Improving nursing workforce diversity

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Abstract

Background: Nurse Leaders are required to have knowledge concerning professional values and an awareness of their perceptions and attitudes about diversity which include unconscious bias. Nurse leaders' alignment to professional values and their perceptions and attitudes of diversity affect decision making, which includes hiring decisions. Therefore, the present survey aimed to describe nurse leaders' existing beliefs of diversity and nursing professional responsibilities and explore the relationship among these and the intent to hire for diversity. This work is foundational to understand how factors of diversity and nursing professional role predict intention to hire and thus could improve nursing workforce diversity.

Methods: A cross-sectional survey of leaders (n=42) who hire nurses in a large metropolitan academic medical center was conducted. The Theory of Planned Behavior was used to describe and explore nurse leaders' existing beliefs of diversity and nursing professional responsibilities and explore the relationship among these and the intent to hire diverse candidates. The data were collected using a four-part survey which included demographics, the Workplace Diversity Survey (WDS) by De Meuse and Hostager, and the Nursing Professional Values Scale -3 (NPVS-3) by Weis and Schank. Additionally, two yes/no questions were included about leaders' intent to consider and hire diverse candidates. Descriptive statistics were used to describe and characterize the sample. Using the Statistical Package for Social Sciences (SPSS) software, the data were analyzed for relationships (correlation) among diversity and nursing professional roles that influence nurse leaders' intention to hire for diversity. Analysis of variance (ANOVA) was used to characterize how themes vary by nurse leader demographics, characteristics, and exposure to diversity training.

Results: Results indicated that the total score of the nurse leaders' professional values (121 ±

12.81) and nurse leaders' perceptions and attitudes about diversity were high (26.85 ± 6.22). All

leaders indicated they intend to consider and intend to hire diverse candidates; because there was

no variation in responses, it was not possible to use professional values and attitudes about

diversity to predict intentions. Years of experience and WDS summary scores are positively

related (r=.45, p<.004). Years in nursing leadership and total WDS summary scores revealed a

statistically significant difference between leaders. Leaders with 16+years of experience

(M=31.4, SD4.70) scored significantly higher than leaders with 0-5years of experience (M=23.9,

SD6.14) on the WDS survey (p=.03).

Conclusion: Leaders were diversity optimists and have strongly aligned professional

values. Leaders demonstrated positive relationships between behavior, normative, and control

beliefs, suggesting they would consider or hire diverse applicants. Additional study is needed to

determine if diversity optimists actually hire for diversity when qualified candidates are

available.

Keywords: diversity, unconscious bias, inclusion, hiring, nursing, professional role, the

theory of planned behavior.

Improving nursing workforce diversity

Description of the Organizational Problem

Structural racism is a term used to exclude minority groups from participation in economic, political, and social institutions. It is a macrosystem of systematically related barriers that creates a structural disadvantage for minority groups (DiAngelo, 2019). Intertwined in this complex problem are health care organizations. Healthcare organizations are key institutions that impact the economic, political, and social outcomes of people within their community. Identifying structural disadvantages in a healthcare system can offer opportunities for improvement and contribute to the demise of structural racism. Recruitment and retention is a pivotal point of decision-making in the healthcare system that directly impacts social and economic advantages for the workforce and increases patient's access to high-quality care.

Oregon's population has become more racially and ethnically diverse over the last decade and the health care workforce is not representative of the population that is served. Oregon's total population is approximately 4.2 million (*United States Census: Oregon*, 2019). The population demographics include "White alone (84%), Black or African American alone (2%), American Indian and Alaska Native alone (1%), Native Hawaiian and other Pacific Islander alone (0.3%), some other race alone (4%), and two or more races (5%) "(*United States Census: Oregon*, 2019, Race and Ethnicity section). The Oregon Health Authority (OHA) reports that racial and ethnic populations in Oregon continue to increase as Oregon's licensed health care workforce in 2020 continues to be "less racially and ethnically diverse than the population being served" (Paige, 2020, p. 5).

OHA performed an analysis of Oregon's nursing workforce by race, ethnicity, and gender compared with the population served for functional nursing roles with direct patient contact,

which included Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Licensed Practical Nurses (LPN), and Certified Nursing Assistants (CNA). The analysis did not include nurses who are in a leadership role. The analysis found that the majority of the nursing workforce in Oregon based on Race, Ethnicity, and Gender distribution was either above or below the comparison to state distribution for the population served.

Black and Indigenous and People of Color (BIPOC) tend to be underrepresented in almost all professions. The analysis data indicated that the majority of nursing functional roles had a largely white population (84-94%) above the state comparison for the population served (Paige, 2020). Whereas, the majority of BIPOC (0-3%) in almost all of nursing functional roles were below the state in comparison for the population served, with the exception of the LPN and CNA roles in which BIPOC (4-7%) were above the state in comparison for the population served (Paige, 2020). Additionally, women tend to be overrepresented compared to men in fields such as nursing (Paige, 2020). In all nursing functional roles, females (53-96%) were above the state in comparison to the population served, in comparison to males (4-15%) being below the state comparison for the population served (Paige, 2020).

Oregon Health and Science University (OHSU) is a large metropolitan academic medical center with approximately 576 beds (OHSU Facts, 2019). There are approximately 300,000 patient admissions per year and approximately a 1.1 million visits (OHSU Facts, 2019). The majority of patients that receive care at OHSU are from Oregon (90%) (OHSU Facts, 2020). The total number of employees at the organization totals 15,959, and 2673 ONA represented clinical nurses are part of this workforce. The nursing staff demographics describe the clinical nursing staff as primarily white (83%) and female (71%) (Oregon Health & Science

University [OHSU], 2021). The nursing workforce demographics are reflective of the OHA findings in which the workforce is "less racially and ethnically diverse than the population being served" (Paige, 2020, p. 5). Thus, this indicates the need to improve nursing workforce diversity for the benefit of both patients and staff.

OHSU has a long-standing history of efforts aimed to address diversity in the organization, starting with a formal Diversity Action Plan. Diversity efforts in the organization started with the recognition of the need to support and enhance an inclusive and culturally competent campus environment to allow the university and community to thrive and lead diversity efforts. The early adopted definition of diversity is "creating a community of inclusion... Diversity includes age, culture, disability, ethnicity, gender, national origin, color, race, religion, sexual orientation, and diversity of thought, ideas, and more. Diversity maximizes our true potential for creativity, innovation, quality patient care, educational excellence, and outstanding service" (Robertson, 2013, p. 9)

Five years later, in 2013, the Diversity Action Plan reaffirmed the institution's mission and commitment to support and sustain a diverse and inclusive learning, living, and working environment. In efforts to advance this work, the Diversity Advisory Council (DAC) was established to create a business case to attract and retain diverse talent across the organization and to advise the President and Executive Leadership Team on ways to enhance diversity, multi-culturalism, and equal opportunity. The business case was documented and supported in the 2013 revision of the policy titled "Equal Opportunity" by the Affirmative Action and Equal Opportunity (AAEO) department. Affirmative Action and Equal Opportunity is the "good faith obligation that all federal contractors have to abide by an equal opportunity policy and regulations" (OHSU, 2020). The Official Equal Employment Opportunity Statement indicates

that "the organization values a diverse and culturally competent workforce…individuals with diverse backgrounds and those that promote diversity and a culture of inclusion are encouraged to apply." There is a long-standing history of legislation that supports anti-discrimination and affirmative action. Diversity policies are one organizational strategy that demonstrates a commitment to diversity however, do little for facilitating an inclusive environment (Jin et al., 2017). Two key components of OHSU's business case include efforts to train the workforce on unconscious bias and offer specialized unconscious bias training for select volunteers. This group of volunteers is called the "Inclusion ambassadors;" the intent of the inclusion ambassador role is to achieve sustainable behavior change, through ongoing unit-level support of the workforce.

In 2018, the effort was put forth to build an inclusive community through the launch of a campus-wide initiative for unconscious bias training as part of the Diversity Action Plan. Unconscious bias, also called implicit bias, has a significant contribution to inequities in hiring, promotion, and compensation for racial, ethnic, gender, and underrepresented groups (OHSU, 2020; Rivera, 2013). Campus-Wide research including two diversity climate surveys over the past several years as well as an organizational-wide employee engagement survey indicated that more work needed to be done on diversity and inclusion. This inspired the launch of unconscious bias training to be required of all employees in the organization. The goal of Unconscious Bias Training (UBT) is to have 17,000 people trained over a three-to-five-year plan. In 2020, the UBT had reached 11,700 members of the organization including a portion of the student body. To date, the measurement of success is limited to the number of employees or students who have attended the training.

