development and sustenance. Research opportunities within parish nursing abound, but the difficulty may be in where to begin the exploration.

Nursing Policy Formation and Action

The intent of this study was to explore the perceptions of empowerment of nurses' in their role as PNs and to examine some of the structures of empowerment within the faith community organization. The results of this study support the need for PNs to receive financial compensation for their roles within faith communities. Salaried PNs work more hours per week and therefore are more available to meet the needs of the faith community. Providing financial compensation could increase the numbers of new RN graduates to serve in the PN role. Without the provision of a salary, faith communities may be hard pressed to recruit nurses to fill positions vacated by retiring PNs. Consideration should be given for further exploration into the relationship between perceptions of empowerment and educational preparation (both in nursing and non-nursing areas). Areas of study include an exploration into the type of basic nursing education needed for the PN role, type of nursing experience necessary to perform adequately in the PN role, and the usefulness of a PN position description. As parish nursing is an evolving specialty practice, future studies should explore the types and numbers of parish nursing related policies used and needed within faith communities.

PNs must become vocal in the political arena in response to the current changes in health care delivery and health policy. With the advent of the recent health care reform legislation, PNs may be called upon to assist faith community members in understanding changes in government programs for senior citizens, uninsured individuals with pre-
existing conditions, and coverage for health promotion services (Democratic Policy Committee, 2009). PNs can, and should also, encourage their faith community members to advocate for access to health care services and for increased attention for health promotion and spiritually healing activities. This includes securing financial support for PNs within their faith community.

Summary

Throughout the years as a parish nurse educational program director, this researcher has heard many stories of the impact (positive and negative) that current faith community organizational structures have on the development and ongoing support of parish nursing ministries. Some PNs have been unable to get a PN ministry integrated into the life of the faith community, and sadly, some PNs have left parish nursing practice due to this struggle. It is disheartening to hear the stories from PNs who feel unsupported and devalued by clergy and members of their faith community. These PNs leave the ministry due to frustration and burnout from unrealistic expectations of themselves and from others in the faith community (Bokinskie & Kloster, 2008). Unfortunately little has been documented in the literature on empowerment of PNs, or the development or presence of job-related empowering structures within faith communities. The absence of such knowledge is currently limiting the effectiveness of PNs. The outcomes of this research will aid in the development of policies and structures related to empowerment, and educational programs to enhance empowerment structures and outcomes for faith communities.
Using a quantitative, descriptive, correlational design, the researcher explored the perceptions of structural empowerment of nurses in their role as PNs. In addition, the relationships between demographic variables and perceptions of structural empowerment of the nurses in their role as PNs were examined. In this study, nurses' perceived a moderate level of empowerment in their role as PNs. Salaried PNs perceived a higher level of empowerment than unpaid PNs, and salaried PNs worked significantly greater number of hours per week than unpaid PNs. Although many PNs reported having a PN position description that accurately reflected their role in the faith community, the position description was less often reviewed and updated yearly or used for evaluation purposes. It is hopeful that the outcomes of this research will aid in the understanding of empowerment within faith communities, and the development and improvement of policies and structures related to empowerment.

This is an exciting time in the development and growth of parish nursing as a community-based practice within professional nursing. Along with this wonderful opportunity comes a challenge in creating PN ministries within faith communities that provide empowering structures.
## Appendix A
Kanter's Theoretical Framework

### Relationships of concepts in Kanter’s Structural Theory of Power in Organizations

<table>
<thead>
<tr>
<th>Systemic power factors</th>
<th>Access to job-related empowerment structures</th>
<th>Personal impact on employees</th>
<th>Work effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location in formal &amp; informal systems</td>
<td>Opportunity structures</td>
<td>Increased self-efficacy</td>
<td>Achievement and successes</td>
</tr>
<tr>
<td><strong>Formal power</strong></td>
<td>-------------------------------</td>
<td>High motivation</td>
<td>Respect and cooperation in organization</td>
</tr>
<tr>
<td>Job definition</td>
<td>Power structures</td>
<td>Increased organizational commitment</td>
<td></td>
</tr>
<tr>
<td>Discretion (flexible)</td>
<td>Resources Information Support</td>
<td>Lowered burnout level</td>
<td></td>
</tr>
<tr>
<td>Recognition (visible)</td>
<td>Proportions structures</td>
<td>Increased perceived autonomy</td>
<td></td>
</tr>
<tr>
<td>Relevance (central)</td>
<td></td>
<td>Increased perceptions of participative management</td>
<td></td>
</tr>
<tr>
<td><strong>Informal power</strong></td>
<td></td>
<td>Increased job satisfaction</td>
<td></td>
</tr>
<tr>
<td>Connections inside the organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alliance with:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sponsors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subordinates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross functional groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connections outside the organization</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appendix B
Sample Position Description

Job Description for the Ministry of Parish Nursing Practice

This position is designed to provide whole person health promotion disease prevention services with an emphasis on spiritual care. The major accountabilities and job activities of the parish nurse role are integrator of faith and health, health educator, personal health counselor, referral agent, developer of support groups, trainer of volunteers and health advocate.