In 2021, OHSU is began taking steps to become an anti-racist institution. The decision to implement additional Unconscious Bias Training was identified as a key commitment. Leaders who make hiring decisions often have "analytical training and background that unconsciously shape the definitions of merit" of the candidate, thus an influencing factor in hiring decisions (Rivera, 2013, para. 5). The organization deemed the Unconscious Bias Training for hiring managers as mandatory and optional for staff members that are participating in hiring practices. The outcome of mandatory training may be variable. Often, the mandatory designation of education can negatively impact achieving the intended outcome of behavior changes commonly sought after (Cooper & Allison, 1973; Dobbin et al., 2007; Hutton, 1987).

The objectives of the unconscious bias training for hiring managers are the following: 1) understand the impact of implicit bias on the search and hiring process, 2) learn various tools and/or interventions that can help mitigate bias in the search and hire process, and 3) access resources that will help lessen the impact of bias on future recruitment efforts (OHSU, 2020). While the training primarily focuses on cognitive processes such as "understanding," the training alone does little to bridge the theory to practice gap necessary for sustained behavior change. A critical measurement of the value of the training is employee behavior changes and corresponding organizational outcomes (De Meuse et al., 2007). Without measuring behavior changes, it is difficult to determine the impact of training on sustained behavior change and to identify best practices to advance diversity efforts in the organization.

Recruitment and retention of a diverse nursing workforce are essential to achieve organizational outcomes such as improved care of patients, narrowing health disparities, increasing employee engagement across a diverse group of the healthcare workforce, reducing turnover rates, and increasing problem-solving abilities for organizational change & system

flexibility (Bell & Berry, 2007). Unconscious bias training is required for nurse leaders at the organization, and there is an opportunity to describe how the initial training has influenced nurse leaders' intention to act on diversity principles, one of which is unconscious bias.

Nurse leaders are responsible to enact their professional responsibilities which include practicing moral courage. Practicing moral courage requires behaviors described in the American Nurses Association (ANA) Code of Ethics. Most nurse leaders strive to embrace diversity and work toward inclusivity but may be unaware of the impact of unconscious bias in their decision-making. Because nurse leaders have significant decision-making power and influence in whom they choose to hire, it is imperative for nurse leaders to reflect on factors that influence decision-making such as bias, norms, professional accountability, values, and attitudes.

In 2015, the American Nurses Association revised the Code of Ethics Provision 1 statement to say "the nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person" (Persaud, 2019, p. 135). Provision 1 is an explicit statement that "nurse leaders must examine their beliefs or attitudes, setting aside their bias and align their behaviors with professional ethics in support of patients, colleagues, and other team members" (Persaud, 2019, p. 130). However well-intentioned nurse leaders may be, there are leaders who do not realize how often bias influences their decision-making. Since professional role competence can impact hiring decisions, promotion, strategic planning, and overall organizational culture there is a necessity for nurse leaders to self-reflect on how they are holding themselves accountable to the profession (Persaud, 2019, p. 130). Although previous efforts in the organization have focused on raising nurse leaders' awareness of their unconscious

bias by implementing unconscious bias training, there is a gap in describing what contributes to nursing leaders' intention to act using diversity principles (Song et al., , 2017).

In 2009, the organization adopted the O'Rourke Professional Practice Model as a framework for understanding professional practice responsibilities. Professional role-based behaviors include: professional role responsibility, authority, autonomy, competency, accountability, ethics, and accepted standards of professional practice (O' Rourke, n.d, p. 10). Although the model was adopted in 2009, variation exists in nurse leaders' understanding and ability to translate the theory of professional standards into performance behaviors. This impacts their knowledge of, self-accountability for and skill in performing behaviors that are aligned with the professional standards and Code of Ethics. The barrier of translating theory to practice extends to integrating the theory of diversity principles such as unconscious bias into performance behaviors.

Available Knowledge

The research reviewed focuses on key topics that inform describing nurse leaders' intention to act using diversity principles for improving nursing workforce diversity. Diversity principles include intersectionality, awareness of unconscious bias, promotion of inclusion (culture and climate), access and equity of a system, and engagement (Ogrin et al., 2020). Although diversity principles are found in streams of literature, there is a gap in the evidence describing the intersectionality of diversity principles with nursing professional responsibilities on nurse leaders' behaviors. Since behavior is dependent on both motivation (intention) and a person's ability to perform, the diversity principles and professional responsibility concepts are key factors that influence nurse leaders' formation of attitudes, values, social norms, and the ease or difficulty of performing a behavior.

Diversity Principles

The overarching diversity principles are described in the literature as intersectionality, awareness of unconscious bias, promotion of inclusion (culture and climate), access and equity of a system, and engagement (Ogrin et al., 2020). The concept of diversity encompasses the range of human characteristics and experiences that comprise an individual's values, attitudes, knowledge, reactions, and perspectives (Bell & Berry, 2007; Roberson, 2006). Diversity concepts are described in three main streams of research as surface-level diversity, deep-level diversity, and the intersectionality of both (Bourke & Dillon, 2018; Page, 2007). Surface-level diversity such as biographical demographics includes race, gender, ethnicity, sexual orientation, age, generation, educational background, social class, work status, professional experiences, and beliefs (Bourke & Dillon, 2018; Page, 2007). Deep-level diversity on the other hand, includes values, attitudes, knowledge, reactions, and perspectives. Deep-level diversity represents a difference that can be learned only through extended interactions with others (Vanderheyden & De Baets, 2015). The third stream of research in health and social sciences, business, and organizational behavior describe the intersection of surface and deep-level diversity as "The richness that each person possesses makes us who we are and shapes our unique perspectives; collectively it results in diverse thoughts"(Sadau & Capeles, 2019, p. 266). Nurse leaders' awareness of the intersection of their own surface and deep-level diversity provides an opportunity for insight into how this intersection is a factor in their values, attitudes, knowledge, reactions, and perspectives. Any insight gained by this awareness can be leveraged to further explore the intent in making decisions in hiring.

Collectively, the three streams of the literature support that diversity is a benefit to organizations at the macro, meso, and microsystem level (Bezrukova et al., 2014; Mor Barak,

2000; Ogrin et al., 2020). Diversity among the nursing workforce fosters better interaction and communication with patients of various backgrounds and is a way to narrow health disparities. Having a diverse nursing workforce also creates teams that have a diverse climate available to learn from each other to continually improve the practice of nursing by making better decisions, experiencing increased motivation, enhanced creativity, retention, and engagement (Diaz, Clarke & Gatua, 2015; Rivera, 2013; RWJF, 2011). In order to harness the benefits of diversity, nurse leaders' hiring decisions are pivotal to improving nursing workforce diversity.

Although the vast majority of research on intersectionality focuses on the surface-level diversity of already existing teams and understanding existing team functions, there is a gap in the literature describing how the intersectionality of surface and deep-level diversity traits influence leader behaviors of decision-making in the hiring process. This project contributes to the literature by describing nurse leaders' existing intention to act on diversity principles and exploring how themes vary by nurse leader demographics, characteristics, and exposure to diversity training.

Unconscious Bias

Searching for the term "unconscious bias" results in a plethora of literature that offers many characteristics that describe unconscious bias. In general, unconscious bias can be described as deeply ingrained and influential on behavior and attitudes unknowingly; it can be quantified, implicit, explicit, and everyone has a bias (Noon, 2017; Maina et al., 2018; Sadau & Capeles, 2019). For the purpose of this literature review, the focus is limited to unconscious bias (implicit bias) rather than explicit bias.

Unconscious bias is an evolutionary process from the human instinct for survival; it is the brain's quick sorting mechanism to protect us from danger. There are several theories that

describe this process of unconscious sorting (i.e. thinking fast and slow, the Theory of Implicit Bias) (Kahneman, 2011; Hong et al., 2004). This quick, unconscious sorting informs first impressions and associations that unknowingly influence memory, perception, attitudes, stereotypes, self-esteem, and self-concept, which then influences motivation for behavior (Greenwald & Krieger, 2006; Kahneman, 2011). Over a lifetime of experiences, one creates a mindmap of assumptions about race, gender, ethnicity, disability, and sexual orientation. This map of assumptions informs an unconscious categorization process that places people in groups based on those assumptions. Categorization is focused on sorting by whichever surface-level diversity characteristic is salient (Hong et al., 2004). Because unconscious bias unknowingly influences motivation or the intent to act, nurse leaders' self-awareness of personal bias may be crucial to examine before making decisions.

One of the most impactful decisions made by leaders includes hiring decisions. Unconscious bias is the largest influencer of hiring decisions (Lee et al., 2014). Several theories identified in the literature describe how unconscious bias influences hiring decisions. The halo effect is "judgment bias that occurs when the interviewer develops a positive global impression of the interviewee that may overpower any subsequent, dis-confirming interview data" (Heslin & Faux, 1991, p. 26). Whereas "like-mindedness" hiring creates a homogenous group of new hires with similar or shared interests, everyone thinks alike, looks alike, has similar thought patterns, or approaches problem-solving similarities, thus unconsciously weeding out diversity in the workforce (Rivera, 2013). Additionally, the "looking-glass" merit posits that leaders tend to hire candidates that make them feel good about themselves (The Advisory Board, 2019, pg 3). Lack of awareness of the unconscious bias by the leader can result in missed opportunities of hiring candidates that may be high performers who are simply different from the average interviewer or

candidates that offer a diverse set of values, attitudes, knowledge, reactions, and perspectives (Rivera, 2012). Although evidence suggests that awareness of one's unconscious bias has positive short-term effects, awareness is not a panacea for sustaining behavior changes.

Measuring antecedents (motivation) or intent to change behavior related to unconscious bias awareness can be difficult. Self-reporting can be argued as an unreliable source of truth because unconscious bias is below the surface (Greenwald & Krieger, 2006). Implicit Association Tests were created over a decade ago as a tool that could examine the automatic thought process of people in different contexts (Greenwald et al., 2015). While there are a number of studies that identify the Implicit Association Test as a way to measure implicit bias, many organizations focus on unconscious bias training. In a meta-analysis of diversity training education over 40 years, recommendations to be implemented in future studies were the need to use "assessment instruments based on implicit measures of attitudes and behaviors to discover unconscious bias (e.g., the IAT)" (Bezrukova et al., 2014, p. 49). Today, many organizations continue to invest exclusively in stand-alone unconscious bias training that focuses on "compliance, harmony, inclusion, justice, and transformation" (Bezrukova et al., 2014, p. 208). Stand-alone UBT does not result in sustained behavior changes often sought after, rather ongoing support that leverages the learning forward must be considered to achieve sustained behavior change.

Unconscious bias training (UBT) is a strategy that intends to raise awareness of individual bias and the impact of bias on relating to and interacting with others. UBT is often a first-line intervention to raise awareness of unconscious bias and the impact it has on behavior. OHSU has invested financial support, human resources, and commitment to UBT as part of the Diversity Action Plan; however, the evidence is mixed on the value of UBT. UBT programs

have never been evaluated with rigor, and many are theoretically ungrounded, leaving questions about the efficacy of the training on sustained behavior change (Equality and Human Rights Commission et al., 2018; Paluck & Green, 2009). Additionally, there is limited evidence identifying factors of before-and-after measures to assess for changes in behavior to evaluate the effectiveness of training (Equality and Human Rights Commission et al., 2018).

Research has shown that pairing UBT with several additional strategies can offer limited success. Recommendations for additional strategies include 1) a debrief to increase awareness and measure changes in implicit bias, 2) deliver training to groups of people who work closely together, 3) educate about unconscious bias theory rather than impact, and 4) include bias education strategies to improve the success of training (Emerson, 2017; Equality and Human Rights Commission et al., 2018, p. 7). Although these paired strategies offer some success for UBT, there is a long way to go to demonstrate sustained behaviors. Many studies use self-report measures for behavior, however, self-report data indicates the participant's intention of behavior rather than actual behavior (Equality and Human Rights Commission et al., 2018). To determine if the intention of behavior will lead to actual behavior change, other preceding factors must be considered. With limited evidence identifying factors of before-and-after measures to assess for behavior in order to evaluate the effectiveness of UBT, it is imperative for leaders to examine their current diversity beliefs prior to and after attending UBT.

Inclusion

The values underpinning inclusion are found in The Declaration of Human Rights, which states "we are all equally entitled to human rights without discrimination. These rights are universal, interrelated, interdependent, and indivisible 'whether they are civil and political rights, such as the right to life, equality before the law and freedom of expression; economic, social, and

cultural rights, such as the right to work, social security and education, or collective rights, such as the rights to development and self-determination" (Paola Bortini et al., 2016, p. 19). As highlighted in the Declaration of Human Rights document, inclusivity is the intersection and interconnectedness of components within complex adaptive systems. The interconnectedness of the organizational climate and culture contributes to understanding the perception of inclusion in an organization.

Organizational climate is the "shared perception of the work environment, including procedures, policies, and practices that guide the expected, supported, and rewarded behaviors" (Boekhorst, 2014, p. 242). Organizational culture is described as the shared values, assumptions, and beliefs held by the employees. The integration-and-learning paradigm posits that organizations that value and embrace diversity by linking it to their work processes, tasks, and strategies, result in significant improvement in group functioning, thus leveraging the diversity of the workforce through inclusion (Boekhorst, 2015).

Professional Role

Nursing professional role responsibilities include practicing to professional standards as well as practicing moral courage, behaviors that are aligned with the Code of Ethics. Most nurse leaders strive to embrace diversity and work toward inclusivity but may be unaware of the impact of unconscious bias in their decision-making. The AACN (American Association of Colleges of Nursing [AACN], 2008) identified that "professional values and their associated behaviors are foundational to the practice of nursing" (Weis & Schank, 2009, p. 401). Because nurse leaders have significant decision-making power and influence in whom they choose to hire, it is imperative for nurse leaders to reflect on factors that may influence decision-making, such as bias, norms, professional accountability, values, and attitudes.

Gaps

There are many gaps in the research on improving nursing workforce diversity. First, the relationships among factors of diversity and nursing professional role and intent to hire for diversity are not well studied. Secondly, there is no evidence exploring how factors of diversity and professional role predict intent to hire for diversity. Third, Unconscious Bias Training (UBT) is a first-line intervention to increase awareness of bias; however, there is limited evidence identifying factors of before-and-after measures to assess for changes in behavior to evaluate the effectiveness of training (Equality and Human Rights Commission et al., 2018). Thus, exposure to diversity training may or may not produce sustained behaviors in attendees. Finally, validated tools for measuring the impact of the intersectionality of diversity and nursing professional role responsibilities on nurse leaders' intent to hire a diverse nursing workforce are not available in the literature. This project has the potential to address the gap in the literature by describing and characterizing nurse leaders current beliefs about diversity and professional role responsibilities, exploring the relationships among factors of diversity and nursing professional role and intent to hire for diversity, exploring how themes vary by nurse leader demographics, characteristics, and exposure to diversity training, and exploring how factors of diversity and professional role responsibilities predict intent to hire for diversity. Meeting the aims will provide a quantitative measurement of the current state of nurse leaders' intent to hire a diverse nursing workforce in the organization.
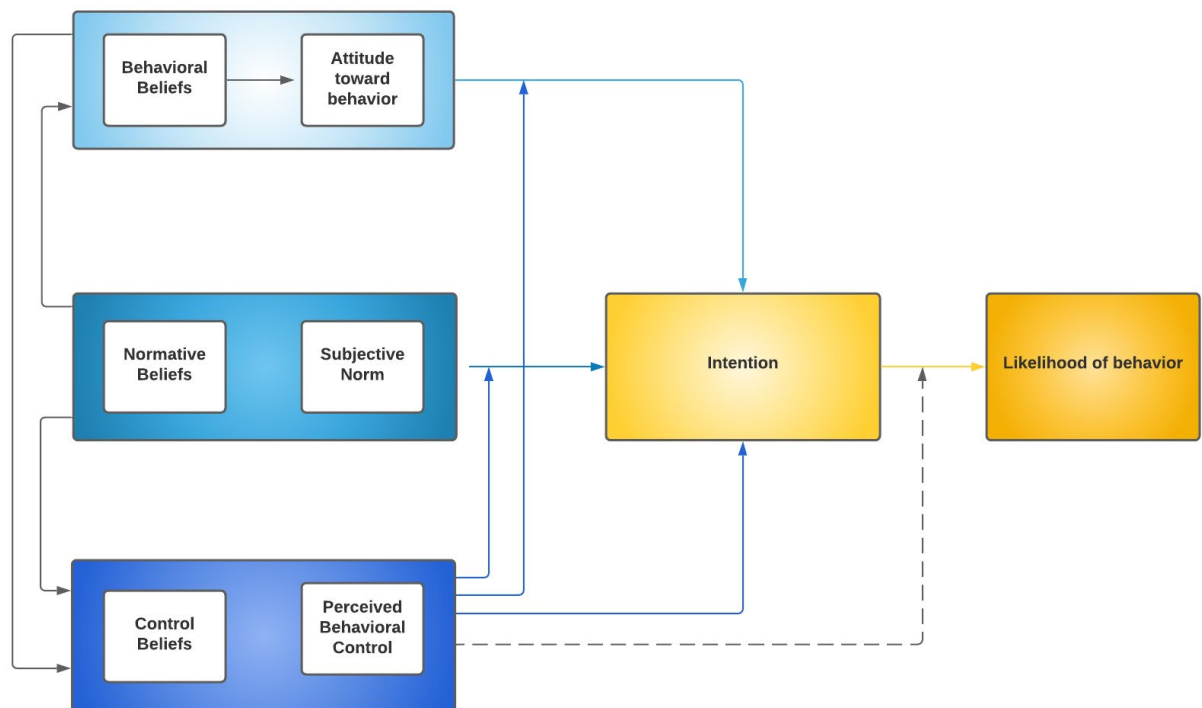
Rationale