I. Accountabilities

- Integrator of faith and health
  1. Assesses congregation's assets and needs incorporating an understanding of the relationship between faith and health.
  2. Participates as a staff member of the congregation, attending all meetings of the staff of the congregation.
  3. Identifies opportunities to enhance the understanding of the relationship of faith and health within the congregation.
  4. Fosters, promotes, and provides opportunities for spiritual care to be discussed and integrated into the parish nurse role documenting spiritual care of groups and individuals.
  5. Participates in the planning and providing of prayer and worship life of the congregation.
  6. Teaches and models the integration of faith and health into daily life.

- Personal Health Counselor
  1. Provides individual health counseling related to health maintenance, disease prevention or illness patterns.
  2. Encourages the client through presence and spiritual support to express their faith beliefs and utilize them regularly especially in time of crisis and despair.
  3. Documents client assessment, nursing diagnosis, interventions and outcomes while maintaining confidential client record in accordance with the policy on documentation.
  4. Make visits to clients as needed providing health counseling, education and spiritual presence/support.
  5. Promotes stewardship of the body emphasizing self care of the whole person.
  6. Collaborates with pastoral staff to plan for health education programming.
  7. Communicates with other health professionals as needed to meet the health needs of clients.
• Health Educator

1. Utilizes information from asset and needs assessments of the congregation and surrounding community in planning for education programs.
2. Prepares, develops and/or coordinates educational programs based on identified needs for healthier lifestyles, early illness detection and health resources.
3. Maintains records of educational programs, including objectives, content, evaluation, attendance and budget.
4. Documents individual educational assessment diagnosis, interventions and outcomes.
5. Provides the pastor, health committee of the congregation, and other designated parties a summary evaluation of educational programs noting attendance and response of participants.
6. Networks with appropriate resources in the community to secure educational program resources.
7. Provides consultation and acts as a health resource to other staff of the congregation.

• Trainer of Volunteers

1. Identifies and recruits professional and lay volunteers who can be available to respond to the health related needs of members of the congregation.
2. Facilitates and when appropriate, trains individuals to assume volunteer responsibilities to meet identified needs of the congregation.
3. Works with staff, health committee or others focusing on the integration of health into the life of the congregation.

• Developer of Support Groups

1. Develops and/or facilitates support groups based on identified needs and resources.
2. Identifies available support groups in the community that could resource the congregation.
3. Refers and documents client participation in designated support groups.

• Referral Agent

1. Provides and documents referrals to health care services and resources within the congregation and external community.
2. Collaborates with community leaders and agencies to facilitate effective working relationships while identifying new health resources.
3. Develops community contacts in order to secure resources and services to meet the needs of members of the congregation.
4. Networks with other parish nurses and professionals.
• Health Advocate

1. Encourages clients to avail themselves of services, which will enhance their overall wellbeing, assisting the clients in identifying values, and choices, which encourage them to be more responsible for their health status.
2. Assists client and client families in making decisions regarding their health, medical services, treatments and care facilities as well as documenting assessments, diagnosis, interventions and outcomes.
3. Identifies, communicates, and works cooperatively with community leaders, elected officials, and agencies to meet health needs of members of the congregation and surrounding community.

II. Job Activities

• Management

1. Prepares an operating budget for program development as needed.
2. Develops reports regarding parish nurse activities as needed.
3. Collaborates with others in developing and managing grant projects.
4. Coordinates all parish nurse programming in the congregation.

• Professional Development, Education and Research

1. Participates in continuing education programs to meet identified professional learning needs.
2. Participates in regular personal spiritual formation.
3. Acts as a preceptor to students from schools of nursing, seminaries and other disciplines as requested.
4. Develops and/or participates in research related to parish nursing.
5. Develops and submits articles for publication on experiences in parish nursing.

produced with permission of the copyright owner. Further reproduction prohibited without permission.
### III. Job Requirements