Theory of planned behavior

The Theory of Planned Behavior (TPB) attempts to predict human behavior. The TPB posits that all human behavior is guided by three constructs; 1) attitude 2) group norms or social pressure 3) ease or difficulty of performing (Asare, 2015).

Figure 1

Theory of Planned Behavior

Note. Representative model of TPB by Icek Ajzen

The first construct is Behavioral beliefs which inform the person's attitude are "beliefs about the likely consequences and experiences associated with the behavior" (Ajzen, 2019, para. 1). Attitude entails a consideration of the outcomes of performing the behavior (Ajzen, 2019).

The second construct is normative beliefs, which result in perceived social pressure from the in-group; people adopt the "norms and behaviors" of the group, which is also known as

subjective norms (Ajzen, 2019; Korte, 2007). Subjective norm beliefs are influenced by whether peers and people of importance to the person think they should engage in the behavior.

The third construct of TPB is control beliefs. These are beliefs about the presence of factors that facilitate or impede the performance of the behavior; they are described as "perceived behavioral control or self-efficacy; a person's perception of the ease or difficulty of performing the behavior of interest"(Ajzen, 2019, para. 1). Perceived power is the presence of factors that may facilitate or impede the performance of a behavior. Perceived power contributes to a person's perceived behavioral control over each of those factors; this varies across situations and actions, which results in a person having varying perceptions of behavioral control depending on the situation (Asare, 2015). Perceived behavioral control can "serve as a proxy for actual control and contribute to the prediction of the behavior in question" (Ajzen, 2019, para. 1).

A key component of this model is a person's intention. The stronger the intention is to engage in a given behavior, the more likely the person is to perform the behavior. Achievement of behavior is dependent on both motivation (intention) and ability (behavioral control) (Asare, 2015; Ajzen, 2019). Both behavioral and normative beliefs influence the intention, the antecedent of behavior. The perception of the ease or difficulty of performing the behavior (perceived behavioral control) is a moderator on the person's attitude and the subjective norms; generally, the more favorable the attitude and subjective norm, the greater the perceived control, the stronger the person's intention to perform the behavior in question (Ajzen, 2019, para. 1).

Determining the influences of behavioral beliefs and normative beliefs allows for the prediction of behavior to happen. The likelihood of behavior occurring is impacted by how many favorable constructs are present. If two out of three constructs are unfavorable, then the

likelihood of behavior happening is significantly decreased. For example, if the person's attitude toward the behavior and the influence of their social group are unfavorable, but the ease of the behavior is high, then the likelihood that the behavior will occur is low.

Although TPB is useful to make predictions about behavior and can be used to gather data about barriers, this model fails to address the gap between intention and behavior. Additionally, this model does not include other behavioral factors such as emotions and how emotions can impact our beliefs in taking action.

Specific Aims

The purpose of this project is to improve nursing workforce diversity by using a Theory of Planned Behavior to describe nurse leaders' intention to act using diversity principles.

Specific Aims

I.   Describe nurse leaders' current beliefs of diversity and professional role responsibilities and intent to hire.

II.   Explore relationships among factors of diversity and nursing professional role and intent to hire for diversity.

III.   Explore how themes vary by nurse leader demographics, characteristics, and exposure to diversity training.

IV.   Explore how factors of diversity and professional role predict intent to hire for diversity.

Methods

Setting

The setting for this improvement project is a metropolitan academic medical center. The health care setting is a 576-bed hospital in Oregon (OHSU Facts, 2019). Approximately 411 beds are for adults and 145 beds are for the pediatric population. The organization serves about

300,000 patients per year for approximately 1.1 million visits (OHSU, 2019). This organization is Magnet-designated, "reflecting a professional practice environment in which patients, nurses, and hospital systems thrive" (Oregon Health and Sciences University [OHSU], n.d., para. 1). There are 11 division clusters that have leaders that hire nurses (1) perioperative & procedural, (2) critical care adult, (3) critical care pediatrics, (4) acute care medical/surgical adult, (5) acute care medical/surgical pediatrics, (6) ambulatory, (7) poison control, (8) nursing informatics, (9) patient relations, (10) women and children's, (11) nursing administration.

Approximately 90% of the population served at the organization is from local and surrounding communities. Oregon's total population is approximately 4.2 million (*United States Census Bureau: Oregon*, 2019). The population demographics include "White alone (84%), Black or African American alone (2%), American Indian and Alaska Native alone (1%), Native Hawaiian and other Pacific Islander alone (0.3%), some other race alone (4%), and two or more races (5%) (*United States Census Bureau: Oregon*, 2019).

A description of the clinical nursing workforce by race, ethnicity, and gender can be seen in Table 1. Student pipelines are an essential contributor to the nursing workforce in the health care organization. In 2020 there were one thousand sixty-eight nurses that enrolled in either an undergraduate or graduate degree program. The student demographics are described by Race and Ethnicity in Table 2 (see Table 2).

Table 1

Clinical Nursing Workforce Representation group, Race/Ethnicity, and Gender 2020

Race/Ethnicity	Gender	Total	Percentage of workforce
American Indian/Alaska Native	Men	*	*
	Women	10	<1%
Asian	Men	27	1%
	Women	165	6%
Black/African American	Men	9	<1%
	Women	24	1%
Native Hawaiian	Men	*	*
	Women	23	<1%
Hispanic/Latino	Men	16	1%
	Women	114	4%
Two or More	Men	*	*
	Women	12	<1%
Total Minority	Men	56	2%
	Women	348	13%
White	Men	325	12%
	Women	1888	71%
Total	Men	437	16%
	Women	2236	84%
Total Workforce		2673	

Note. Source: Organization Human Resources

Table 2

Nursing Student Headcount Enrollment by Race/Ethnicity and level of study

	BS	Master's	DNP
American Indian/Alaska Native	6	3	2
	0.8%	0.6%	1.1%
Black/African American	20	14	4
	2.5%	2.6%	2.2%
Native Hawaiian/Pacific Islander	7	1	0
	0.9%	0.2%	0%
Hispanic/Latino	141	45	20
	17.7%	8.4%	10.8%
Two or more races	56	30	9
	7.0%	5.6%	4.8%
Total Minority	274	153	48
	34.3%	28.7%	25.8%
White	524	380	138

	65.7%	71.3%	74.2%
Total	798	533	186

Note. Organization Institutional Enrollment report 2020

The clinical enterprise strategies focus on attracting and retaining a diverse talent pool through an engaged and supportive culture. Metrics associated with these strategies are engagement and retention of faculty and staff in the top quartile to national benchmarks and recruitment of a diverse talent pool, provision of equitable advancement opportunities, and improve retention across all positions. The nursing strategies that dovetail with these metrics are 1) expand leadership development and 2) hire the right staff (OHSU, 2019).

Center for Diversity & Inclusion

The Center for Diversity and Inclusion (CDI) at the organization supports university-wide initiatives to create an environment of respect and inclusion for all people (OHSU, 2020). Among other services, the CDI offers recommendations on recruitment and retention as an inclusive approach for OHSU faculty and staff. Hiring staff with cultural knowledge, skills, and values is critical to ensuring cultural responsiveness (OHSU, 2020). The CDI offers an unconscious bias class for hiring managers as well as a recruitment manual. The manual is designed to support efforts that are inclusive and keeps the organization moving toward the goal of diverse people and ideas (OHSU, 2020).

The hiring manager's unconscious bias course is 90min and has the following course objectives; 1) understand the impact of implicit bias on the search and hiring process, 2) learn various tools and/or interventions that can help mitigate bias in the search and hire process, 3) access resources that will help lessen the impact of bias on future recruitment efforts (OHSU, 2020).

Intervention

This study is a cross-sectional survey of leaders who hire nurses. In this project, the investigator will used the Theory of Planned Behavior to describe nurse leaders' intention to act using diversity principles.

Subjects and Population

Inclusion

Nurse leaders and non-nurse leaders who make hiring decisions in the organization were invited to participate.

Exclusion

The Assistant Nurse Managers (ANM), Professional Practice Leaders (PPL), Specialty Practice Leaders (SPL), and clinical staff participating in interviewing were excluded.

Sample Size and Rationale

There are 96 leaders who hire nurses at OHSU and 42 leaders participated.

Vulnerable Populations

There are no children, neonates, decisionally-impaired adults, or prisoners who participated in the questionnaires. There may be respondents that incidentally are pregnant, which is unrelated to this project.

Recruitment plan

The recruitment plan included a prompt at nurse leader meetings and sending an email including the information sheet. There were two follow-up emails sent as reminders, one each week for a total of two weeks.

Protection of Human Subjects

There was minimal risk of breach of confidentiality in data recognition from collecting questionnaire responses. An application was submitted to and approved by the Institutional

Review Board (IRB for minimal risk protocol). A summary of the findings may be shared with nurse leaders, staff, newsletters, and publications.

Study of the Intervention

Data were collected using REDCap. The data from the questionnaires was collected and stored in OCTRI's installation of REDCap, a highly secure and robust web-based research data collection and management system. Features of REDCap that protect participants' privacy and data security include

I. Physical Security: OCTRI's REDCap software is housed on servers located in ITG's Advanced Computing Center providing locked physical security

II. Electronic Security: The REDCap servers are housed behind both the firewall and a second ACC firewall. All web-based data transmissions are encrypted with industry-standard SSL methods.

III. Controlled User Access: REDCap employs a robust multi-level security system that enables researchers to easily implement "minimum necessary" data access for their research staff, including specification of data fields that are identifiers. This feature includes the "single-click" ability to provide completely de-identified (removing all identified data fields and shifting dates) for analysis or other purposes. User activities are logged to enable auditing of all data access. Access is integrated with the organization's network such that users who are also employees are authenticated against their network credentials.

IV. Data Integrity: REDCap is jointly managed in accordance with Information Security Directives by ACC staff and members of OCTRI's Biomedical Informatics Program,

ensuring the fidelity of database configuration and back-ups. User activities are logged to enable auditing of all data changes.

V.   Data collected in REDCap were exported and stored in Microsoft Excel or Statistical Package for the Social Sciences (SPSS) software for analysis. The data analysis information will be kept for 12 months.

Measures

Data were collected using a four-part survey. The first section of the survey asked about participant's demographic characteristics, including what cluster worked in, length of time in a leadership role, length of time in a nursing leadership role, attendance of a UBT in the organization or outside of the organization, and when. The second part of the survey was Weis and Schank's Nursing Professional Values Scale-3 (NPVS-3). The third part of the survey was DeMeuse and Hostager's Workplace Diversity Survey (WDS). The final part of the survey was two questions in a yes/no format that asked about the intention to consider hiring diverse candidates and the intention to hire diverse candidates.

Nursing Professional Values Scale-3

The NPVS-3 is the only known instrument to measure nursing professional values that reflect the provisions and interpreting commentary in the Code of Ethics. The NPVS-3 is a 28 item scale in three dimensions of Caring (10 items), Activism (10 items), and Professionalism (8 items). Each of the three dimensions is related to the provisions in the Code of Ethics. Caring is a concept central to nursing practice and inherent to provisions 1-3 in the Code of Ethics. Provisions 1-3 describe the commitment to patient, family, population, personal and patient health, and nursing practice without bias. Activism is related to provisions 7-9 in the Code of Ethics; duties beyond individual patient encounters, reflecting the activist role in the

nursing profession, which focuses on the responsibility to the public and global community (Weis & Schank, 2017).   The final dimension is Professionalism, which focuses on provisions 4-6 in the Code of Ethics. Provisions 4-6 focus on boundaries of duty and loyalty; nurses' authority, accountability and responsibility for nursing practice, leadership in promoting health, duty for the person and professional well-being, and duty to ethical & quality care (Weis & Schank, 2017). The NPVS-3 used a 5-point Likert-scale format ranging from 1 (not important) to 5 (most important). The questions are phrased in a positive direction. The possible range of scores is 28-140, the higher the score, the greater congruency with the nurse's professional values measured in the NPVS-3. The total score is obtained by summing numeric responses to each item.

Work Place Diversity Scale

The WDS is a known instrument that measures the range of generalized biases to workplace diversity perceptions and attitudes. The WDS is a 20 item scale with five subscales of Emotional Reactions (4 items), Judgments (4 items), Behavioral Reactions (4 items), Personal Consequences (4 items), and Organizational Outcomes (4 items) (De Meuse & Hostager, 2001).

The subscales descriptions include: 1) Emotional reactions, the initial, visceral response to the concept of workplace diversity; a person's "gut feeling" about diversity in general, 2) Behavioral reactions is what a person does (or intends to do) in response to diversity; a person's verbal as well as nonverbal actions, 3) Judgments, a person's normative evaluation of diversity; a person's value judgment with regard to diversity in principle (i.e., is diversity good or bad), 4) Personal consequences, a person's views on how diversity will affect him or her personally; ones' beliefs regarding the perceived outcomes of diversity on an individual level, and, 5)

Organizational outcomes, a person's views on how diversity will affect the organization as a whole; one's beliefs regarding the perceived outcomes of diversity on a company-wide level.

The WDS used a 5-point Likert-scale format ranging from 1 (disagree) to 5 (agree). Individual summary scores can range from +40 to -40 based on the extent to which the participant agrees with the item. The summary scores can be useful in distinction when considering positive respondents versus negative respondents. A classification system of diversity optimists (upper one-third), diversity realists (middle one-third), and diversity pessimists (lower one-third) can be useful in determining diversity efforts between groups or across the organization. Additionally, individual subscale scores for each of the five dimensions range from +8 to -8 on the extent to which the participant agrees with the item. The subscale scores also capture differences between individuals as a concrete measure of participant attitudes and perceptions to individualize a customized approach to diversity training efforts as well as to measure the efficacy of diversity training efforts (De Meuse & Hostager, 2001).

Intent to hire

The investigator used two yes/no questions to gather data about leader's intent to consider and intent to hire. The following statements were included in the survey:

I.   I intend to consider diverse candidates

II.   I intend to hire diverse candidates

The data were stored in organizationally approved software systems BOX cloud, Redcap, and SPSS. The electronic data will be stored for five years. A summary of the findings may be shared with nurse leaders, staff, newsletters, and publications.