<table>
<thead>
<tr>
<th></th>
<th>Competent Level Qualifications</th>
<th>Minimum Level Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skills</strong></td>
<td>1. Organizing Skill&lt;br&gt;2. Basic computer skills&lt;br&gt;3. Excellent communication skills&lt;br&gt;4. Ability to develop reports</td>
<td>1. Excellent communication skills&lt;br&gt;2. Organizing skills</td>
</tr>
<tr>
<td><strong>Education and Experience</strong></td>
<td>1. BSN required&lt;br&gt;2. 5+ years experience in med-surg&lt;br&gt;3. Community health nursing experience desirable&lt;br&gt;4. Ability to do community assessments&lt;br&gt;5. Ability to do health counseling</td>
<td>1. BS preferred&lt;br&gt;2. 5 years clinical nursing experience&lt;br&gt;3. Assessment skills</td>
</tr>
<tr>
<td><strong>Professional Preparation</strong></td>
<td>1. Current license as a registered nurse in the state the congregation is located.&lt;br&gt;2. Completion of a basic preparation course in parish nursing based on the standardized core curriculum endorsed through the International Parish Nurse Resource Center.</td>
<td>1. Current license as a registered nurse in the state the congregation is located.</td>
</tr>
<tr>
<td><strong>Special Job Characteristics</strong></td>
<td>1. Spiritual leadership as evidenced by experience in congregational ministries, lay leadership, theological education and other related spiritual development.&lt;br&gt;2. Substantial weekend and evening work.</td>
<td>1. Works well independently and yet can function well as part of a work team.&lt;br&gt;2. Has a good understanding of spirituality and religiosity.</td>
</tr>
</tbody>
</table>
Appendix C
Approval Letter from Dr. Laschinger

Western

NURSING WORK EMPOWERMENT SCALE
Request Form

I request permission to copy the Nursing Work Empowerment Scale as developed by Dr. G. Chandler and Dr. Heather K. Spence Laschinger. Upon completion of the research, I will provide Dr. Laschinger with a brief summary of the results, including information related to the use of the Nursing Work Empowerment Scale used in my study.

Questionnaires Requested:
Conditions of Work Effectiveness-I (includes JAS and ORS):
Conditions of Work Effectiveness-II (includes JAS-II and ORS-II): Yes
Job Activity Scale (JAS) only:
Organizational Relationship Scale (ORS) only:
Organizational Development Opinionnaire or Manager Activity Scale:
Other Instruments:

Please complete the following information:
Date: July 14, 2009
Name: Jean C. Bokinskie
Title: Doctoral Student, Nursing
University/Organization: University of North Dakota College of Nursing
Address: 430 Oxford Street, Stop 9025 Grand Forks, North Dakota 58202-9025
Phone: 701-866-3063
E-mail: bokinski@cord.edu

Description of Study: This will be a quantitative, descriptive study on perceptions of empowerment for parish nurses (or faith community nurses) in the Upper Midwest. There are nearly 1,500 alumni of the Parish Nurse Center, Concordia College, Moorhead, MN. The survey will be focused on practicing parish nurses, therefore my sample size should be about 400. I would also like permission to revise the tool slightly to reflect administration in faith communities and also to place the tool on a web-based platform. I recently sent an e-mail to Dr. Laschinger outlining my request more completely.

Permission is hereby granted to copy and use the Nursing Work Empowerment Scale.

190
Date: June 30, 2009
Signature:

Dr. Heather K. Spence Laschinger, Professor
School of Nursing, University of Western Ontario
London, Ontario, Canada N6A 5C1
Tel: 519-661-4065 Fax: 519-661-3410
E-mail: hkl@uwo.ca
Appendix D
Sample Postcard & Electronic Mail

Dear Parish Nurse Alumni: November 20, 2009

This postcard is a reminder to encourage you to consider completing the research study. The purpose of the study is to explore perceptions of empowerment of practicing PNs. The web-based survey is available at http://www.cord.edu/Offices/parishnurse1.php, then follow the link to the survey. If you would prefer a paper version (mailed) of this survey, please call the Parish Nurse Center at 218-299-3893. Please complete the survey by December 30th.

Blessings,
Jean Bokinskie
Doctoral Student, Principal Investigator
Contact: 701-866-3063 (cell); 218-299-3825 (office); electronic mail bokinski@cord.edu

Dear Parish Nurse Alumni: September 30, 2009[date variable]

This e-mail is a reminder to encourage you to consider completing the research study. The purpose of the study is to explore perceptions of empowerment of practicing PNs. The web-based survey is available at http://www.cord.edu/Offices/parishnurse1.php, then follow the link to the survey. If you would prefer a paper version (mailed) of this survey, please call the Parish Nurse Center at 218-299-3893. Please complete the survey by November 30th [date variable]

Blessings,
Jean Bokinskie
Doctoral Student, Principal Investigator
References


199