Figure 2

Theory of Planned Behavior (TPB)
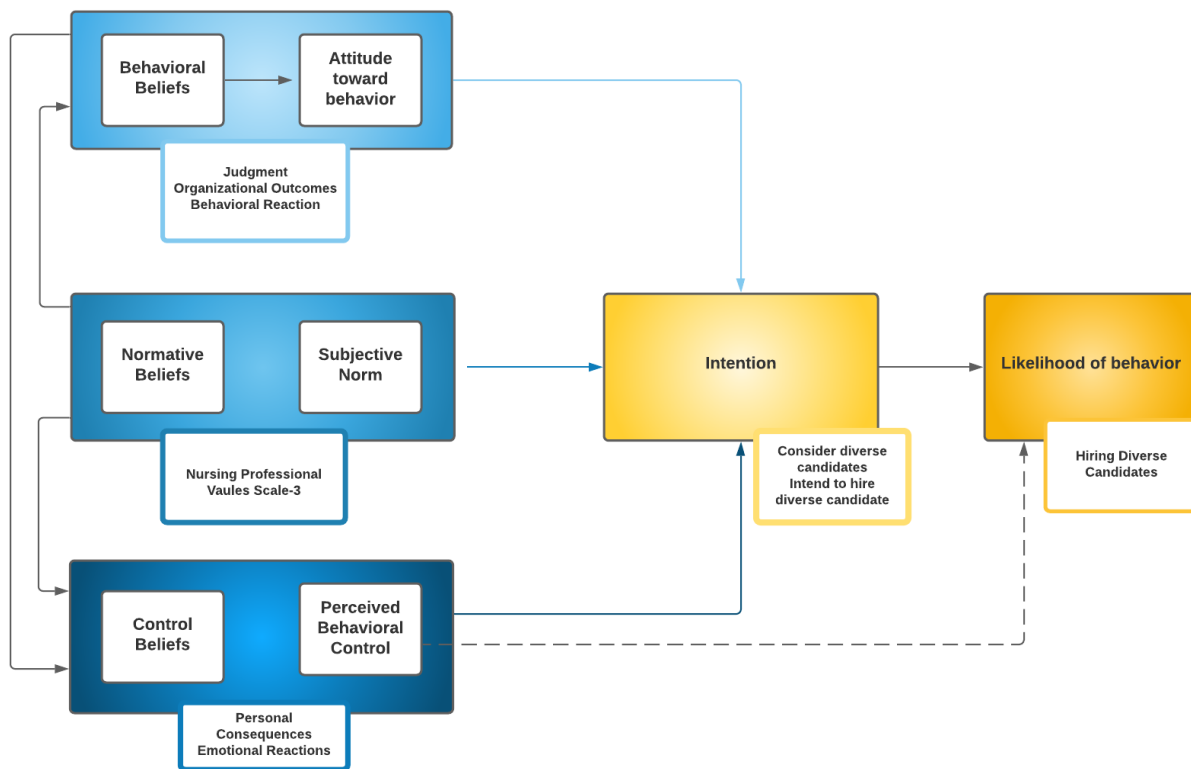
Analysis

Descriptive statistics were used to describe and characterize the sample, identify the

mean and standard deviation. Using SPSS software, the data will be analyzed for relationships

(correlation) among diversity and nursing professional roles that influence nurse leaders'

intention to hire for diversity. Analysis of variance (ANOVA) will be used to characterize how

themes vary by nurse leader demographics, characteristics, and exposure to diversity training and

test for differences. Multiple regression analysis will be used to determine the effect of diversity

and professional responsibilities on the intent to hire a diverse nursing workforce. The data will be stored on password-protected computers for 5years and then destroyed.

Ethical Considerations

The project was approved through the IRB process for the protection of human subjects as a minimal risk protocol. A consent information sheet was provided describing possible risks, benefits, and consent for participation. Several modifications were made to the consent-information sheet, recruitment instructions, and survey completion message. The edits to the consent information sheet included informing the participants that the study would not be anonymous, but rather that their responses will be kept confidential. The OCTRI installation of REDCap does not allow for anonymous surveys when the investigator is creating the survey. The participants' emails are associated with their responses and are only accessible to the PI and Co-investigator. Secondly, the consent question was made more definitive. The initial question stated "if you would like to participate in the study, no further action is needed" and revised to provide the following options: "Yes, I agree to participate" or "No, I do not wish to participate." The recruitment email was revised to inform participants that all questions require a response to the survey for completion. This was an effort to improve the data collection of necessary data for analysis. Lastly, there was a "survey complete" message added to the end of the survey that instructed the participant to reach out to the study team with any questions about the survey.

<div align="center">

Results

</div>

The data of nurse leaders/managers and non-nurse leaders who hire nurses were collected using OCTRI's installation of REDCap. The survey was launched using OCTRI's installation of REDCap proceeded by two follow-up messages, one reminder message per week

for two consecutive weeks, prompting participants to consider completing the survey. The survey closed one week after the last reminder message.

Sample Characteristics

The survey was distributed to 96 leaders in the organization and 42 leaders completed the survey, a response rate of 44%. The participants are unequally distributed throughout six clusters within the organization. All of the participants have attended UBT (See Tables 3 and Table 6).

Table 3

Years in nursing leadership groups per cluster

			Years in nursing leadership groups				
			0-5	6-10	11-15	16 and older	Total
Cluster	Critical Care	Count	1	0	1	2	4
		% within cluster	25.0%	0.0%	25.0%	50.0%	100.0%
		% within years in nursing leadership by group	9.1%	0.0%	16.7%	20.0%	10.3%
	Acute Care	Count	0	6	0	2	8
		% within cluster	0.0%	75.0%	0.0%	25.0%	100.0%
		% within years in nursing leadership by group	0.0%	50.0%	0.0%	20.0%	20.5%
	Periop & Procedural	Count	4	3	1	3	11
		% within cluster	36.4%	27.3%	9.1%	27.3%	100.0%
		% within years in nursing leadership by group	36.4%	25.0%	16.7%	30.0%	28.2%
	Nursing Admin	Count	3	2	2	2	9
		% within cluster	33.3%	22.2%	22.2%	22.2%	100.0%
		% within years in nursing leadership by group	27.3%	16.7%	33.3%	20.0%	23.1%
	Ambulatory	Count	2	1	0	1	4
		% within cluster	50.0%	25.0%	0.0%	25.0%	100.0%
		% within years in nursing leadership by group	18.2%	8.3%	0.0%	10.0%	10.3%
	Women's & Children's	Count	1	0	2	0	3
		% within cluster	33.3%	0.0%	66.7%	0.0%	100.0%
		% within years in nursing leadership by group	9.1%	0.0%	33.3%	0.0%	7.7%
Total		Count	11	12	6	10	39
		% within cluster	28.2%	30.8%	15.4%	25.6%	100.0%

% within years in nursing leadership by group	100.0%	100.0%	100.0%	100.0%	100.0%

Aim 1: Describe nurse leaders' current beliefs of diversity and professional role responsibilities and intent to hire.

NPVS-3 Scale

Descriptive statistics were used to describe and characterize the sample. The total NPVS-3 comprises all questions asked on the scale. The factors are collections of grouped questions that are reflective of and inherent to the provisions located in the Nursing Code of Ethics (See Table 4).

Table 4

Descriptive Statistics NPVS3 and Factors

	N	Mean	Std. Deviation	Minimum	Maximum
Total NPVS3	42	121	12.81	95	140
Caring Factor	42	46.52	3..38	40	50
Activism Factor	42	39.28	7.08	25	50
Professionalism Factor	42	35.19	4.15	27	40

Note. Adapted from Nursing Professional Values Scale-3, by Weis & Schank, 2009. Used with permission from authors.

WDS Scale and subscales

The WDS summary score was computed by adding the 10 positive WDS questions together to create a Positive WDS group. The 10 negative WDS questions were added together to create a negative WDS group. The negative WDS group was then added to the positive WDS score to create a Total WDS summary variable. The WDS survey has a total range of scores -40

to +40 based on the extent to which the participant agreed with the statement (N=42; M=26.85, SD=6.22) (Table 5).

There are five subscales for WDS, each subscale score was computed by added the 2 positive questions and the 2 negative questions for each subscale to create a subscale factor score. Each factor has the possible range of points from +8 to -8 based on the extent to which the participant agreed with the statement (Table 5). The judgment factor is about the individual's beliefs about diversity in principle; if diversity is either "good" or bad" (M=6.8, SD=1.32). The emotional factor is the initial responses to workplace diversity or their visceral reaction when they think about diversity, (M=4.54, SD=1.32). The behavioral reaction factor is the intention to responding to the diversity that is either planned or unplanned (M=6.69, SD=2.71). The personal consequences are the perceived outcomes for the leader and perceptions of how diversity affects them (M=4.54, SD=2.71). The organizational outcomes are the person's view on how diversity impacts or affects the company as a whole (M=2.69, SD=1.63) (Table 5).

Table 5

Descriptive Statistics Total WDS and WDS subscales

	N	Mean	Std Deviation	Minimum	Maximum
Total WDS	42	26.85	6.22	16	38
WDS Judgement	42	6.80	1.32	4	8
WDS Emotional	42	4.54	2.71	-1	8
WDS Behavioral Reaction	42	6.69	1.53	3	8
WDS Personal Consequence	42	4.54	2.71	-1	8
WDS Organizational Outcomes	42	2.69	1.63	-2	6

Note: Adapted from the Workplace Diversity Scale, by DeMeuse, Hostager, & ONeill, 2007). Used with permission from the author.

Intent to consider and hire diverse candidates

There were two questions on the survey that captured Leaders' intent to consider and intent to hire diverse candidates. All leaders (N=42) answered "yes, that they intend to consider diverse candidates", and "yes they intend to hire diverse candidates."

Aim 2: Explore relationships among factors of diversity and nursing professional role and intent to hire for diversity.

A Pearson Correlation examined the relationship between several variables: years in nursing leadership, total WDS scores, subscales scores of the WDS, total NPVS3 scores, and attendance of UBT at OHSU or outside of OHSU (Table 6). The years of experience as a leader and diversity perceptions and attitudes as measured by the total WDS summary are positively related, whereas the years of nursing leadership and Nursing Professional Values as measured by the NPVS-3 are not related.

Years of leadership are positively related to the Behavioral Reaction subscale. Four subscales are positively related with the total WDS summary; Emotional subscale), Personal Consequence subscale, Behavioral Reaction subscale, and the Organizational Outcomes subscale. The Judgment subscale and the total WDS summary have a relationship that is positive, medium in strength, and statically significant, however, the Personal Consequence subscale has a relationship that is positive, strong in strength, and statistically significant with the Emotional subscale.

Additionally, the Emotional subscale has a relationship that is positive, medium in strength, and statistically significant with the Behavioral Reaction subscale, and the Organizational Outcomes subscale. There are two subscales that have a relationship that is positive, medium in strength, and statistically significant with the NPVS-3; Behavioral Reaction subscale, and the Organizational Outcomes subscale. The Judgement subscale was not correlated

with statistical significance with the NPVS-3(r=.07, ns) or any of the other subscales; Emotional (r=.06, ns), Behavioral Reactions (r=.27, p<ns), Personal Consequence (r=.06, p<.ns), or Organizational Outcomes (r=.28, p<ns). There were two subscales that were not correlated to years of leadership; the Personal Consequence subscale and the Emotional subscale.

There was no correlation between attending a UBT and years in leadership, total WDS summary or the WDS subscales, the NPVS3, or intent to consider or hire.

Table 6

Correlation Matrix

		Years in nursing leadership	Total WDS Summary Score	Total NPVS 3	WDS Judgment	WDS Emotional	WDS Behavioral Reaction	WDS Personal Consequence	WDS Org Outcome	Intend to consider diverse candidate	Intend to hire diverse candidate
Years in nursing leadership	Pearson Correlation										
	Sig. (2-tailed)										
Total WDS	Pearson Correlation	.450									
	Sig. (2-tailed)	0.004									
TotalNPVS3	Pearson Correlation	0.120	.539								
	Sig. (2-tailed)	0.467	0.000								
WDS Judgment	Pearson Correlation	0.299	.477	0.067							
	Sig. (2-tailed)	0.064	0.001	0.672							
WDS Emotional	Pearson Correlation	0.265	.795	.446	0.057						
	Sig. (2-tailed)	0.103	0.000	0.003	0.722						
WDS Behavioral Reaction	Pearson Correlation	.416	.709	.446	0.269	.450					
	Sig. (2-tailed)	0.008	0.000	0.003	0.085	0.003					

WDS Personal Consequence	Pearson Correlation	0.265	.795	.446	0.057	1.000	.450				
	Sig. (2-tailed)	0.103	0.000	0.003	0.722	0.000	0.003				
WDS Organizational Outcomes	Pearson Correlation	0.298	.719	.446	0.208	.502	.457	.502			
	Sig. (2-tailed)	0.066	0.000	0.003	0.185	0.001	0.002	0.001			
Intend to Consider Divers Candidates	Pearson Correlation	.b	.b	.b	.b	.b	.b	.b	.b		
	Sig. (2-tailed)										
Intend to hire diverse candidates	Pearson Correlation	.b	.b	.b	.b	.b	.b	.b	.b	.b	.b
	Sig. (2-tailed)										

**. Correlation is significant at the 0.01 level (2-tailed).

b. Cannot be computed because at least one of the variables is constant.

Aim 3: Explore how themes vary by nurse leader demographics, characteristics, and exposure to diversity training.

The sample included both nurse leaders (n=38) and non-nurse leaders (n=4). Independent samples t-tests were conducted to test for differences between the two groups for the WDS summary scores and the NPVS-3 scores. There was no significant difference in the scores of nurse leaders' WDS summary scores (*M*=26.7, *SD*=6.09) and non-nurse leaders' WDS summary scores (*M*=28.3, SD=9.29) or nurse leaders' NPVS-3 scores (*M*=121, *SD*=12.7) and non-nurse leaders' NPVS-3 scores (*M*=116, *SD*=14.9). Conditions; total WDS Summary scores t(.42)=0.39, p=0.67, and NPVS-3 scores t(-.56)=2.23, p=0.62. Levene's test for equality of variances was found to be violated for the present analysis.

WDS

A one-way between-subjects ANOVA was conducted to compare the effect of years in nursing leadership (0-5 years, 6-10 years, 11-15 years, 16+ years) as the independent variable and workplace diversity perceptions and attitudes overall and each subscale as the dependent variables. The results of the ANOVA revealed a statistically significant difference between groups of leaders with years of nursing leadership experience (0-5yrs, 6-10yrs, 11-15yrs,

16+years) and total WDS summary scores (F(3,35) = 3.41, p<.028), and in the subscale of

workplace diversity Behavioral Reactions; (F(3,35) = 2.88, p<.050). The Bonferroni post-hoc

analysis revealed that leaders with 16+years of experience (*M*=31.40, *SD*=4.70) scored

significantly higher than leaders with 0-5years of experience (*M*=23.91, *SD*=6.14) on the WDS

survey (p=.025). (See table 7 & 8)

There was no significant difference among leadership groups on Judgment, Emotional,

Personal Consequence, or Organizational Outcomes. The null hypothesis that there is no

difference in workplace diversity perceptions and attitudes in groups of leaders based on years of

leadership and between groups of leaders based on years of leadership would be rejected.

NPVS-3

A one-way ANOVA was conducted to determine if there was a difference between years

in nursing leadership as the independent variable and nursing professional values as measured by

the NPVS-3 survey. The results of a one-way ANOVA revealed no difference in years of nursing

leadership experience on overall nursing professional values (F(3,35)=1.10, p<.36). (Table 7)

UBT

A one-way between-subjects ANOVA was conducted to compare the effect of years in

nursing leadership as the independent variable and exposure to diversity training through

attending an OHSU UBT or attending any UBT. The results of the ANOVA revealed

no difference between groups of leaders with years of nursing leadership experience (0-5yr, 6-

10yrs, 11-15yrs, 16+years) and attendance to an OHSU UBT (F(3,35)=2.23, p<.10) or attending

any UBT (F(3,35)=1.04, p<.39).

Table 7

	ANOVA				
	Sum of Squares	df	Mean Square	F	Sig.

Total WDS	Between Groups	319.043	3	106.348	3.414	0.028
	Within Groups	1090.392	35	31.154		
	Total	1409.436	38			
TotalNPVS3	Between Groups	535.847	3	178.616	1.101	0.362
	Within Groups	5677.127	35	162.204		
	Total	6212.974	38			
WDS Judgement	Between Groups	6.215	3	2.072	1.291	0.293
	Within Groups	56.144	35	1.604		
	Total	62.359	38			
WDS Emotional	Between Groups	27.883	3	9.294	1.262	0.302
	Within Groups	257.809	35	7.366		
	Total	285.692	38			
WDS Behavioral reaction	Between Groups	18.472	3	6.157	2.883	0.050
	Within Groups	74.759	35	2.136		
	Total	93.231	38			
WDS Personal Consequence	Between Groups	27.883	3	9.294	1.262	0.302
	Within Groups	257.809	35	7.366		
	Total	285.692	38			
WDS Organizational Outcomes	Between Groups	15.508	3	5.169	1.985	0.134
	Within Groups	91.159	35	2.605		
	Total	106.667	38			

Table 8

Dependent Variable			Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Total WDS	0-5	6-10	-1.84091	2.32988	1.000	-8.3567	4.6749
		11-15	-2.25758	2.83276	1.000	-10.1797	5.6645
		16 and older	-7.49091	2.43877	0.025	-14.3112	-0.6706
	6-10	0-5	1.84091	2.32988	1.000	-4.6749	8.3567
		11-15	-0.41667	2.79079	1.000	-8.2214	7.3881
		16 and older	-5.65000	2.38989	0.143	-12.3336	1.0336
	11-15	0-5	2.25758	2.83276	1.000	-5.6645	10.1797
		6-10	0.41667	2.79079	1.000	-7.3881	8.2214
		16 and older	-5.23333	2.88232	0.468	-13.2940	2.8274
	16 and older	0-5	7.49091	2.43877	0.025	0.6706	14.3112
		6-10	5.65000	2.38989	0.143	-1.0336	12.3336
		11-15	5.23333	2.88232	0.468	-2.8274	13.2940

*. The mean difference is significant at the 0.05 level.

Aim 4: Explore how factors of diversity and professional role predict intent to hire for diversity

The aim to explore how factors of diversity and professional role predict the intent to hire for diversity was unable to be met. There was no variation in responses to the questions of "do you intend to consider diverse candidates" and "do you intend to hire diverse candidates." With no variation in responses, it was not possible to conduct multiple regression

Discussion

Understanding nurse leaders' existing beliefs of diversity and unique professional responsibilities and exploring the relationship among these and the intent to hire for diversity is essential to improve nursing workforce diversity. In this project, a survey was developed and implemented to collect data about nurse leaders' current beliefs of diversity and professional role responsibilities to meet the aims of this project to improve nursing workforce diversity.

Using the Theory of Planned behavior to predict nurse leaders' intention to hire diverse candidates was beneficial to identify how perceptions and attitudes of diversity (Behavioral Beliefs), professional role accountability (Normative Beliefs), and perception of personal consequences (Perceived Behavioral Control) may influence nurse leaders' intention to hire diverse candidates. Several important findings emerged from the data. Leaders' behavioral beliefs related to diversity were positive overall (WDS Summary score), which indicates that the leaders' beliefs or attitudes are that diversity is good in principle (Judgment subscale) and they plan to support diversity (Behavior Reaction subscale).

Many of the scores are in the upper one-third of the possible scores indicate that the leaders in the organization can be considered diversity optimists rather than realists or pessimists (De Meuse et al., 2007). In contrast to the DeMeuse et al. (2007) study, all the

participants of this survey are "diversity optimists," whereas De Meuse et al. (2007) study 50%

of managers were optimists and 50% were realists. The differences in scoring could be

influenced by the current state of global unrest over racial injustices and/or the commitment to

diversity and inclusion efforts at a personal or organizational level.

Years of experience as a leader and diversity perceptions and attitudes are positively

related. As leaders gain years of experience in leadership, their overall feelings, responses to

diversity, and beliefs about the advantages of diversity also increase. This finding is an

important consideration when reviewing the landscape of leadership and determining succession

planning. Newly emerging leaders may face challenges with advancing diversity efforts and

in hiring a diverse nursing workforce. Using the WDS subscale to explore detailed information

about new leaders' perceptions and attitudes about diversity may provide valuable insight into

developing an individualized approach for training and resource allocation to support leadership

development (De Meuse & Hostager, 2001). Additionally, the organization would benefit from

knowledge about diversity perceptions and attitudes of the team that influence culture and

climate.

All five of the WDS subscales have a relationship with the WDS summary score, which

is not surprising; these relationships are consistent with the results of previous studies (De Meuse

& Hostager, 2001). Interestingly, the Judgement subscale was independent of the other

subscales and the NPVS-3. The items in the Judgment subscale require a determination about

diversity being fair or worthless, good or unjust. The judgment scale being independent in this

survey may be due to the current social climate of social injustice and anti-racism

movement. Participants may have perceived that these items initiated reflection about their

values and that this outward declaration is a reflection of them in either a positive or negative

way, depending on how the participants choose to respond. Thus, participants may experience

vulnerability in responding to questions that they perceived as a direct reflection of them in a

time of social injustice. Overall, the leaders' behavioral belief system about diversity positively

contributes to their intention to consider and hire diverse candidates. Thus the construct of

behavioral beliefs and attitudes was favorable and contributes to leaders' intention to consider

and hire diverse candidates.

The normative beliefs construct in the TPB posit that people adopt the norms of the

group. Enacting professional responsibilities such as moral courage are the norms of the nursing

profession. Leaders' responses were in the top quartile of overall possible scores

indicating a high degree of alignment with professional values (Weis & Schank, 2009). Leaders

hiring nurses recognize the importance of professional values. Consistent with the Leduc and

Kotzer's study (Le Duc & Kotzer, 2009), years of nursing leadership and Nursing Professional

Values were not correlated, indicating that nurse leaders at any level of experience may have

values strongly aligned with professional values, thus recognizing the importance of professional

values. Using the TPB, the normative beliefs of strong alignment with professional values

positively contributes to the intention and behavior of hiring diverse candidates.

The final construct of TPB is control belief. The Personal Consequences subscale and

emotional subscale responses had a direct relationship. A gap in the Theory of Planned Behavior

is that the framework does not account for emotions, and how emotions can impact belief in

taking action (Ajzen, 2019). The leaders' responses to the Emotional subscale provided

information about their visceral response to diversity. The leaders' scores were on the higher end

of the subscales indicating that diversity has a positive impact on them personally and

emotionally and contributes to the prediction that leaders are more likely to hire diverse candidates.

All three constructs in the TPB were favorable. Although it was not possible to predict intent to hire, the favorable constructs suggest nurse leaders would make decision to hire diverse candidates.

Limitations

This survey was a cross-sectional survey and provided data at one point in time. The survey focused on describing leaders' current beliefs of diversity and professional role responsibilities and the intent to hire a diverse nursing workforce. The NPVS-3 survey created in REDCap was transcribed directly from the survey found in the literature. This direct transcription of survey questions resulted in the questions being grouped by factors 1) Caring, 2) Activism, and, 3) Professionalism, instead of how the instrument author intended. Arranging questions in groups may have influenced how leaders scored the questions.

This author's review of the evidence concluded that the relationships between nursing professional values and leaders' perceptions and attitudes of diversity may influence hiring decisions. Confirmation bias may have influenced the lack of seeking evidence that opposes this stream of thinking and offers additional perspectives when considering improvement efforts.

In the current state of global unrest over social injustice and the anti-racism movement following the deaths of Ahmaud Arbery, George Floyd, and Breonna Taylor, among many others, participants may have been influenced to respond to the questions in a socially desirable way. Secondly, this survey was conducted during a pandemic at a health care organization that had slowed hiring in response to cost constraints immediately before the pandemic restricted hiring opportunities. Leaders' attitudes may have been influenced by these situational factors.

The generalizability of these results may be limited because the study was conducted in a single institution that was predominantly not diverse. This project is a snapshot of time in the setting of the current organizational climate of taking beginning steps to become an anti-racist organization, in the larger context of global injustice.

Conclusions

In general, the WDS survey of leaders found that leaders were diversity optimists. Leaders demonstrated positive relationships between behavior, normative, and control beliefs, suggesting they would consider or hire diverse applicants. Additional study is needed to determine if diversity optimists actually hire for diversity when qualified candidates are available and that's reflected in the nurse population data in the next few years.

This project can inform human resource efforts for leader development through individualized training and resource allocation. Newly emerging leaders may face challenges with advancing diversity efforts and in hiring a diverse nursing workforce. There is value in expanding the WDS and NPVS-3 survey to all clinical nursing staff to compare leaders' attitudes and perceptions of diversity with the clinical staff they lead. There is also an opportunity to expand the WDS and NPVS-3 survey to other members of the interview team that may influence hiring decisions, although have no direct hiring authority. There is also opportunity to expand the WDS survey to other health care team members such as Certified Nursing Assistants. Replicating this project in another setting or state with a more diverse nursing staff may provide additional insight about perceptions and attitudes of diversity and the intention to hire diverse candidates.

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